Stanislaus County BHRS

Substance Use Disorder Services Programs

Program Monitoring

Monitoring Instrument FY __/__

Program Name:	**Program Monitor:**
Program Staff in Attendance:	
Date Completed:	**CAP Required: Yes / No**
Funding Source: □ SABG □ DMC □ Other:	
Service Modality: □ Res □ W/M □ IOT □ OP □ NTP □ Youth TX □ Ed/Prev. □ Other:	

INSTRUCTIONS:

- This Monitoring Tool applies to both BHRS-Managed and BHRS-Subcontracted Providers.
- Intended for Compliance with the Requirements of the SABG, DHCS IA, and the DHCS SUDS Contract Terms.
- Users of this Monitoring Tool should familiarize themselves with the documents referenced herein.
- A Standard Rating of Met, N/I (Needs Improvement), I/A (Immediate Action required), or N/A (Not Applicable) is to be determined. TA (Technical Assistance) can be provided upon the request of the provider.
- Submit this document, the Annual Site Review, the Peer Review Monitoring Letter and any other required documents for this Fiscal Year to contracts

#	Compliance	Regulation	Ratings	Monitor Use Only
1	**Perinatal Services Network Guidelines** (Perinatal Providers Only) Please attest that your program is in compliance with Perinatal Service Network Guidelines. ___ Program Staff initials Please provide an example of a component of the Perinatal Services Network Guidelines that your program uses:	DHCS Perinatal Services Network Guidelines promulgated pursuant to 45 CFR 96.137	Check One √ **Met** **N/I** **I/A** **N/A** TA requested: **Y / N**	Target Population of Pregnant and Parenting Women, Admission Priority to Pregnant Women, Primary Medical Care that includes child care services Primary Pediatric, Care for the children of Pregnant and Parenting Women, Gender-Specific Services, Therapeutic Interventions for children, CM, Transportation, Capacity Management, Referrals, Waiting list, Interim Services, Outreach Services, Best Practices
2	**Youth Treatment Guidelines** (All SUD Youth Treatment Providers) Please attest that your program is in compliance with Youth Treatment Guidelines. ___ Program Staff initials Please provide an example of a component of the Youth Treatment Guidelines that your program uses:	DHCS Youth Treatment Guidelines	Check One √ **Met** **N/I** **I/A** **N/A** TA requested: **Y / N**	Target Population for Youth Treatment, Assessing the Desired Client Outcomes, Outreach Services, Screening Services, Initial and Continuing Assessment Services, Diagnostic Services and Assessment, Placement, Services, Treatment Planning Services, Counseling Services, Youth Development Approaches to Treatment, Family Interventions and Support Services, Educational and Vocational Activities, Structural Recovery-Related Activities, Alcohol and Drug Testing, Discharge Planning, Continuing Care, CM and Complementary Services, Critical Linkages and Collaboration, Culture and Language Appropriate Services, Health and Safety Issues, Medication Management, Emergency Services, Detoxification Services, Building/Grounds Licensure and Condition, Legal, Ethical and Administrative Issues

3	**Primary Prevention** (All Primary Prevention Programs) Please attest that your program is in compliance with Stanislaus County BHRS Strategic Plan for Substance Use Disorder Prevention. ___ Program Staff initials Which of the below prevention strategy(s) does your program use: ___Information Dissemination ___Education ___Alternatives ___Problem ID & Referral ___Community Based ___Environmental ___SPFCs ___Sustainability ___Cultural Competence	SAPT BG requirements of 45 CFR 96.125 Current Stanislaus County BHRS Strategic Plan for Alcohol and Other Drug Prevention	Check One √ **Met** **N/I** **I/A** **N/A** TA requested: **Y / N**	Information Dissemination Strategy, Education Strategy, Alternatives Strategy, Problem Identification and Referral Strategy, Community-Based Process Strategy, Strategic Prevention Framework Components and Cycle: Assessment, Capacity, Planning, Implementation, & Evaluation, Sustainability, Cultural Competence.
4	**Culturally and Linguistically Appropriate Services (CLAS)** (All BHRS Programs and Providers) Does your program send a representative to Cultural Competency, Equity and Social Justice Committee (CCESJC)? Who attends? How does this representative disseminate the information from CCESJC meeting back to the program?	Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards	Check One √ **Met** **N/I** **I/A** **N/A** TA requested: **Y / N**	Principle Standard: 1) Governance, Leadership, & Workforce: 2) 3) 4) Communication and Language Assistance: 5) 6) 7) 8) Engagement, Continuous Improvement, & Accountability: 9) 10) 11) 12) 13) 14) 15)

5	**Nondiscrimination Employment and Services** (All BHRS Programs and Providers) Please attest that your program is in compliance with Federal and State, Nondiscrimination Employment and Service Regulations. ___ Program Staff initials Please provide an example of your programs compliance with the Nondiscrimination Employment and Services regulations:	Title VI of the Civil Rights Act of 1964, Section 2000d. Title VIII of the Civil Rights Act of 1968 (42 USC 3601 et seq.).42 CFR Part 90. 29. CFR Part 1625. 29 CFR Part 1630. 28 CFR Part 35. 28 CFR 36 Section 504 of the Rehabilitation Act of 1973 (29 USC Section 794). Executive Order 11246 (42 USC 2000e & 41 CFR Part 60). Executive Order 13166 (67 FR 41455) The Drug Abuse Office & Treatment Act of 1972, as amended. The Drug Abuse Office & Treatment Act of 1972, as amended. The Comprehensive Alcohol Abuse & Alcoholism & Prevention Treatment & Rehabilitation Act of 1970 (P.L. 91-616, as amended). The California Fair Employment & Housing Act (Government Code Section 12900 et seq.) & the applicable regulations promulgated thereunder (California Administrative Code Title 2, Section 7285.0 et seq.). Title 2, Division 3, Article 9.5 of the Government code, commencing with Section 11135. Title 9, Division 4, Ch. 6 of the CCR, commencing with Section 10800.	Check One √ **Met** **N/I** **I/A** **N/A** TA requested: **Y / N**	
6	**California Outcomes Measurement Services (CalOMS)** (All SUD BHRS Programs and Providers) Does your treatment program submit CalOMS data at admit, annual update and discharge? Who is responsible for correcting CalOMS error reports sent by BHRS DMS/PM? Does Prevention Services collect and submit service/activity and evaluation data into CalOMS Pv.?	California Outcomes Measurement System (CalOMS) rules and requirements State-County Contract, Exhibit A, Attachment I, Part III, B, 7	Check One √ **Met** **N/I** **I/A** **N/A** TA requested: **Y / N**	

7	**DATAR/Waiting List Record** (All BHRS and Provider SUD Treatment Providers) Does your program submit a monthly DATAR report? Who is at your program is responsible for submitting this report? What date must this report be submitted by? In the last year has your program used the Waiting List Record report of DATAR to report applicants not immediately admitted due to lack of capacity?	45 C.F.R§ 96.126 (c) State-County Contract Exhibit A, Attachment I, Part II, M	Check One √ **Met** **N/I** **I/A** **N/A** TA requested: **Y / N**	
8	**Group Counseling Sign-in Sheets** (All BHRS and Provider SUD Treatment Providers) Please provide a copy of one of your programs group sign-in sheets.	Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 13	Check One √ **Met** **N/I** **I/A** **N/A** TA requested: **Y / N**	(A) The typed or legibly printed name and signature of the therapist(s) and/or counselor(s) conducting the counseling session. By signing the sign-in sheet the therapist(s) and/or counselor(s) certify that the sign-in sheet is accurate and complete. (B) The date of the counseling session. (C) The topic of the counseling session. (D) The start and end time of the counseling session. (E) A typed or legibly printed list of the participants' names and the signature of each participant that attended the counseling session. The participants shall sign the sign-in sheet at the start of or during the counseling session.
9	**DMC-ODS Training** (All SUD Treatment Providers) Please provide verification of your programs DMC-ODS training attendance.	Intergovernmental Agreement Exhibit A, Attachment I, III, GG, 3, i	Check One √ **Met** **N/I** **I/A** **N/A** TA requested: **Y / N**	

10	**Interim Services** (All SUD Treatment Providers) Has your program provided Interim Services due to a waiting list for treatment in the last year? If so, what information is provided? What additional topic(s) and/or referral(s) are provided for pregnant women in Interim Services?	State-County Contract Exhibit A, Attachment I, Part II, R Perinatal Services Network Guidelines FY 2016-17 45 CFR § 96.126 (b) (2); 96.131 (d)(2)	Check One √ **Met** **N/I** **I/A** **N/A** TA requested: **Y / N**	-Human Immunodeficiency Virus (HIV) -Tuberculosis (TB) -Risks of needle sharing -Risks of HIV & TB transmission to sexual partners & infants -Steps to ensure HIV & TB transmission does not occur -If necessary, referral for HIV or TB treatment services Additionally for pregnant women: -Counseling on the effects of alcohol & drugs use on the fetus, and -Referral for prenatal care
11	**TB Screening** (All SUD Treatment Providers) How does your program screen for TB? If a client is identified to be at risk or is suspected of having TB, what further steps would your program take?	State-County Contract Exhibit A, Attachment I, Part II, M State-County Contract Exhibit A, Attachment I, Part I, Section 3, A, 1, a-e or Provider Contract	Check One √ **Met** **N/I** **I/A** **N/A** TA requested: **Y / N**	
12	**Charitable Choice** (SAPT Block Grant Providers) Did the contract provider respond to the County with the total number of referrals necessitated by religious objection to other alternative substance abuse providers (including zero)?	State-County Contract, Exhibit A, Attachment I, Part III, F Title 42 CFR, Part 54	Check One √ **Met** **N/I** **I/A** **N/A** TA requested: **Y / N**	-Nondiscrimination against religious organizations Religious activities -Religious character and independence -Employment practices -Nondiscrimination requirement -Right to services from an alternative provider -Assurances and State oversight of the Charitable Choice requirements -Fiscal accountability -Effects on State and local funds -Treatment of intermediate organizations -Educational requirements for personnel in drug treatment programs

13	**Intravenous Drug User (IVDU) Services** (SAPT Block Grant Providers) How does your program ensure that IVDU are identified and triaged into SUD treatment?	State-County Contract Exhibit A, Attachment I, Part I, Section 3, A, 1, a-e or Provider Contract	Check One √ **Met** **N/I** **I/A** **N/A** TA requested: **Y / N**	
14	**Americans with Disabilities Act** (All BHRS Programs and Providers) Please attest that your program is in compliance with Americans with Disabilities Act requirements. ___ Program Staff initials	Americans with Disabilities Act (ADA) of 1990 State-County Contract Exhibit A, Attachment I, Part I, Section 3, B, 2, f & g	Check One √ **Met** **N/I** **I/A** **N/A** TA requested: **Y / N**	
15	**Trafficking Victims Protection** (All BHRS Programs and Providers) Please attest that your program is in compliance with Trafficking Victims Protection Act (TVPA) of 2000. ___ Program Staff initials	Section 106(g) of the Trafficking Victims Protection Act of 2000 as amended (22 U.S.C. 7104)	Check One √ **Met** **N/I** **I/A** **N/A** TA requested: **Y / N**	
16	**Fiscal Requirements** (SAPT Block Grant Providers) Please attest that your non-profit program is in compliance with the financial management standards. ___ Program Staff initials	Title 45, CFR, Part 74, Sections 74.21(b)(1) through (4) and (b)(7), and Part 96, Section 96.30.	Check One √ **Met** **N/I** **I/A** **N/A** TA requested: **Y / N**	

17	**Counselor Certification** (All SUD Treatment Providers) Does your program require that all SUD treatment staff be registered, certified or licensed? Does your program ensure that at least 30% of SUD treatment staff are certified? Please provide proof that all of your SUD treatment staff are registered, certified or licensed and that at least 30% are certified.	Title 9, CCR, Division 4, Chapter 8. State-County Contract Exhibit A, Attachment I, Part II, J, Exhibit A, Attachment I, Part II, Y, Exhibit A, Attachment I, Part II, J	Check One √ **Met** **N/I** **I/A** **N/A** TA requested: **Y / N**	
18	**Minimum Quality Drug Treatment Standards** (All SUD Treatment Providers) Compliance with the following Minimum Quality Treatment Standards is required for all SUD treatment programs (contractors and sub-contractors) either partially or fully funded by Substance Abuse and Prevention Treatment Block Grant (SABG) and/or Drug Medi-Cal). Please attest that your program is in compliance with the Minimum Quality Drug Treatment Standards. ___ Program Staff initials	State-County Contract Exhibit A, Attachment I, Part I, Section 1, C, 5 or Provider Contract	Check One √ **Met** **N/I** **I/A** **N/A** TA requested: **Y / N**	
19	**Continuing Education for LPHAs** (All SUD Treatment Providers) Please provide a list of all of your LPHAs providing SUD treatment and proof they have completed their annual 5 CEUs in Addiction Medicine.	IA, Exhibit A, Attachment I, III, A, 1, iv. or Provider Contact	Check One √ **Met** **N/I** **I/A** **N/A** TA requested: **Y / N**	

20	**Needs of Persons with a Disability** (All SUD Treatment Providers) Please attest that barriers to services are considered and addressed for needs of persons with disabilities. ___ Program Staff initials	State-County Contract Exhibit A, Attachment I, Part I, Section 3, B, 2, f & g. or Provider Contract	Check One √ **Met** **N/I** **I/A** **N/A** TA requested: **Y / N**	
21	**Language Accessibility** (All SUD Treatment Providers) Please attest that language differences are not, and do not, become a barrier to services. ___ Program Staff initials Please describe the program specific procedure for handling language differences.	SABG State-County Contract Exhibit A, Attachment I A1, Part I, Section 3, B, 2, (d-e). or Provider Contract	Check One √ **Met** **N/I** **I/A** **N/A** TA requested: **Y / N**	
22	**Evidence Based Practices** (All SUD Treatment Providers) Please describe how your program implements the two required Evidence Based Practices: Motivational Interviewing and Trauma Informed Care	Intergovernmental Agreement Exhibit A, Attachment I, III, AA, 3, iii		

23	**DMC Eligibility** (All SUD Treatment Providers) Please attest that your program verifies DMC eligibility each month of service. ___ Program Staff initials	Intergovernmental Agreement Exhibit A, Attachment I, III, BB, 2, ii		
24	**Coordination of Care/Continuity of Care** (All SUD Treatment Providers) Please describe how your program ensures that coordination of care/continuity of care procedures are followed.	Intergovernmental Agreement Exhibit A, Attachment I, II, E, 3, iii, a		
25	**Substance Use Disorder Medical Director** (All SUD Treatment Providers) Please attest that your medical director's responsibilities include at minimum as outlined in Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 6. ___ Program Staff initials	Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 6		

26	**Provider Personnel** (All SUD Treatment Providers) Please attest that your program personnel files are maintained to that standards outlined in Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 7. ___ Program Staff initials	Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 7		
27	**Beneficiary Admission** (All SUD Treatment Providers) Please attest that your program admission criteria meets the standards outlined in Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 8. ___ Program Staff initials Please confirm with last peer review results____%	Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 8		
28	**Substance Use Disorder Assessments** (All SUD Treatment Providers) Please attest that your program ensures Substance Use Disorder assessments meet the standards outlined in Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 9. ___ Program Staff initials Please confirm with last peer review results____%	Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 9		

29	**Diagnosis Requirements** (All SUD Treatment Providers) Please attest that your program ensures client diagnosis meet the standards outlined in Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 10. ___ Program Staff initials Please confirm with last peer review results____%	Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 10		
30	**Physical Examination Requirements** (All SUD Treatment Providers) Please attest that your program ensures each client has met the physical examination requirements outlined in Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 11. ___ Program Staff initials Please confirm with last peer review results____%	Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 11		
31	**Treatment Plan** (All SUD Treatment Providers) Please attest that your program ensures that client treatment plans meet the treatment plan requirements outlined in Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 12. ___ Program Staff initials Please confirm with last peer review results____%	Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 12		

32	**Progress Notes** (All SUD Treatment Providers) Please attest that your program ensures that client progress notes meet the progress note requirements outlined in Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 14. ___ Program Staff initials Please confirm with last peer review results____%	Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 14		
33	**Continuing Services** (OP, IOT, CCT SUD Treatment Providers) Please attest that your program ensures that continuing services are justified according to the requirements outlined in Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 15. ___ Program Staff initials Please confirm with last peer review results____%	Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 15		

34	**Discharge** (All SUD Treatment Providers) Please attest that your program ensures that discharges are documented according to the standards outlined in Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 16. ___ Program Staff initials Please confirm with last peer review results____%	Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 16		
35	**Reimbursement of Documentation** (All SUD Treatment Providers) Please attest that your program ensures that documented time is documented according to the standards outlined in Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 17. ___ Program Staff initials Please confirm with last peer review results____%	Intergovernmental Agreement Exhibit A, Attachment I, III, PP, 17		

Revised by CC Jan. 09, 2020