

Department of
Health Services

Division of Behavioral Health Services

Implementation Plan for
Drug Medi-Cal
Organized Delivery System
Waiver



Part I

Plan Questions

This part is a series of questions regarding the county's DMC-ODS program.

Part II

Plan Description: Narrative Description of the County's Plan

In this part, the county describes its DMC-ODS program based on guidelines provided by the Department of Health Care Services.

PART I PLAN QUESTIONS

This part is a series of questions that summarize the county's DMC-ODS plan.

1. Identify the county agencies and other entities involved in developing the county plan. (Check all that apply) Input from stakeholders in the development of the county implementation plan is required; however, all stakeholders listed are not required to participate.

- County Behavioral Health Agency
- County Substance Use Disorder Agency
- Providers of drug/alcohol treatment services in the community
- Representatives of drug/alcohol treatment associations in the community
- Physical Health Care Providers
- Medi-Cal Managed Care Plans
- Federally Qualified Health Centers (FQHCs)
- Clients/Client Advocate Groups
- County Executive Office
- County Public Health
- County Social Services
- Child Protective Services
- Law Enforcement
- Court
- Probation Department
- Education
- Recovery support service providers (including recovery residences)
- Health Information technology stakeholders
- Other (specify) Representatives from underserved cultural, racial, ethnic and LGBTQ communities _____

2. How was community input collected?

- Community meetings
- County advisory groups
- Focus groups
- Other method(s): Existing meetings and committees

3. Specify how often entities and impacted community parties will meet during the implementation of this plan to continue ongoing coordination of services and activities.

- Monthly
- Bi-monthly
- Quarterly
- Other: Existing committees, stakeholder boards and other forums were leveraged to ensure the broadest participation.

4. Prior to any meetings to discuss development of this implementation plan, did representatives from Substance Use Disorders (SUD), Mental Health (MH) and Physical Health all meet together regularly on other topics, or has preparation for the Waiver been the catalyst for these new meetings?

SUD, MH, and physical health representatives in our county have been holding regular meetings to discuss other topics prior to waiver discussions.

There were previously some meetings, but they have increased in frequency or intensity as a result of the Waiver.

There were no regular meetings previously. Waiver planning has been the catalyst for new planning meetings.

There were no regular meetings previously, but they will occur during implementation.

There were no regular meetings previously, and none are anticipated.

5. What services will be available to DMC-ODS clients upon year one implementation under this county plan?

REQUIRED

- Withdrawal Management (minimum one level)
- Residential Services (minimum one level)
- Intensive Outpatient
- Outpatient
- Opioid (Narcotic) Treatment Programs
- Recovery Services
- Case Management
- Physician Consultation

How will these required services be provided?

- All County operated
- Some County and some contracted
- All contracted

OPTIONAL

- Additional Medication Assisted Treatment
- Partial Hospitalization
- Recovery Residences
- Other (specify) _____

6. Has the county established a toll free 24/7 number with prevalent languages for prospective clients to call to access DMC-ODS services?

- Yes (required)
- No. Plan to establish by: _____

Review Note: If the county is establishing a number, please note the date it will be established and operational.

7. The county will participate in providing data and information to the University of California, Los Angeles (UCLA) Integrated Substance Abuse Programs for the DMC-ODS evaluation.

- Yes (required)
- No

8. The county will comply with all quarterly reporting requirements as contained in the STCs.

- Yes (required)
- No

9. Each county's Quality Improvement Committee will review the following data at a minimum on a quarterly basis since external quality review (EQR) site reviews will begin after county implementation. These data elements will be incorporated into the EQRO protocol:

- Number of days to first DMC-ODS service/follow-up appointments at appropriate level of care after referral and assessment
- Existence of a 24/7 telephone access line with prevalent non-English language(s)
- Access to DMC-ODS services with translation services in the prevalent non-English language(s)
- Number, percentage of denied and time period of authorization requests approved or denied

Yes (required)

No

PART II PLAN DESCRIPTION (Narrative)

Narrative Description

1. Collaborative Process

Sacramento County has a long history of collaborating with other county agencies, departments and the contracted provider network to enhance system wide efforts. With the rich history of contracted service delivery working side by side with County operated programs and administrative support, this initiative also reached out to the many community stakeholders, consumers, family members and public interest representatives to reflect different perspectives on substance use services. Examples of the types of meetings conducted to gather these viewpoints are listed below:

- Child Protective Services/Alcohol and Drug Services Meetings
- Collaborative Court Meetings
- Criminal Justice Meetings
- Medi-Cal Geographic Managed Care Meetings
- Mental Health/Alcohol and Drug Meetings
- Public Health/Alcohol and Drug Services Meetings
- Service Provider Meetings

Sacramento County Department of Health Services includes the Division of Behavioral Health Services (DBHS). Alcohol and Drug Services (ADS) and Mental Health Services, through a broad organization that includes County operated and contracted providers, manage and deliver a wide variety of behavioral health services across a geographically diverse county. DBHS has a joint administration with the Behavioral Health Director overseeing both ADS and MHS. This structure will be strengthened and further integrated through this implementation plan. In 2015, ADS began a comprehensive community-wide strategic planning process for substance use disorder (SUD) treatment and intervention services. ADS introduced the Drug Medi- Cal Organized Delivery System (DMC-ODS) waiver and the need to develop an implementation plan to community stakeholders through various forums where input and feedback was derived, and a series of Substance Use Disorder (SUD) meetings focused specifically on relevant components of the DMC-ODS Waiver.

The Sacramento County ADS implementation plan development involved receiving feedback from stakeholders and community providers regarding the current alcohol and drug treatment system and anticipated needs for developing an integrated continuum of care. The planning process examined the current level of substance use

disorder services provided by community-based agencies including prevention, early intervention, outpatient treatment, withdrawal management, residential treatment and aftercare; the existing “gaps” within the current service delivery system were also reviewed and assessed. The completed plan serves as a structural foundation for the development and implementation of a comprehensive, integrated continuum of care that is modeled after the American Society of Addiction Medicine (ASAM).

Sacramento County proceeded with conducting a series of stakeholder engagement meetings to ensure the availability of a variety of opportunities to provide feedback on the development of a draft implementation plan and how it will ultimately be operationalized. Sacramento County reached out to a diverse range of stakeholders throughout the community. The stakeholders participating in the process included:

Sacramento County Organized Delivery System Waiver Stakeholder Group Participants	
Adult Protective Services County Administration staff	Law Enforcement (Sacramento Police Department, Sacramento Sheriff’s Department)
Alcohol and Drug Advisory Board members	Mental Health Board members
Alcohol and Drug Services County Administration staff	Mental Health County Administration staff
Alcohol and Drug Services contracted service providers	Mental Health County and contracted service providers
Behavioral Health Services Cultural Competence Committee members	Physical Health service providers
Child Protective Services County Administration staff	Primary Health Division County Administration staff
Community Prevention Coalition members	Probation Department Administration staff
Criminal Justice Partners (District Attorney’s Office, Public Defender’s Office, Correctional Health Administration)	Public Health Advisory Board members
Education Agencies	Public Health Division Administration staff
Geographic Managed Care Health Plans and Hospitals	Youth, Adult and Family Consumer Advocates

Stakeholders and providers have been engaged in the development of the county waiver implementation plan with a focus on improving the quality and availability of SUD services and ensuring increased oversight of the DMC certification requirements with the goal of establishing a partnership with behavioral health providers and community stakeholders in developing an expanded and enhanced comprehensive continuum of care.

Information on SUD needs and resources was collected through several large community meetings. These meetings have been held with other county agencies and stakeholders to discuss and receive feedback regarding the Medi-Cal Waiver plan. The initial kickoff meeting was on July 22, 2016, presenting key features of California's DMC-ODS Waiver, the County implementation plan template, and the process for eliciting stakeholders' feedback. This initial meeting was followed by 15 additional meetings through April, 2017, that provided a review of the plan and produced feedback on each section of the plan.

The feedback and information obtained during these planning sessions served as a structural foundation for the development of a comprehensive, integrated continuum of care that is modeled after the American Society of Addiction Medicine (ASAM).

The following questions anchored the meetings that collecting stakeholder feedback.

1. What are the benefits of the proposed service delivery model to those in need of treatment in Sacramento County?
2. Which of the levels of care need the most attention?
3. What might be some challenges in developing this system of care?
4. Are services in Sacramento County accessible for beneficiaries who need the service? Geographically? Linguistically? Timely?
5. Given the requirements for timely access, what are the barriers to meet them and what are some suggested steps to mitigate the barriers?
6. Recommendations for future information and input?

Discussions with substance use disorder (SUD) treatment providers also included the following questions:

1. What screening or assessment tools are currently used by providers to ensure placement of clients into the appropriate level of care?
2. Describe how clients are referred to other levels of care.
3. Describe how care is coordinated with Mental Health and Primary Care.
4. What indicators and processes does your program use to determine how often to reassess clients?

ADS has been actively involved in building and maintaining partnerships and capacity building efforts to support this system change. Opportunities for ongoing involvement by the various stakeholder groups during implementation will occur in a variety of settings including but not limited to: regularly scheduled meetings between Alcohol and Drug Services and contracted SUD providers; Behavioral Health Services (BHS) meetings; collaborative meetings between BHS/ADS management staff and various stakeholders including probation, law enforcement, physical health, public health, child welfare, advisory boards, hospitals and others. These encounters will include updates on the ongoing involvement in implementation of DMC-ODS services. The focus of discussion at these inter-agency collaborative meetings will include the status of implementation of DMC-ODS services; screening, brief intervention and referral of potential clients; strengthening linkages between referring agencies and DMC-ODS services providers; and addressing issues regarding accessibility and quality of services that may arise.

Examples of collaborative meetings/forums where the county waiver plan has been discussed includes:

- Monthly SUD provider meetings for Executive Directors or designees;
- Participation in Quarterly Behavioral Health Services contracted mental health provider meetings;
- Meetings with methadone clinic directors;
- Weekly Behavioral Health management meetings including, management, administrative staff and youth/family advocates;
- Monthly Quality Improvement Committee (QIC) meetings;
- Monthly prevention provider meetings with the prevention coordinator present;
- Monthly/ Sacramento County Division of Behavioral Health Services Cultural Competence Committee meetings;
- Monthly Alcohol and Drug Advisory Board, Mental Health Board and Public Health Board meetings;
- Monthly ADS budget meetings;
- Other monthly stakeholder meetings are held with Probation, law enforcement, criminal justice partners, Behavioral Health Services, Office of Education staff to coordinate care and improve processes for the assessment and placement of youth in appropriate levels of care. With guidance from the Department of Health Care Services Youth Treatment Guidelines, the Courts, Probation Department, community advocates and community-based treatment providers will be involved in the review and development of the youth System of Care over the next three years.

The implementation plan will continue to engage system and community with a focus on the following areas:

- Hosting focus groups facilitated by the AOD Administrator for contracting partners in preparation for new service - requirements under DMC;
- Providing ongoing DMC technical assistance to providers;
- Assigning designated staff to support DMC certification and documentation requirements;
- Developing a SUD-DMC provider manual and certification and audit tools.

Future collaborative county waiver plan activities will include the alignment of treatment criteria with the American Society of Addiction Medicine (ASAM) Criteria for SUD treatment services, greater accountability for use of evidence-based practices, development of a continuum of care that includes all waiver required services, expanded consumer engagement, development of a measurable system, program and client level outcomes to improve service quality, access and cost efficiency.

The transformation of Sacramento County’s continuum of care will continue to advance through collaborative partnerships and communication. The Alcohol and Drug Advisory Board will also assist with recommendations for the progressive development of the SUD continuum of care. Members of the Alcohol and Drug Advisory Board include:

Adult Protective Services	Provider Community
Child Protective Services	Public Defender’s Office
Community Advocates	Public Health Department
District Attorney’s Office	Sacramento City Police Department
Probation Department	Sacramento Sheriff’s Department

Sacramento County Behavioral Health staff will be responsible for evaluating important functional aspects of the DMC-ODS including but not limited to; the client referral and transitional placement process; coordination and delivery of services for youth and families; accessibility of SUD treatment in unserved/underserved areas, including analysis of disparities; provision of services in primary language of the beneficiary; monitoring human resources to meet the cultural and linguistic needs of beneficiaries and analyze cultural competence and language proficiency across the system; and the increased availability of co-occurring treatment. In addition, DMC-ODS service implementation is a standing agenda item during monthly BHS Quality Improvement Committee meetings and BHS Management meetings. ADS will also present recommendations to other forums such as the BHS Quality Improvement sub-committees and Cultural Competence Committee for consideration and authorization. These committees will be expanded to include Alcohol and Drug Services.

Alcohol and Drug Advisory Board Meetings and SUD prevention/education and treatment provider meetings will continue to occur on a monthly basis providing a forum for addressing the operational status of the DMC-ODS; the assessment, linkage and client support process; service placement/interventions; and issues related to accessibility, service authorizations and transition procedures for high utilizers.

2 Client Flow. Describe how clients move through the different levels identified in the continuum of care (referral, assessment, authorization, placement, transitions to another level of care). Describe what entity or entities will conduct ASAM criteria interviews, the professional qualifications of individuals who will conduct ASAM criteria interviews and assessments, how admissions to the recommended level of care will take place, how often clients will be re-assessed, and how they will be transitioned to another level of care accordingly. Include the role of how the case manager will help with the transition through levels of care and who is providing the case management services. Also describe if there will be timelines established for the movement between one level of care to another. Please describe how you plan to ensure successful care transitions for high-utilizers or individuals at risk of unsuccessful transitions.

Referral

Sacramento County will develop and operate a continuum of care/system of care for Substance Use Disorder (SUD) treatment services for qualified beneficiaries across all ages who meet SUD treatment criteria. Referrals are accepted from all sources including, but not limited to; self, family, schools, hospitals, mental health, criminal justice, juvenile justice, and child welfare services.

Irrespective of the entry point, each beneficiary is screened following the same process and screening tools. The centralized referral process receives referrals via telephone, fax, e-mails and routes referrals to geographically appropriate providers, clinics, services based on the client's preference of location or area to be seen for services. All beneficiaries seeking SUD treatment can access services by contacting the centralized referral process, the BHS 24/7 Access Line or by contacting any network provider and requesting services. All materials for referral to services will be identical and processes will be similar regardless of location and language.

Beneficiaries move through the continuum of care via the BHS 24/7 Beneficiary Access Line, County System of Care Access Points and/or the SUD community provider network.

This implementation is designed with a "no wrong door" vision to enter SUD screening and assessment services. All beneficiaries seeking admission to SUD services can access them by contacting the toll-free 24/7 Beneficiary Access Line, multiple County Access Points or by contacting any county contracted SUD service provider. At that time, the beneficiary will participate in a brief triage assessment, conducted by a licensed or certified/registered counselor with the required experience and as required by ADS policy, to determine the provisional level of care (LOC) based on the American Society of Addiction Medicine (ASAM) Criteria and Medi-Cal eligibility status.

Adults will be referred to the provisional LOC for further assessment. Youth will be referred to a qualified youth outpatient treatment agency where they will receive a full assessment and referral to an appropriate higher LOC as necessary.

If the beneficiary initially presents at a SUD treatment provider that does not offer the appropriate provisional LOC, because the beneficiary may not meet criteria for that level of care, that agency will identify alternate referral options in accordance with County requirements to ensure a beneficiary is offered services at the appropriate LOC. Contracted providers will operate based on a warm handoff model and assist the beneficiary in connecting with the selected provider; agency. Honoring client preference and choice, the beneficiary may elect to remain with the initial provider after receiving other referral options (e.g., the beneficiary prefers to receive intensive outpatient services despite being eligible for residential services). The County System of Care access point will be available to beneficiaries and providers to assist with any continuity of care in making warm handoffs.

All Medi-Cal eligible beneficiaries will be referred to and served by a Drug Medi-Cal certified agency for DMC reimbursable services.

Beneficiaries who request and need SUD services must receive SUD services within 10 business days of request. As there are multiple treatment entry points and service providers, the expectation of this implementation plan is treatment on demand which will likely reflect more prompt responsiveness for treatment requests. For residential services, authorization will be provided within 24 hours of request with an admission to treatment within 10 days. At this appointment, the provider will conduct a more intensive biopsychosocial clinical assessment using a standardized tool based on the ASAM Criteria to establish and/or confirm the appropriate LOC placement, and initiate services as indicated.

Both the brief triage assessment and the more comprehensive ASAM assessment will be performed by certified/registered counselors or a Licensed Practitioner of the Healing Arts (LPHA) with the required experience and as permitted by Sacramento County BHS/ADS. Given that the brief triage assessment yields only a provisional LOC determination, initial medical necessity will need to be confirmed at the provider site and an LPHA will need to sign off on the more comprehensive ASAM assessment. If the initial brief triage assessment and the full ASAM-based assessment to determine medical necessity and the appropriate LOC involve different providers, the initial provider will be responsible for ensuring a “warm hand-off” to support completion of assessment appointment and enrollment in services. A full assessment will then be completed by the new LOC provider.

When the brief triage assessment and/or the full ASAM assessment indicates that placement in a residential treatment program (ASAM level 3.1, 3.3, 3.5) is needed, the selected provider will submit a pre-authorization service request to Sacramento County ADS which will conduct a pre-authorization review, and then approve or deny

the request within 24 hours of receiving the request. If relapse risk is deemed to be significant without immediate placement in residential care, a County contracted residential treatment provider may admit a beneficiary prior to receiving residential authorization (on a weekend), with the understanding that authorization denials will result in financial loss (e.g., not billable to other state and federal sources) whereas authorization approvals will be retroactively issued to the date of admission. Pre-authorization by the County is not required for admission into other ASAM levels of care.

ASAM criteria interviews will be conducted by Licensed Practitioners of the Healing Arts (LPHAs)—or by certified/registered alcohol and drug counselors and reviewed and approved by an LPHA. Staff performing the ASAM criteria interviews must at a minimum complete ASAM e-training Modules 1 (Multidimensional Assessment) and 2 (From Assessment to Service Planning) and provide evidence of successful completion to Alcohol and Drug Services prior to claiming for assessment services. All ADS staff and contracted DMC service providers will be trained in and use the ASAM criteria for assessment. Sacramento County ADS will explore integrating the ASAM Continuum into AVATAR (Electronic Health Record for substance use services) and will be made available to designated staff at DMC-ODS provider sites that have completed the required ASAM trainings.

Once admitted into services, an individualized treatment plan will be developed by, at minimum, a registered counselor with the required experience and as permitted by Sacramento County ADS and signed by an LPHA. At a minimum, treatment plan reviews for youth and adults are required at least every 30 calendar days and treatment plan updates are required at least every 90 calendar days in outpatient, intensive outpatient, and opioid treatment program settings. For residential settings, treatment plan updates are required at least every 30 days. Treatment plans in more intensive LOCs, such as residential settings, should be updated more frequently when there is a notable event that requires a change in the treatment plan. As beneficiaries advance through treatment, the corresponding treatment plan should be reviewed and adjusted accordingly based on stability and any rapid changes in the beneficiary's condition. If a beneficiary's condition does not show improvement at a given LOC or with a particular intervention, then a review of the case is warranted. A re-assessment would be completed and a modification to the treatment plan made in order to improve therapeutic outcomes.

If a beneficiary requires a change in LOC during the course of treatment, the current treatment provider will assist the beneficiary in transferring to the appropriate LOC within the provider organization or by coordinating a referral to another treatment program. A beneficiary can move between LOCs, or in some cases be in services concurrently (e.g., residential treatment and opioid treatment programs), as clinically appropriate. Transitions between LOCs will be documented in the client progress notes to better ensure successful connections with the new service location/provider, including the facilitation of warm hand-offs whenever possible. Residential treatment referrals would need to be authorized prior to admission.

Discharge planning between LOCs, during treatment exit, and between systems of care (mental health, physical health and substance use systems) is an integral component of the treatment process and begins at the time of admission. Processes to prepare the beneficiary for return or reentry into the community include linkages to essential supportive services such as education, employment training, employment, housing, benefit enrollment, and other ancillary services as indicated at assessment and during the treatment process.

Beneficiaries who completed their episode of treatment, or prematurely exit the SUD system of care, are eligible to receive recovery support services, and linkage can be provided to other supportive services or additional treatment if needed.

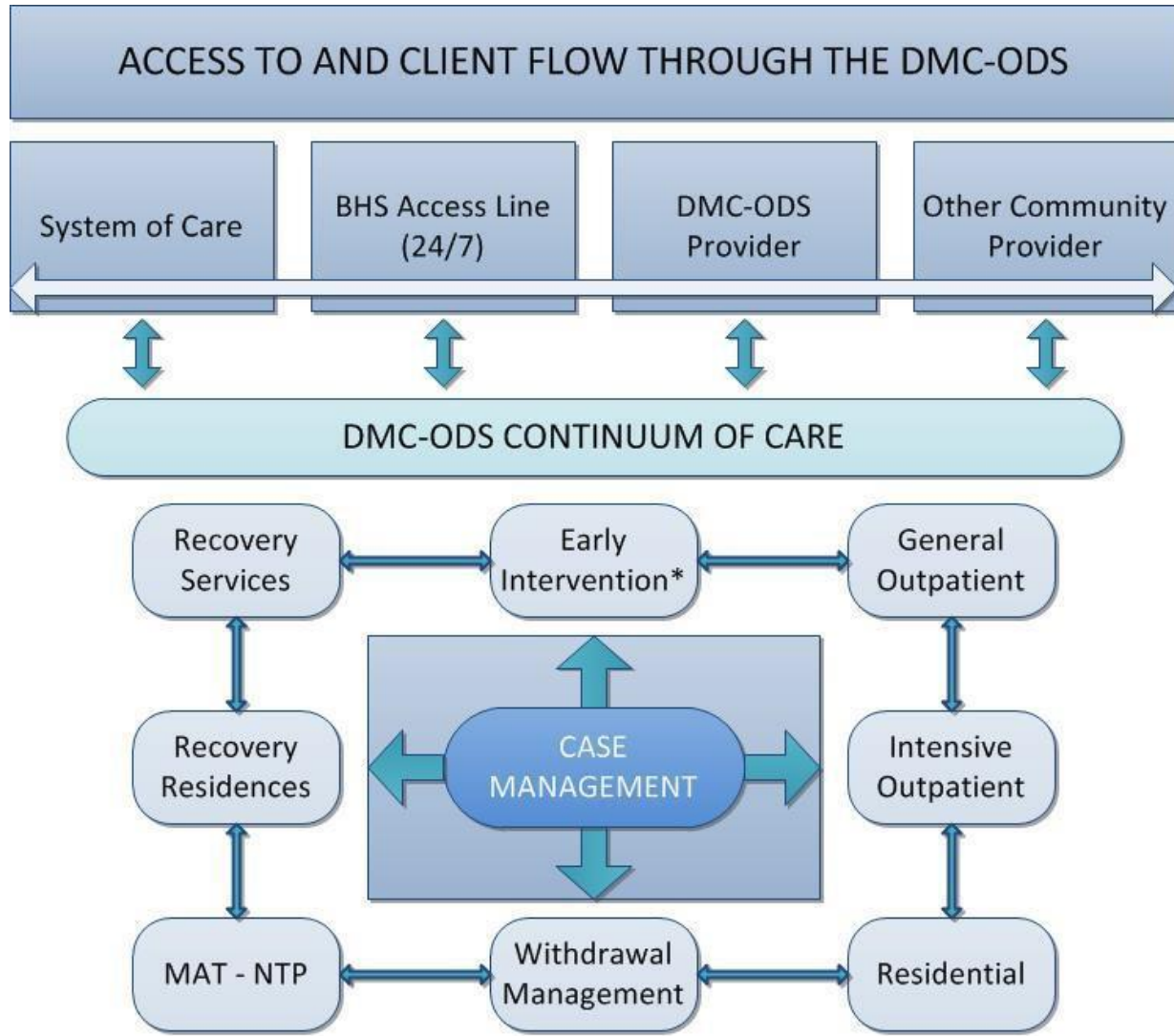
Assessment, Referral and Admissions to Appropriate ASAM Level of Care

Beneficiaries that utilize the BHS 24/7 Access Line will initially be screened over the telephone and the BHS Access staff will determine whether there is sufficient information to make a referral for an ADS screening/assessment. BHS Access Line staff will work with the beneficiary during the call/appointment to schedule an intake appointment at the selected provider offering the appropriate ASAM level of care.

Beneficiaries who choose to directly contact a DMC-ODS service provider will be screened and assessed, if indicated, and offered admission to the appropriate ASAM level of care. If a beneficiary goes to a DMC-ODS service provider without an appointment and there is qualified staff to perform an assessment, then the beneficiary will be seen the same day. If there is no qualified staff available to perform an assessment on the same day, then they will be given an appointment to return for a face-to-face assessment within 3 days. If after assessing the beneficiary they are determined to be more appropriate for an ASAM level of care not offered by the provider, then the provider will immediately refer the beneficiary to another DMC-ODS service provider that provides the indicated ASAM level of care, to the BHS Access Line, or the System of Care and will document the referral.

DMC-ODS providers will aim to admit eligible beneficiaries within five (5) business days—but will be no later than 10 business days—from the assessment. In the unlikely event that admission to treatment will be greater than 10 business days, DMC-ODS providers shall provide access to interim services and seek to link the beneficiary with another provider offering the appropriate ASAM level of care. In addition to providing interim services within the required timeframe, the program must also provide the beneficiary with referrals to other programs that have immediate availability. In instances where a Residential treatment provider submits a prior authorization request to the System of Care or Access Line, ADS shall respond with an approval or denial within 24 hours of the request.

See flow chart below.



*Early Intervention services will be provided as medically necessary, though are not reimbursable through DMC-ODS.

Residential Authorizations:

The process for authorizations for Residential treatment can be initiated at either the Residential provider site or at a County service access point. For authorization requests that are initiated from the Residential provider site, the provider shall send a Treatment Authorization Request form and additional documentation supporting medical necessity for the recommended ASAM level of care to the System of Care to be authorized by County staff. Requests for Initial Prior Authorization should be

submitted at least 24 hours before the scheduled admission date and must be requested prior to the admission of the client. Requests for Continuing Authorization (30 days) should be submitted at least seven calendar days before the expiration of the initial authorization (90 days).

The length of residential services range from 1 to 90 days with a 90-day maximum for adults, unless medical necessity requires a one-time extension of up to 30 days on an annual basis. Only two non-continuous 90-day regimens will be authorized in a one-year period. Perinatal and criminal justice clients may receive a longer length of stay based on medical necessity. If longer lengths of stay are needed, other non-Medi-Cal funds can be used. The authorization and preliminary payment source will be entered into the System of Care Residential placement list. Beneficiaries participating in a face-to-face assessment with System of Care staff that meet the Title 22 and ASAM Criteria definitions of medical necessity for Residential treatment will be referred to the appropriate ASAM level of care. System of Care will authorize services and send the provider an authorization approval.

Upon receipt of a Residential Treatment Authorization Request form and Assessment summary, System of Care staff will review the request and based on the review, provide one of the following responses to the requesting agency within 24 hours: approved; pending; denied. If the Residential TAR is incomplete or additional information is needed in order to make an authorization decision, System of Care will indicate that the authorization is pending and will send the request for additional information to the provider, who shall respond within 24 hours. System of Care will refer the beneficiary to the appropriate ASAM Level of Care within 72 hours.

Re-Assessments:

Providers are required to demonstrate that clients continue to meet current LOC criteria or determine that an alternative is most appropriate. All clients will be reassessed any time there is a significant change in their status, diagnosis, a revision to the client’s individual treatment plan, and as requested by the client. Providers will reassess for medical necessity and appropriate LOC within the maximum time frames noted below:

Level of Care Reassessment Timeframe Maximum:

Residential Detoxification (Level 3.2)	5 days, 3 days, 1 day, thereafter
Residential Treatment (Levels 3.1, 3.3, 3.5)	30 days
Intensive Outpatient (Level 2.1)	90 days
Outpatient Treatment (Level 1)	90 days
Narcotic Treatment Programs	1 year
Medication Assisted Treatment	1 year
Recovery Services	180 days
Case Management	Evaluate as part of above services

Changes that could warrant a re-assessment and possibly a transfer to a higher or lower level of care include, but are not limited to:

- Achieving treatment plan goals
- Inability to achieve treatment plan goals despite amendments to the treatment plan
- Identification of intensified or new problems that cannot adequately be addressed in the current level of care or change in diagnosis or status
- At the request of the beneficiary

Transitions to Other Levels of Care:

A beneficiary can be assigned a higher or lower level of care according to identified need or assessment. Each transition will have a justification to continue treatment and the treatment plan will be updated. Similar to initial admission to DMC-ODS services, transitions to other levels of care will be conducted with sensitivity to the client service need and a warm handoff principle.

If the beneficiary is transitioning to Residential treatment, a Treatment Authorization Review request shall be submitted to System of Care and authorization review shall occur within 24 hours of the request from the DMC-ODS service provider. Case managers will be responsible to facilitate the transition between levels of care, including assisting in scheduling an intake appointment, within 72 hours, ensuring a minimal delay between discharge and admission at the next level of care, and documenting all information in the client progress note. If the discharging provider is unable to determine an appropriate referral, the provider or client's case manager shall engage System of Care to assist in identifying an appropriate referral and assisting with the linkage.

The Role of the Case Manager:

Case-management and care coordination will be an essential component to ensuring that beneficiaries successfully engage in the initial treatment episode, receive necessary services, and transition through care as clinically appropriate. These services will assist beneficiaries in accessing needed medical, educational, social, vocational, rehabilitative or other community services, and will be provided by certified/registered counselors or LPHA with the required experience and as permitted by Sacramento County ADS. The initial treating provider will be responsible for providing or arranging case management services and communicating with the next provider along the continuum of care to ensure smooth transitions between levels of care. Once a beneficiary has successfully admitted for services at the next level of care, the new treatment provider (if a different agency) will assume case-management responsibilities. Sacramento County will use a comprehensive case management model based on the ASAM bio-psychosocial assessment to identify needs and develop a case plan and follow the SAMHSA/CSAT TIP 27(Treatment Improvement Protocol) Comprehensive Case Management for Substance Abuse Treatment. Alternate models of case management will also be explored and considered and procedures finalized before service delivery.

All beneficiaries, where medical necessity for SUD services has been determined, will have access to case-management and/or care coordination services to assist with admission into SUD services, transitioning from one level of care to another, and navigating the mental health, physical health and social service systems. Treatment provider staff will monitor and track beneficiary progress, coordinate care, and provide linkages with community support services, as well as coordinate referrals to other levels of care. They will also communicate with other network providers as beneficiaries move between levels of care and into post-discharge recovery services to support successful transition(s).

In some instances, the primary case manager may be based from a local health plan. In this way, case management for this high-risk population would ensure that appropriate levels of care are tailored to individual need within both the SUD system and other health systems. In the interim, Sacramento County BHS/ADS will continue to collaborate with the health plans and primary health to ensure effective coordination of services.

3. Beneficiary Notification and Access Line. For the beneficiary toll free access number, what data will be collected (i.e.: measure the number of calls, waiting times, and call abandonment)? How will individuals be able to locate the access number? The access line must be toll-free, functional 24/7, accessible in prevalent non-English languages, and ADA-compliant (TTY).

Review Note: Please note that all written information must be available in the prevalent non-English languages identified by the state in a particular service area. The plan must notify beneficiaries of free oral interpretation services and how to access those services.

Beneficiary Notification

All new clients that access Substance Use Services will be provided a copy of the Member Handbook and Provider List upon intake. Existing clients will be provided a copy of the Member Handbook and Provider List upon request. The Member Handbook includes county specific information as well as State information that relates to substance use services provided to the Medi-Cal Population in California.

Both the Member Handbook and Provider list will be available in English as well as the county's five threshold languages (Spanish, Hmong, Chinese, Russian, and Vietnamese). The most updated version of the documents will be posted on the county's website in the translated versions.

The Member Handbook will be updated as needed and the Provider List will be updated in accordance with Center for Medicaid and Medicare Service (CMS) requirements.

Beneficiary Access Line

Sacramento County DBHS has an established toll-free 24/7 Access line with language capability in all threshold languages which is ADA TTY compliant for mental health services. DBHS for will leverage this existing resource to include Alcohol and Drug Services. The current number is: 24-Hour Access Helpline: 1-888-881-4881. The toll-free Access number is posted on the BHS website and is currently on all mental health brochures and promotional materials, including the County 211. The toll-free number will be added to all ADS brochures and promotional materials as well.

Sacramento County DBHS is committed to providing culturally and linguistically appropriate services to the community. In instances where the caller's primary language is other than English, services will be provided in the primary language of the caller by bilingual staff who are available onsite, or by over-the-phone interpreter services which are provided at no cost to the caller. Staff will remain on the line with callers until a connection is made with the interpreter. Staff will continue to remain on the line for the duration of the call.

During normal business hours (Monday through Friday, 8:00 am to 5:00 pm), calls for ADS services will be received and responded to by the ADS System of Care staff. After hours and holidays, the toll-free line rolls over to the Sacramento County Intake Stabilization Unit (ISU). ISU staff will provide information on how to access ADS services, the problem resolution process/appeals, as well as community resources. All requests for services received after hours will be followed up on the next business day by ADS System of Care staff, as needed.

All calls during business and after hours are screened for crisis situations and are referred appropriately.

Information on each call will be collected and will include, but may not be limited to, date, caller name, telephone number, nature of request and disposition of request. Data will also be collected and reported on the number of calls, dropped calls and wait times. This information will be used to inform program business processes.

Compliance with the 24/7 access line will be monitored on a monthly basis by conducting test calls during regular business hours and after hours. Test calls will test the 24/7 Access line requirements, as defined by the State. The QM Program Coordinator will provide immediate verbal and written feedback to the ADS System of Care and ISU management on the results of the test calls. The System of Care and ISU staff will also receive ongoing training and a written protocol on 24/7 requirements and customer service standards.

On a quarterly basis, test call and other data related to the 24/7 line will be reviewed by BHS management and QIC to identify issues and/or trends relating to the accessibility, quality and responsiveness of the 24/7 toll free access line. Any issues identified will be used to inform and improve the business processes related to the 24/7 access line.

4. Treatment Services. Describe the required types of DMC-ODS services (withdrawal management, residential, intensive outpatient, outpatient, opioid/narcotic treatment programs, recovery services, case management, physician consultation) and optional (additional medication assisted treatment, recovery residences) to be provided. What barriers, if any, does the county have with the required service levels?

Review Note: Include in each description the corresponding American Society of Addiction Medicine (ASAM) level, including opioid treatment programs. Names and descriptions of individual providers are not required in this section; however, a list of all contracted providers will be required within 30 days of the waiver implementation date. This list will be used for billing purposes for the Short Doyle 2 system.

Sacramento County Alcohol and Drug Services maintains and monitors a network of providers under Board of Supervisors approved contracts, ensuring adequate access to services for beneficiaries. Services are individualized for beneficiaries when determined medically necessary and based on the level of care indicated utilizing the ASAM multidimensional assessment criteria. It is an expectation that all providers connect beneficiaries to services to meet other physical health, mental health, and ancillary service needs based on the ASAM multidimensional assessment. All DMC network providers are required to meet established timely access standards. Contracted DMC provider facilities are required to maintain DHCS SUD licensure, in addition to DMC certification. Perinatal Services Network Guidelines and Youth Treatment Guidelines are followed by the appropriate providers. All provider staff are licensed or certified/registered and are in compliance with certification requirements. All contracted providers are required to comply with Federal, State, and local requirements, including Sacramento County standards and evidence-based practices that meet the DMC- ODS quality requirements.

For those beneficiaries in custody, jail alcohol and drug screenings are conducted prior to release for timely access to care and placement by County staff that go into the jail to complete the assessment. An appropriate treatment recommendation and referral is made and provided to the beneficiary.

If an individual does not meet medical necessity, they will not be entered into the Alcohol and Drug system/continuum of care. Youth who do not meet medical necessity will be referred to education services, prevention or appropriate treatment programming. Sacramento County Alcohol and Drug Services offers education groups weekly at geographic locations across the County (Elk Grove, Citrus Heights, other locations as needed).

Below is a list of services Sacramento County Alcohol and Drug Services will provide as part of the DMC-ODS System:

ORGANIZED DELIVERY SYSTEM SERVICES			
	Service Type	ASAM Level	Required or Optional
A	Early Intervention	0.5	Required
B	Outpatient Treatment	1	Required
C	Intensive Outpatient Treatment	2.1	Required
D	Withdrawal Management	2-WM, 3.2-WM	One Level Required
E	Residential Treatment	3.1/3.3/3.5 (3.7/4.0 will be coordinated for by County)	Required
F	Opioid Treatment Program	1	Required
G	Additional Medication Assisted Treatment	1	Optional
H	Recovery Services	N/A	Required
I	Case Management	N/A	Required
J	Physician Consultation	N/A	Required
K	Recovery Residence	N/A	Optional
L	Optional Services	N/A	Optional

Service Descriptions

A. Early Intervention (ASAM Level 0.5) Alcohol and Drug Services staff provide Screening, Brief Intervention, and Referral to Treatment (SBIRT) for all substance use conditions at some County access points and in collaboration with the primary care clinic, specialty care clinics, Emergency Department and Psychiatric Emergency Services Department. Beneficiaries at risk of developing an SUD or those with an existing SUD are identified and offered: screening for youth and adults and when indicated and a referral to treatment with formal linkage to services. Screening and education are provided for at risk individuals who do not

meet medical necessity for SUD treatment. Services may include; youth prevention services, education services for youth and adults and DUI programs. Programs at this level are designed to explore services and address risk factors related to the use of alcohol or other drugs and help recognize the consequences of high risk use and associated behaviors.

Sacramento County also provides Driving Under the Influence (DUI) Program services. The DUI Program aims to reduce the number of repeat DUI offenses by persons who complete a state-licensed DUI Program and provide participants an opportunity to address problems related to the use of alcohol and/or other drugs. Sacramento County currently contracts with 4 providers who provide alcohol and drug education and other DUI program requirements.

- B. Outpatient Services (ASAM Level 1.0) consist of up to 9 hours per week of medically necessary services for adults and less than 6 hours per week of services for adolescents. Providers will offer ASAM Level 1 services including: assessment, treatment planning; individual and group counseling; family therapy; patient education; medication services; collateral services; crisis intervention services; and discharge planning and coordination. Services may be provided in-person, by telephone, or by tele-health in any appropriate setting in the community. Sacramento County currently has 6 adult providers and 4 youth providers.
- C. Intensive Outpatient Services (ASAM Level 2.1) involves structured programming provided to beneficiaries as medically necessary for a minimum of nine (9) hours and a maximum of 19 hours per week for adult perinatal and non-perinatal clients. Adolescents are provided a minimum of six (6) and a maximum of 19 services per week. Services include assessment, treatment planning, individual and/or group counseling, patient education, family therapy, medication services, collateral services, crisis intervention services, treatment planning, and discharge planning and coordination. Services may be provided in-person, by telephone, or by telehealth in any appropriate setting in the community. Sacramento County currently has 4 adult providers and 2 youth providers.
- D. Withdrawal Management Services (ASAM Levels 2-WM, 3.2-WM) are provided as medically necessary to beneficiaries and include: assessment, observation, medication services, and discharge planning and coordination.

Beneficiaries receiving residential withdrawal management, 3.2-WM shall reside at the facility for monitoring during the detoxification process. Alcohol and Drug Services will also offer ASAM Levels 2-WM: Ambulatory Withdrawal Management with Extended On-Site Monitoring. Sacramento County will explore opportunities for capacity building and expansion for these services or will coordinate with the Sacramento County Division of Primary Health Services. Sacramento County currently has 4 withdrawal management providers.

Sacramento County BHS/ADS will work with local hospitals and other area service providers to assist beneficiaries to access ASAM Levels 3.7-WM (Medically-Monitored Inpatient Withdrawal Management) and 4.0-WM (Medically-Managed Inpatient Withdrawal Management) when medically necessary. BHS/ADS will coordinate with these providers to smoothly transition and support beneficiaries to less intensive levels of care available within the DMC- ODS. Sacramento County has no existing programs. BHS will release a request for proposal (RFP) to identify qualified providers for ASAM Level 2-WM and 3.2-WM as needed services expansion presents itself.

- E. Residential Treatment Services (ASAM Levels 3.1, 3.3, 3.5) are a 24-hour, non-institutional, non-medical, short-term service that provides residential rehabilitation services to youth, adult, and perinatal beneficiaries. Residential services are provided in facilities designated by DHCS as capable of delivering care consistent with ASAM Level 3.1: Clinically-Managed Low-Intensity Residential, ASAM Level 3.3: Clinically Managed Population-Specific High-Intensity Residential Services (Adult only), and ASAM Level 3.5: Clinically-Managed High-Intensity Residential.

Beneficiaries are approved for residential treatment through a prior authorization process based on the results identified by the ASAM assessment. The length of stay for residential services may range from 1-90 days, unless a reassessment of medical necessity justifies a one-time services reauthorization/extension of up to 30 days. Only two non-continuous 90-day regimens will be authorized in a one-year period. Perinatal and criminal justice involved clients may receive a longer length of stay based on medical necessity. Residential treatment services includes assessment, treatment planning, individual and group counseling, client education, family therapy, collateral services, crisis intervention services, treatment planning, transportation to medically necessary treatments, and discharge planning and coordination. All providers are required to accept and support clients who are receiving medication-assisted treatments. Sacramento County currently has 5 residential providers and will explore opportunities for capacity building and expansion of services.

DHCS has issued all provisional ASAM designations for currently contracted licensed residential providers. Current providers offer ASAM residential levels 3.1, and 3.5 and these services will be available upon the Sacramento County DMC-ODS implementation. For clients in any residential treatment program, case management services will be provided to facilitate “step down” to lower levels of care and support.

Sacramento County BHS/ADS will work with local hospitals and other area service providers to assist beneficiaries to access ASAM residential levels 3.7 (Medically Monitored Intensive Inpatient Services) and 4.0 (Medically Managed Intensive Inpatient Services) when medically necessary. BHS/ADS will coordinate with these providers for transitions and support beneficiaries to less intensive levels of care available within the DMC-ODS.

Capacity for adolescent residential treatment is a current barrier as no adolescent residential treatment provider currently exists in Sacramento County. We will be reaching out to county adolescent treatment providers, inviting them to consider and explore a youth residential facility. Medically necessary adolescent residential services will be considered at Year 2 of implementation. Prior to this implementation, Sacramento County will refer medically necessary adolescent residential services to out of county network providers. Sacramento County will explore contracting options with these agencies.

F. Opioid (Narcotic) Treatment Program (OTP/NTP, ASAM OTP Level 1) Alcohol and Drug Services contracts with 4 licensed Narcotic Treatment Programs (NTPs) at five locations to offer services to beneficiaries who meet medical necessity criteria requirements. Services are provided in accordance with an individualized client care plan determined by a licensed prescriber. An opioid maintenance criterion is a two year history of addiction, two treatment failures and one year of episodic or continued use pursuant to Title VIII regulations. Prescribed medications offered currently include methadone. Buprenorphine will be available through the County primary health clinic in Year 1. Plans to expand to offer buprenorphine, naloxone, disulfiram and other medications covered under the DMC- ODS formulary through contracted service providers will occur by Year 2 of implementation. NTP programs will be required to offer and record proof of beneficiary understanding on choices of medications and treatment without medications. Services provided as part of an Opioid Treatment Program include: assessment, treatment planning, individual and group counseling, patient education; medication services; collateral services; crisis intervention services; treatment planning; and discharge services. Clients receive between 50 and 200 minutes of counseling per calendar month with a therapist or certified/registered counselor, and, when medically necessary, additional services may be provided below:

- Opiate overdose prevention: naloxone (Narcan)
- Opiate use treatment: buprenorphine-naloxone (Suboxone) and naltrexone (oral). (Note: Methadone will continue to be available through the licensed narcotic treatment programs)

G. Additional Medication Assisted Treatment (MAT) Services (Optional, ASAM Level 1): Alcohol and Drug Services will offer additional MAT related treatment services through the Sacramento County primary care clinic, Managed Care Plan Providers and Federally Qualified Health Centers. Services include: assessment, treatment planning, treatment, case management, ordering, prescribing, administering, and monitoring of medication for substance use disorders.

Sacramento County is continuing to assess the need and explore the feasibility of expanding MAT services to offer the use of additional medications for beneficiaries with chronic alcohol related disorders or opiate use. Medications will include:

naltrexone, both oral (ReVia) and extended release injectable (Vivitrol), topiramate (Topamax), gabapentin (Neurontin), acamprosate (Campral), and disulfiram (Antabuse).

Given the existing NTP network in Sacramento and a robust primary care and existing FQHC relationship with service delivery system, the implementation plan will explore utilizing those existing provider networks. Additionally, Alcohol and Drug Services will consider coordinating care and expanding the availability of MAT by building the capacity of the current system to use these treatments for beneficiaries with a substance use disorder. ADS will consult with physicians, nurse practitioners, and psychiatrists in primary care and specialty mental health clinics on the efficacy of using MAT, practice guidelines, and medication administration. Physician consultation is supporting implementation in areas such as: medication selection, dosing, side effect management, adherence, and drug-drug interactions.

- H. Recovery Services (ASAM Dimension 6, Recovery Environment) are available once a beneficiary has completed the primary course of treatment and during the transition process. Beneficiaries accessing recovery services are supported to manage their own health care, use effective self-management support strategies, and use community resources to provide ongoing support. Recovery services may be provided face-to face, by telephone, via the internet, or elsewhere in the community. Services may include: outpatient individual or group counseling to support the stabilization of the client or reassess the need for further care; recovery monitoring/recovering coaching; peer-to-peer services and relapse prevention, education and job skills; family support; support groups and linkages to various ancillary services. Any eligible DMC provider within the network may provide medically necessary recovery services to beneficiaries. Linkages to these services are provided by a certified/registered SUD counselor, licensed clinician or peer support specialist. Sacramento County currently offers these services through collaborative court programs and will expand to include other eligible providers in the network.
- I. Case Management Services support beneficiaries as they move through the DMC-ODS continuum of care from initial engagement and early intervention, through treatment, to recovery supports. Case management services are provided for beneficiaries who may be challenging to engage, requiring assistance connecting to treatment services or other supportive services, and/or those clients stepping down to lower levels of care and support. Sacramento County will use a comprehensive case management model based on the ASAM bio- psychosocial assessment to identify needs and develop a case plan and follow the SAMHSA/CSAT TIP 27(Treatment Improvement Protocol) Comprehensive Case Management for Substance Abuse Treatment. Case management services may include: comprehensive assessment, level of care identification; client plan development; coordination of care with mental health and physical health;

monitoring access; client advocacy and linkages to other supports including but not limited to mental health, housing, transportation, food, and benefits enrollment. Case managers will be trained and utilize Motivational Interviewing (MI) and Motivational Enhancement Therapy (MET), and strength based approaches. Case management services will be provided as needed to all beneficiaries by contract providers and Alcohol and Drug Services staff with a strong emphasis on high utilizers, multi-system users to avoid hospitalization and other medical costs. All case management services are consistent with confidentiality requirements identified in 42 CFR, Part 2, and California law, and the Health Insurance Portability and Accountability Act (HIPAA). Linkages to these services are provided by a certified/registered SUD counselor, licensed clinician or peer support specialist. Sacramento County currently offers these services through collaborative court programs and will expand to include other eligible providers in the system of care.

Linkage and support from assigned case management staff can include needs such as:

- Chemical Dependency and Rehabilitative
- Medical
- Legal
- Social
- Educational
- Employment
- Financial

Sacramento County will explore and develop a referral process and tracking mechanism for case management services based on data in the claims reporting system.

- J. Physician Consultation services assist physicians and provider staff seeking expert advice on complex client cases and designing the treatment plan in such areas as: medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. DHS has a Public Health Officer and addiction medicine specialist available for consultation on substance use disorder concerns. All contracted DMC providers have a physician available for consultation. Physician consultation to primary care and behavioral health providers for the use of Vivitrol, buprenorphine, other medications, and pain management will be made available in an effort to build the capacity of the entire health system to treat beneficiaries with substance use disorders. Sacramento County may use existing staff, or contract with physicians, psychiatrists, or clinical pharmacists to provide consultation services. The Sacramento County Opioid Task Force has been a collaborative between Public Health and Behavioral Health Services and will be an area for building greater physician consultation.

- K. Recovery Residences (RR) also known as Transitional Living/Sober Living Environments are available for beneficiaries who require housing assistance in order to support their health, wellness and recovery. There is no formal treatment provided at these facilities; however residents are required to have previously completed outpatient treatment or actively participate in outpatient treatment and/or recovery supports during their stay. On a case by case or program basis, ADS will determine the length of stay which can be based on funding or search for permanent housing. The County is developing standards for contracted RR providers and will monitor to these standards. RRs are not reimbursable through the Medi-Cal system. Sacramento County currently has 3 recovery residences and will explore opportunities for expansion. This includes housing for men, women, perinatal specific, and women and children.
- L. Optional Service Levels Pending ASAM Utilization Review. Alcohol and Drug Services will consider whether to offer additional optional services available under the waiver once baseline data on beneficiary ASAM service need and utilization has been collected and analyzed. If an unmet need for a service is determined, ADS will amend this plan to incorporate the additional service(s) and will initiate an RFP process to identify qualified providers. Service levels which ADS anticipates for possible expansion include: Additional MAT Services, Recovery Residence expansion, Peer support services.

Barriers with Required Service Levels

- Youth residential treatment program
- Facility siting challenges
- Workforce shortages
- Drug Medi-Cal certification delays
- New provider orientation, identification and development
- Existing provider capacity and culture change
- Medical Detoxification-hospital based

Coordination with Opt-Out Counties

Sacramento County has established relationships and plans to coordinate with surrounding counties. Sacramento County plans to coordinate with opt-out counties in order to limit disruption of services to beneficiaries who reside in an opt-out county by:

1. Assisting beneficiaries who have moved to Sacramento County in obtaining DMC eligibility for Sacramento County.
2. Assisting beneficiaries DMC eligible in an opt-out county to obtain services within their residency.

Until Sacramento County receives clear direction from DHCS regarding county of residency matters, the following questions will be considered before making a recommendation.

1. Where does the client wish to obtain services? In home county? In Sac

County? Is s/he relocating to get a fresh start and get away for people, places, or things?

2. If client has M/Cal in another county, does s/he have other important physical or mental health services/providers s/he obtains there? Would it be disruptive to the individual to change these providers?
3. Does the client have dependent family members in his/her home county who receive M/Cal benefits? If the client seeks to transfer benefits to Sacramento, this can cause a disruption in care to family members. This is an important consideration when a client is thinking of changing his/her Medi-Cal.
4. Transferring Medi-Cal from one county to another can take up to 60 days. While a DMC provider can serve the client and use a "delay reason code" to submit retroactive billing and get paid once the client is part of Medi-Cal in Sacramento, other providers, such as primary care and mental health may not serve the client while s/he is in a Medi-Cal pending status. This can limit access/cause delays to important and needed services.
5. Is treatment mandated by Sac County Courts, Probation, or Child Welfare?
6. Is the care medically necessary? Or Not?

5. Coordination with Mental Health. How will the county coordinate mental health services for beneficiaries with co-occurring disorders? Are there minimum initial coordination requirements or goals that you plan to specify for your providers? How will these be monitored? Please briefly describe the county structure for delivering SUD and mental health services. When these structures are separate, how is care coordinated?

The Department of Health Services consists of substance use and mental health (MH) services consolidated into a single Behavioral Health Division within Sacramento County. The Division is supervised under a single executive management structure consisting of a Behavioral Health Director/Alcohol and Drug Administrator, division managers and a team of program managers. BHS staff and programming are integrated into the organization, sharing some of the same policies and procedures and administrative support. The DMC-ODS provides further opportunity to fully align programs and services not only for cases of co-occurring disorders, but to assure that there is no wrong door when a beneficiary makes the decision to seek treatment and begin their recovery.

Alcohol and Drug Services and Mental Health services collaborate on service delivery to beneficiaries with co-occurring substance use and mental health disorders with a common understanding, that people with co-occurring SUD and MH conditions are to be treated for both conditions for optimum wellness and recovery. This collaboration has led to a reorganization that established Behavioral Health Services and brought under a single administrative structure SUD and MH services. Training and technical assistance to staff and providers in both systems has been provided. There is still

work to be done around cross training for full integration. Care coordination and referral procedures have been evolving and improving over the past several years. Minimum initial coordination requirements or goals for providers: Various access points throughout Sacramento County will serve as the primary portals for entry into the Alcohol and Drug Services system, the initial screening and placement will be conducted by staff trained to handle clients with co-occurring disorders. Clients will be referred to the appropriate providers, identified as capable of providing treatment for co-occurring disorders. Youth with co-occurring disorders will be referred to a co-occurring disorder provider or a provider that is most conveniently located near home or school.

Care coordination within the Sacramento County treatment continuum occurs in many forums, workgroups and committees pertaining to various programs and services to identify beneficiaries who are experiencing significant challenges, most frequently including co-occurring issues, and not well connected to services. In the DMC-ODS planning process, Sacramento County wanted to avoid the development of another specific meeting for this task. Instead, opportunities to build upon were identified within the existing structures of Behavioral Health Services. Taking this approach, ADS can expand the support structures that already exist, not duplicate existing systems, and broaden the existing infrastructure to further support beneficiaries seeking treatment for substance use disorders. This includes expanding quality assurance and improvement functions by extending the oversight of the quality management unit to include DMC-ODS programs and services, staff and contract providers. The experience and skill of quality review and research staff in cooperation with fiscal, technical, and administrative staff will prove invaluable during performance reviews, audits, reporting, and evaluations, assuring compliance within DMC-ODS requirements. This approach provides the support to conduct regular internal reviews and ongoing monitoring to test for compliance and help to achieve performance standards and benchmarks. Additionally, this creates opportunities for more holistic quality improvement measures that incorporate both SUD and MH practices, which will have greater impact on client outcomes when conducted within an integrated service delivery system.

Currently, BHS makes every effort to coordinate services between programs for beneficiaries with co-occurring disorders through a referral process to coordinate care. Integrated or coordinated service teams that remain in communication with one another since employees belong to the same organization, are often co-located, share the same email, calendaring, and telephone systems. All HIPPA and 42 CFR part 2 requirements are met.

Monitoring coordination requirements:

Monitoring of integration activities will be phased in to account for education, training and culture change. The first phase will be mapping 24/7 responsiveness. The ADS Access and Mental Health Access require similar business process change to align the “front door” of programs. The integration between mental health and substance use treatment services is occurring in phases, with specific programs slated to begin

integrated services. The Behavioral Health Services Quality Management and Research Evaluation and Performance Outcomes units will collect data and monitor DMC-ODS system in a similar structure to the Mental Health Plan (MHP).

Current structure for delivery of SUD & MH services:

The Alcohol and Drug Services unit collaborates with Mental Health Services primarily through the substance use disorder screening process and through collaborative courts and specialty programs in our current system. The Collaborative Courts have some Mental Health staff who assess for both mental health and substance use treatment. The Behavioral Health Teams of these collaborative courts are composed of mental health and substance use treatment staff and managed by a Program Coordinator and Program Manager. Behavioral Health Team staff use an integrated instrument to assess clients and refer clients to mental health and substance use treatment services. Beneficiaries also have access to the Mental Health Access Team for assessment and referral into the Mental Health Plan.

Currently, youth can access substance use disorder and/or mental health care through the Juvenile Court (if on Probation) or through the outpatient provider network. Screening and comprehensive assessments are completed where mental health risks and needs are identified. A referral is made to the Mental Health Access Team if deemed appropriate. There are youth who currently receive treatment in both systems through care coordination.

6. Coordination with Physical Health. Describe how the counties will coordinate physical health services within the waiver. Are there minimum initial coordination requirements or goals that you plan to specify for your providers? How will these be monitored?

Sacramento County is a Geographic Managed Care (GMC) county with four (soon to be six) Managed Care Plans. These include: Kaiser, Molina, Health Net, Blue Cross, and soon to include Aetna and United Healthcare Services. GMCs utilize a variety of clinics, individual providers and provider groups to deliver managed care health benefits. Sacramento County has a robust relationship with its Managed Care Plans and is working to expand its existing MOUs to increase coordination efforts. Within the past few years, an increased level of integration and coordination between Primary Health and BHS has been achieved on the mental health side which has created improved performance standards, compliance monitoring and reporting requirements that reinforce quality, responsiveness, timeliness, and effective services to beneficiaries. These same processes will be utilized to expand the MOU to include the ODS implementation plan. The care coordination protocols will include, not limited to:

- Screening and assessment procedures and tools to identify mental health, physical health and substance use disorders
- Written procedures for linking beneficiaries with mental health services, which can include a referral to BHS Access for an assessment and

authorization for mental health services

- Written procedures for coordinating care with mental health providers, whether the services are provided within the agency or by an external provider.
- Monitoring will be conducted twice annually by designated Division of Behavioral Health Services representative reviewing provider contract requirements.
- BHS Quarterly GMC meetings will include addressing any ODS Waiver issues, program oversight, quality improvement, problem and dispute resolution, resolution of MOU addendum and clinical operations.

Sacramento County operates a Mental Health Treatment Center which houses a psychiatric crisis unit and inpatient unit. The County operates a primary care center and also contracts with private hospitals throughout the county as part of the Health System of Sacramento County. Integrating behavioral health and physical health care in Sacramento County began several years ago by out stationing mental health and substance use counselors in the primary care center, mental health treatment center, provider sites and multiple access points to serve youth and adults living with a serious mental illness (many of whom have a co-occurring SUD).

Both the adult and youth alcohol and drug services system refer clients with co-morbidities that include chronic and other medical conditions that require treatment as well to the county's health care system where a full complement of medical services, from urgent care, emergency department, ambulatory clinics and an inpatient facility, is available. Coordination with physical health providers involves a combination of case management and care coordination, and tasks that range from linkage with health insurance to assist or arrange transportation to medical appointments.

Currently, health evaluations are integrated into the general assessment process and are initiated during admission in the youth, adult and MAT systems. Beneficiaries complete a Health Screen Questionnaire at admission in the youth and adult mental health systems to identify any physical health symptoms. Appropriate referrals are made at that time. Alcohol and Drug Services will make every effort to connect beneficiaries to a primary care provider if they do not have one.

Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment; the examinations are provided by a licensed physician and are documented in the client chart. If a client is in need of specialized medical services, provider staff will assist with linkage to a local medical specialist and help arrange transportation.

ADS will make available screening, counseling and linkage to care and other referrals

for TB and HIV services. Upon assessment and admission to outpatient and residential substance use treatment programs, clients receive information about physical health care including contact information and resources to primary care, prevention and treatment of sexually transmitted diseases, HIV/AIDS prevention and testing. ADS will monitor these requirements on an annual basis. ADS will utilize case managers to assist with communication that a referral was received, communication that a beneficiary has started treatment, ongoing communication regarding shared cases and notification when a client has concluded treatment.

The Adult and Youth System of Care treatment providers currently collaborate closely with a licensed physician/Medical Director per regulations and as part of overall treatment for a youth. The Medical Director determines medical necessity and consults with treatment provider staff on client care and treatment plan. Ongoing care coordination will continue. Youth treatment providers have direct access to their agency Medical Director, a contracted physician or on-site medical staff for consultation regarding medical issues related to a client's treatment.

When the Medi-Cal Waiver demonstration project is implemented, assessments will be reviewed by the medical director, who will work with the treatment provider staff to coordinate with the client's primary care physician as needed. The client's primary care physician will have access to information about the client's substance use and be able to consult with the youth treatment Medical Director to provide comprehensive and coordinated care to treat health conditions that are affected by substance use.

The MAT Providers will continue to provide coordinated care to clients enrolled in treatment. The complete plan of care for MAT clients is based upon laboratory results, physical exam and the ASAM bio-psychosocial assessment. ASAM Dimension II findings are sent to the Medical Director, who initiates an in-depth substance abuse history evaluation and a full physical exam in order to determine the best plan of care. In the case of patients who are pregnant, the primary care physician and obstetrician/gynecologist will be informed about the admission and treatment services.

Sacramento County is in the planning stages to implement a fully integrated Electronic Health Record System and allow for the basic sharing of patient information to improve care coordination. It will also allow for data analysis across the mental health and alcohol and drug service providers to determine if referrals from one unit to another were completed, to determine if a patient is commonly known to several programs, and for sharing of electronic health record data so services are integrated, coordinated, and effective. All information sharing will be compliant with HIPPA and 42 CFR Part 2.

BHS, through its coordination with all Managed Care Plans (MCP) delivering services in Sacramento will explore new electronic pathways for increased information exchange. BHS/ADS will also continue to develop the resources made available through contract providers by expanding the number of contract providers and recruiting organizations with significant experience in response to the implementation of the DMC-ODS.

Sacramento County currently has a contracted treatment provider that is both a Drug Medi-Cal certified SUD treatment provider and a Federally Qualified Health Center, a primary care services clinic so that beneficiaries seeking substance use disorder treatment can also have their physical health needs met as well as be able to avail themselves of medication assisted treatments. This provider will be adding capacity over time in hope that they can meet the primary care needs of BHS/ADS clients. Existing relationships, contractual obligations to collect and analyze performance data, ongoing and regular meetings, treatment programs embedded in primary care, open access data sharing, and the development of contract providers will help with coordination between the DMC-ODS and physical health. BHS will reach out to other primary care clinics, that are also in many cases part of the contract MCP network, to explore increased coordination and access for the ODS plan.

7. Coordination Assistance. The following coordination elements are listed in the STCs. Based on discussions with your health plan and providers, do you anticipate substantial challenges and/or need for technical assistance with any of the following? If so, please indicate which and briefly explain the nature of the challenges you are facing.

- **Comprehensive substance use, physical, and mental health screening:** The SBIRT is utilized at the Sacramento County Primary Care Center and some Sacramento County System of Care access points in addition to a requirement for all GMC Plans and their contracted network. . ADS will work to assess whether technical assistance in engaging and incentivizing primary care providers is necessary. Increasing the bidirectional use of the SBIRT to improve client outcomes may require education and follow-up across both provider and GMC networks.
- **Beneficiary engagement and participation in an integrated care program as needed:** To decrease barriers and help facilitate access to care for beneficiaries, ADS implemented a decentralized SUD screening process approximately 2 years ago that will continue to require significant training, coordination and oversight. Implementation of the standard terms and conditions will place new expectations on providers and county staff that may require individualized technical assistance at each access point location.
- **Collaborative treatment planning with managed care:** BHS works closely with Managed Care Plans on coordination of care issues for mental health, however there will be more emphasis on substance use and physical health. Planning and problem solving will occur at the individual client levels of care. Part of the initial implementation will be to educate on the specific levels of the Drug Medi-Cal Delivery System implementation

plan of care, and referral and assessment protocols for the DMC- ODS.

ADS would be interested in information and/or technical assistance on models of care coordination with managed care plans.

- **Care coordination and effective communication among providers:** With the implementation of the full continuum of care of the DMC- ODS and the emphasis on levels of care based on ASAM criteria, there will be an increased expectation and need for care coordination among providers. We anticipate some challenges during the initial implementation and BHS/ADS will be working closely with providers to identify obstacles and develop improvements. ADS will also evaluate all complaints to determine if beneficiaries are experiencing any negative repercussions due to problems with care coordination. ADS may seek technical assistance to improve care coordination if challenges arise.
- **Navigation support for patients and caregivers:** The implementation of case management and recovery supports will be significant system improvements in assisting clients and others in service linkage and navigating services.
- **Facilitation and tracking of referrals between systems:** Data collection and sharing

8. Availability of Services. Pursuant to 42 CFR 438.206, the pilot County must ensure availability and accessibility of adequate number and types of providers of medically necessary services. At minimum, the County must maintain and monitor a network of providers that is supported by written agreements for subcontractors and that is sufficient to provide adequate access to all services covered under this contract. In establishing and monitoring the network, describe how the County will consider the following:

- The anticipated number of Medi-Cal clients.
- The expected utilization of services by service type.
- The numbers and types of providers required to furnish the contracted Medi-Cal services.
- A demonstration of how the current network of providers compares to the expected utilization by service type.
- Hours of operation of providers.
- Language capability for the county threshold languages.
- Specified access standards and timeliness requirements, including number of days to first face-to-face visit after initial contact and first DMC- ODS treatment service, timeliness of services for urgent conditions and access afterhours care, and frequency of follow-up appointments in accordance with individualized treatment plans.
- The geographic location of providers and Medi-Cal beneficiaries, considering distance, travel time, transportation, and access for beneficiaries with disabilities
- How will the county address service gaps, including access to MAT

- services?
- As an appendix document, please include a list of network providers indicating, if they provide MAT, their current patient load, their total DMC-ODS patient capacity, and the populations they treat (i.e., adolescent, adult, perinatal).

Access to all service modalities:

Beneficiaries will access treatment services through the centralized BHS 24/7 Access Line, provider sites or one of the System of Care access sites. Clients who are admitted to the System of Care are automatically offered any service within the System of Care, based on their treatment needs. Sacramento County has a continuum of care that provides the levels of care described in Section 4- Treatment Services. The Continuum of Care will be expanded across both the youth and adult systems of care. Care will be coordinated by the System of Care, case managers or providers. The County System of Care authorizes residential treatment, extension of stays and provides consultation on other client care issues.

Addressing service gaps:

The County acknowledges historic gaps at different levels of service. To address these gaps, the County will review and map local providers who may historically not been part of county services and explore opportunities to partner with these entities. Examples of this would be reaching out to community clinics, network to build additional MAT services and continue to explore provider interest in developing youth residential services.

Maintenance of network:

Sacramento County's current treatment network consists of 8 ASAM levels of care, distributed over 4 treatment modalities and several treatment providers. Treatment providers in the system have applied for Medi-Cal certifications for the appropriate levels of service. These current providers are able to offer services in facilities certified for specific levels of service.

Anticipated number of Medi-Cal Clients:

Using the most recently available 2012 California Mental Health prevalence estimates by County, Sacramento County utilized household populations under 200% poverty data to identify unmet need statistics for its current system.

Prevalence:

	Total Population			Household Population <200% Poverty		
	Cases	Population	%	Cases	Population	%
Alcohol or Drug Dx	108,748	1,485,372	7.32	35495	464,861	7.64
Alcohol Only Dx	90,156	1,485,372	6.07	27915	464,861	6
Drug Only Dx	34,268	1,485,372	2.31	14199	464,861	3.05
Drug Dependence	22,768	1,485,372	1.53	9813	464,861	2.11
Drug Abuse	14,457	1,485,372	0.09	5478	464,861	1.18
Alcohol Abuse	47,323	1,485,372	3.19	12809	464,861	2.76
Alcohol Dependence	42,549	1,485,372	2.86	15060	464,861	3.24

Unmet need:

	# of Cases in Household Population <200% Poverty	# Served in Sac Co ADS System	% of Need Met By Sac Co ADS*
Need			
Alcohol or Drug Dx	35,495	4,917	13.9

- According to the results of the 2016 National Survey on Drug Use and Health, 1 in 10 people age 12 and older that need SUD treatment, received treatment at a specialty facility in the past year. This is equal to about 10% that need services, received services. The Sacramento County system is currently meeting approximately 13.9 percent of projected need for services.

Number & type of providers needed for Medi-Cal services:

The current continuum of care is adequate to meet the projected needs of the Medi-Cal population. Services are provided throughout the county by contract providers. The current providers with county contracts are all Medi-Cal certified. The Sacramento County system serves approximately 6,500 total admissions per year to all modalities. This includes 2,500 outpatient admissions, 1,200 residential admissions, 300 detoxification services admissions, over 2,500 MAT admissions. Recovery support services are offered to a limited number of clients currently in specialty programs (collaborative courts) and will need to be expanded to include a larger percent of residential and outpatient services. Projections below for recovery services based on 50% of all Drug Medi-Cal eligible residential and outpatient clients receiving these additional services. The amount of Recovery Services will be assessed per modality and individualized to client needs.

The projected number of admissions by modality for the System of Care in FY 2017-18 is shown in the table below. In the first year of the Medi-Cal Waiver, the department

projects that the overall Medi-Cal client population will be approximately 64% of the total admissions for outpatient, residential and detoxification services, and clients served in the MAT programs, based on data gathered from open clients served in the system from July 1, 2015, to June 30, 2016. Projections for detoxification and residential treatment services assume: (a) an annual growth in admission based on the population growth rate for the county and (b) distribution of admissions by modalities based on historical trends. Projections for recovery services are based on the number of outpatient clients who complete treatment and are referred to recovery services.

Projected total admissions by modality and percent Medi-Cal based on 2016-17 projected admissions	Number of Providers/ Capacity	Medi-Cal Waiver Expansion	Medi-Cal Traditional	Other Payors
Withdrawal Management (ASAM 2-WM, 3.2-WM)	3 Providers 31 Beds	58	134	108
Residential Treatment (ASAM 3.1, 3.3, 3.5)	5 Providers 263 Beds	230	538	432
Outpatient (ASAM 1, 2.1, 2.5)	8 Providers No Capacity Limit	480	1,115	905
Medication-Assisted Treatment Program (MAT)	4 Providers 3,001 Slots	750	1,750	0
Recovery Services	Unknown	355	826	0
TOTAL (All Services)		1,873	4,363	1,445

Hours of operation:

Hours of operation vary depending on level of care. Hours of operation are clearly posted at each facility. For new referrals, appointments will be made five days a week during normal business hours. Residential treatment and withdrawal management facilities will operate 24 hours a day, 7 days a week basis. Narcotic/Opioid Treatment Programs will provide dosing 7 days per week. Outpatient and Intensive outpatient providers will be required to operate 5 days per week during regular business hours; evening hours may also be included based on particular population of program at selected locations. During the first year of the Waiver, the Alcohol and Drug Services Unit will review hours of operation of all providers and make changes that best meet the needs of the Medi-Cal beneficiaries.

The plan will consider entry to treatment 7 days a week. While Sacramento County will strive for 24 hour placement standard, the capacity to fulfill this condition will depend on provider network capacity and future network expansion.

Language capability – Threshold languages:

The Sacramento County Cultural Competence Plan has been in place since 1998. Since that time, there have been updates as required, as well as annual reviews of the Cultural Competence Plan Objectives. Current Cultural Competency Plan Objectives include:

1. Increase the percentage of direct service staff by 5% annually to reflect the racial, cultural and linguistic makeup of the county until the makeup of direct services staff is proportionate to the makeup of Medi-Cal beneficiaries plus 200% of poverty population.

Maintain the standard that 98% of staff identified as interpreters complete the approved mental health/behavioral health interpreter training and receive certification. Include system partners in training to expand pool of trained interpreters in emerging language populations.

2. By the end of FY 2016/17, 75% of direct service (including ADS) staff and supervisors will have completed the California Brief Multicultural Competence Scale (CBMCS) and/or equivalent cultural competence training approved by DBHS.
3. Ensure progress in the delivery of culturally competent services through the biennial completion and analysis of a system-wide Agency Self-Assessment of Cultural Competence.

All contracted providers are required contractually to provide interpreter and translation services. The 5 threshold languages for Sacramento County include Cantonese, Hmong, Russian, Spanish, and Vietnamese. DBHS has specific goals for language proficiency that are monitored annually to ensure that language access is provided throughout the system. Both county-operated and contract provider staffing are monitored for language proficiency, as noted in the Cultural Competence Plan Objectives. As needed, DBHS utilizes outside contracts for interpreting needs. Sacramento County maintains several contracts with interpreter service agencies in special cases as needed and/or requested. All service providers, including County and contracted providers, have access to these interpretation services. Deaf and Hard of Hearing clients are provided sign-language interpreters. The DBHS Policy and Procedure entitled “Procedure for Access to Interpreter Services” states the County’s expectations for providing language access to all beneficiaries at no cost to the beneficiary.

Consistent with federal and state requirements, Sacramento requires translation, in all threshold languages, of materials that include, but are not limited to signage, informational brochures, and other written materials. As an example, the following brochures which describe how to access Alcohol and Drug Services were translated in 2016: Alcohol and Drug Prevention Services, Alcohol and Drug Services – Options for Recovery, Alcohol and Drug Services – Adult System of Care; Alcohol and Drug

Services – Youth Treatment Services.

Americans With Disabilities Act (ADA):

Consumers with disabilities have access to all ADA compliant County clinics and contracted providers. Additionally, they are contractually compelled to adhere to ADA guidelines and national standards for Culturally and Linguistically Appropriate Services (CLAS) which are monitored annually for compliance. Sacramento County will aid consumers with disabilities and transportation difficulties in accessing primary care, mental health treatment, and substance abuse treatment by guiding and teaching to use community resources.

Training:

All providers are required to attend mandatory training:

- CLAS standards
- ADA
- Interpreter Services Training

Timely Access to Service:

Sacramento County is committed to providing timely access to SUD services. The following minimum timeliness standards will apply to all SUD services:

- First Face-to-Face Visit: Within 10 business days of the request
- Urgent Conditions: Within 48 hours of the request
- Access to Afterhours Care: Afterhours access is provided by the 24/7 BHS Access Helpline (1-888-881-4881)

BHS staff will work with Sacramento County Research and Evaluation staff to develop additional access and timeliness standards including but not limited to; timeliness of services to first dose of NTP services within 72 hours, timeliness to residential treatment and frequency of follow-up appointments based on client need and approval and denial rates of services within 72 hours. Timeliness standards will be included in the Quality Improvement (QI) work-plan and monitored quarterly at Quality Improvement Committee (QIC).

Geographic distribution of services:

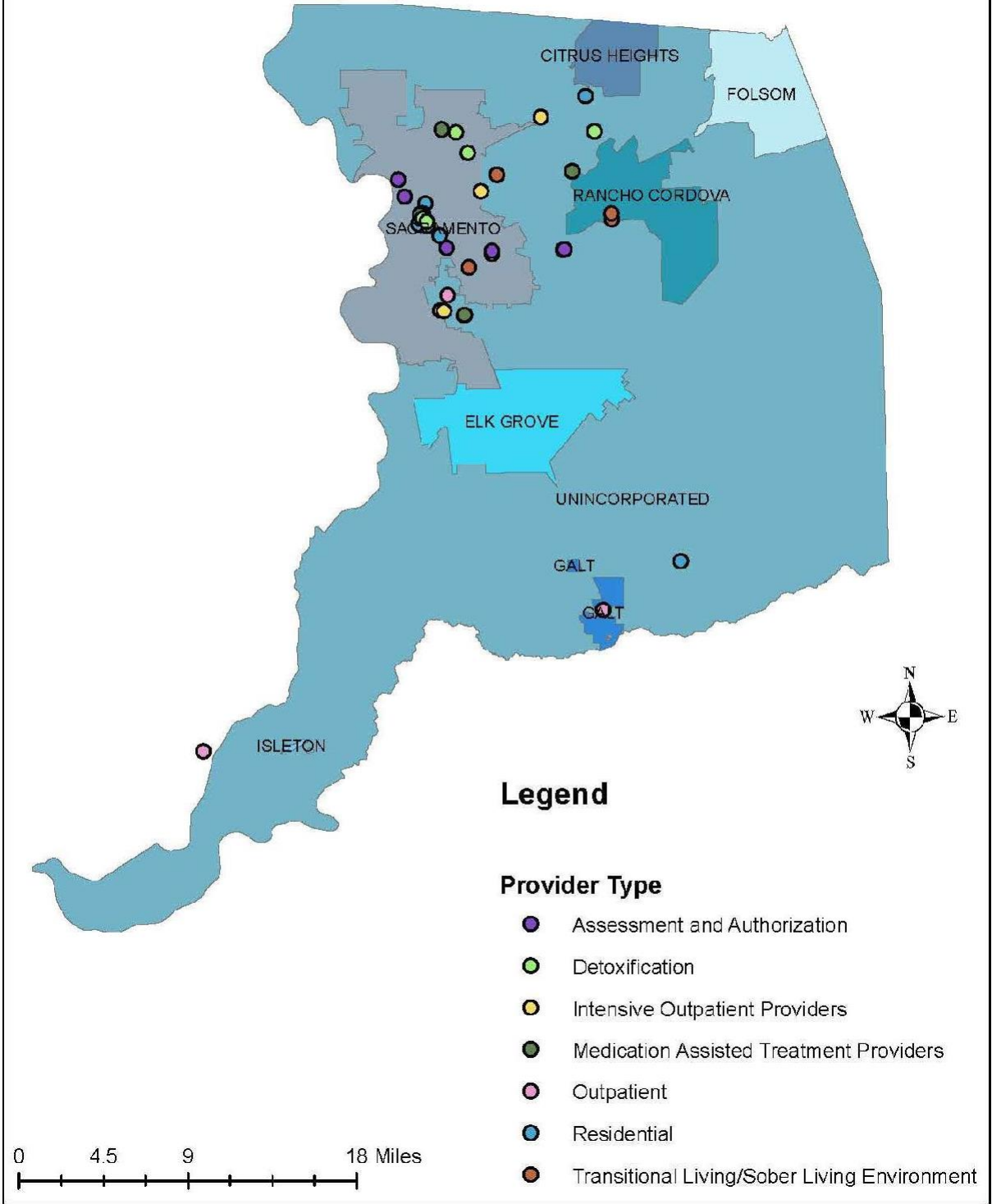
The Sacramento County Alcohol and Drug Services unit has developed services within the major geographic locations of the county North, Central, East, and South where Medi-Cal beneficiaries are most located. Most treatment sites are on or near a major transportation line with the County. Beneficiaries will be offered services near their home or school. The quality improvement team will review the county's census tracts to determine if there are adequate treatment locations throughout Sacramento County within 15 miles or 30 minutes of travel time to meet the Medi-Cal population service needs. Sacramento County utilizes and applies these distance and travel time requirements under The Department of Managed Health Care (DMHC) Title 28 regulations that apply to geographic managed care established service area

accessibility.

See Sacramento County map of contracted providers based on service type and geographic location below:

Alcohol and Drug Providers, Sacramento County

May 1, 2017



Addressing Service Gaps:

The County will utilize needs assessments by health and other system partners that evaluate through geo-mapping of provider network capacity biannually to identify any service gaps related to service availability and the correlation with population density, especially as it relates to Medi-Cal beneficiaries in the system. If a service gap is identified, the County will evaluate and develop a strategic plan with action items, goals, objectives and timelines to address these areas. Examples of this include coordinating with other community clinics, building increased networking with non-contracted providers, and continuing to explore provider interest in developing needed services such as youth residential facilities.

9. Access to Services. In accordance with 42 CFR 438.206, describe how the County will assure the following:

- Meet and require providers to meet standards for timely access to care and services, taking into account the urgency of need for services.
- Require subcontracted providers to have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal patients.
- Make services available to beneficiaries 24 hours a day, 7 days a week, when medically necessary.
- Establish mechanisms to ensure that network providers comply with the timely access requirements.
- Monitor network providers regularly to determine compliance with timely access requirements.
- Take corrective action if there is a failure to comply with timely access requirements.

Sacramento County Behavioral Health Services/Alcohol and Drug requires contracted providers to attend a mandatory monthly meeting where treatment standards and expectations are discussed. Contracted providers must adhere to the terms of their contracts with Sacramento County Behavioral Health Services, which will clearly outline the requirements for hours of operations and 24/7 language access that are outlined in the County/State Agreement.

ADS contract monitors will coordinate with the BHS Quality Management team and will monitor contracted providers on a bi-annual basis, using components of substance use program specific monitoring tools. With Waiver implementation, adjustments will be made to the current monitoring tools to ensure appropriate adherence to the conditions of the County/State Agreement, including evaluation of the provider's ability to comply with timely access requirements. Any deviations by providers to meet the timely access requirements will result in the Quality Management team escalating protocol for corrective action compliance.

10. Training Provided. What training will be offered to providers chosen to participate in the waiver? How often will training be provided? Are there training topics that the county wants to provide but needs assistance?

Training for agencies participating in the Waiver demonstration:

The County will require all contracted DMC service providers participate in mandatory trainings to ensure compliance with DMC regulations and County contracting requirements. Compliance with training will be monitored through the contract monitoring process.

Trainings will be mandatory and offered on an annual basis for DMC/Title 22 regulations, ASAM, ADA, CLAS standards and related cultural and linguistic competence training, co-occurring disorder symptoms and diagnoses, the DSM 5 and Motivational Interviewing, 42 CFR Part 2. All of the trainings offered by DBHS must have cultural and linguistic competence woven throughout the curriculum. Additional required training will be provided to the provider network to ensure that, at a minimum, every program/provider offers evidence-based practices and community defined practices, where appropriate, to address the specific needs of diverse communities. Examples of these trainings include, but are not limited to, Cognitive Behavioral Therapy, Contingency Management, Seeking Safety, 12 Step Facilitation Therapy, The Matrix Model, and Relapse Prevention. Additional optional training that address critical system issues such as client engagement will also be offered and strongly encouraged to participate in as part of the implementation of the Drug Medi-Cal Organized Delivery System. Information about all of the trainings offered that pertain to cultural competence are maintained in a log. The log contains information about the training, including title of training, description of training, duration and frequency of the training, number of attendees by function, training date, and name of presenter(s). All network providers will be required to establish a training plan for employees and submit information to the County regarding cultural competence trainings they attended. All providers will be monitored for compliance with this contract requirement.

ASAM trainings are offered and will continue to be offered regularly to County staff and contract provider staff through coordination with the California Institute for Behavioral Health Solutions. As a result, County and provider staff will be trained to use ASAM routinely in their practice. The use of ASAM is reinforced by the use of ASAM-based assessment for client placement, which has established ASAM as the basis for making placement decisions throughout the system.

Trainings are also offered routinely through the Behavioral Health Services Division, the Alcohol and Drug Services Unit and the Workforce Development and Training Committee. The trainings are made available to county and contract providers of substance use, co-occurring disorders and mental health treatment services. Trainings offered cover a range of topics, including utilizing CLAS Standards when providing culturally competent alcohol and drug services; behavioral health interpreter training for

interpreters; how to work with behavioral health interpreters; cultural competence foundational training utilizing the California Brief Multicultural Competence Scale, and other specific training tailored to the unique needs of the diverse communities living in Sacramento County.

Review Note: Include the frequency of training and whether it is required or optional.

11. Technical Assistance. What technical assistance will the county need from DHCS?

Sacramento County is requesting technical assistance from DHCS at this time in the areas of:

- Use of brief ASAM screening tool
- Financial and administrative issues related to rate setting, reimbursement structures, documentation requirements and cost reporting of DMC-ODS services
- Youth Residential certification and Community Care Licensing regulations as needed during ODS implementation.
- Provider training
- Current list of certified youth residential facilities
- Understanding how to report and obtain reimbursement for out of county clients

12. Quality Assurance. Describe the County's Quality Management and Quality Improvement programs. This includes a description of the Quality Improvement (QI) Committee (or integration of DMC-ODS responsibilities into the existing MHP QI Committee). The monitoring of accessibility of services outlined in the Quality Improvement Plan will at a minimum include:

- Timeliness of first initial contact to face-to-face appointment
- Frequency of follow-up appointments in accordance with individualized treatment plans
- Timeliness of services of the first dose of NTP services
- Access to after-hours care
- Responsiveness of the beneficiary access line
- Strategies to reduce avoidable hospitalizations
- Coordination of physical and mental health services with waiver services at the provider level
- Assessment of the beneficiaries' experiences, including complaints, grievances and appeals
- Telephone access line and services in the prevalent non-English languages.

Review Note: Plans must also include how beneficiary complaints data shall be collected, categorized and assessed for monitoring Grievances and Appeals. At a

minimum, plans shall specify:

- How to submit a grievance, appeal, and state fair hearing
- The timeframe for resolution of appeals (including expedited appeal)
- The content of an appeal resolution
- Record Keeping
- Continuation of Benefits
- Requirements of state fair hearings.

Current DBHS structure includes a BHS Support Services Unit which encompasses the Quality Management (QM), the Research, Evaluation and Performance Outcomes (REPO) and the Electronic Health Care Record/Billing (EHR) Units. There are a total of 44 staff in the Support Services unit that support the QA/QI, performance and outcome measurement, and billing functions for Behavioral Health Services, primarily mental health services. DBHS will leverage the expertise and resources in the Support Services Unit to assist with the oversight, monitoring and reporting activities required in the ODS Waiver.

The QM unit is responsible for and will oversee Quality Assurance (QA) and Improvement (QI) across the entire continuum of care. The basic framework for quality improvement will continue under the Medi-Cal Waiver demonstration project, with modifications where necessary. The QM unit will build on existing quality assurance and utilization management capacity and processes within the mental health system of care while developing alcohol and drug specific processes required by the DMC- ODS Waiver. ADS will work with QM to conduct QA activities such as DMC audits, clinical chart audits, monitor compliance with State, Federal and Local regulations, and assure program integrity.

The REPO unit is responsible for the collection, analysis and reporting of behavioral health data. The REPO unit will support the data collection and reporting requirements required by the DMC-ODC Waiver.

The Avatar/Billing Unit is responsible for the implementation and maintenance of the BHS electronic health record as well as all BHS billing functions. QM and REPO will work closely with the Avatar/Billing unit to ensure that the EHR is set up to comply with the DMC-ODS Waiver requirements, including CFR42 confidentiality requirements and data reporting requirements.

Quality Assurance and Quality Improvement

The Mental Health Plan (MHP) currently has a well-established, comprehensive quality management/ improvement program that monitors service delivery and system capacity. DBHS will establish SUD quality assurance and quality Improvement functions into the existing quality management and improvement processes that include:

1. QI Work plan and Report
2. QIC and subcommittees
3. Utilization Management
4. Problem Resolution
5. Adverse Incident Reporting
6. Data Collection and Performance Measurement
7. Performance Improvement Projects
8. EQRO annual review

The Quality Improvement Plan:

DBHS will have an integrated Mental Health and Substance Use Disorder Quality Improvement Work Plan that will guide annual QI activities to ensure quality care and compliance with Federal, State, and local requirements. Additionally, DBHS recognizes the importance of developing a QI Plan that integrates the goals of the BHS Cultural Competence Plan as well as cultural competence elements throughout the plan to help us better understand the needs of groups accessing our BHS services and to identify where disparities may exist. The annual QI Plan will outline in detail the planned activities associated with identified ongoing and time-limited performance improvement and compliance monitoring activities. QI Plan will set standards, benchmarks and goals which will be derived from a number of sources related to quality of care and service issues such as State and Federal requirements, Department initiatives, client and family feedback, and community stakeholder input. Measures will be analyzed on an on-going basis to ensure continuous quality improvement. The BHS QI Work Plan includes four essential domains: Access, Timeliness, Quality and Consumer Outcomes. BHS will include, at a minimum, the following substance use Waiver elements into the integrated QI Plan:

Access

- Provide a toll-free telephone that can be utilized 24 hours, 7 days a week, with language capability in all languages spoken by beneficiaries in the County
- Compliance with the 24/7 access line will be monitored on a monthly basis by conducting test calls during regular business hours and after hours.
- Demonstrate equal access to ADS SOC for all cultures
- ADS services will be provided in geographically diverse locations that best represents the community needs
- Access to after-hours care
- Frequency of follow-up appointments based on client need
- Approval and denial rates of requests for service

Timeliness

- Timeliness of first initial contact to first face-to-face outpatient appointment
- Timeliness of services to first dose of NTP services
- Timeliness to residential treatment

Quality of Care

- Coordination of care with primary health and mental health
- Assessment of consumer complaints and grievances and appeals

Consumer Outcomes – Based on SAMHSA’s National Outcome Measures (NOM)

- Abstinence
- Housing stability
- Perception of care
- Social connectedness

This includes a hospitalization and recidivism QI Work Plan Report, summarizing the data and activities outlined in the QI Work Plan, will be produced annually. The QI Plan and year-end QI Work Plan report will be reviewed and approved by the DBHS Management Team and the QI Committee (QIC). At year end, the QI Work Plan will be updated based on findings from the annual QI Work Plan Report, current initiatives, DBHS goals and feedback received by QIC and DBHS Management Team.

Quality Improvement Committee:

The BHS Quality Improvement Committee (QIC), as part of the Mental Health Plan, has been in existence for 20 years, since 1997. ADS involvement was added to the existing committee in 2012 as part of ongoing efforts to integrate and redefine ADS and the MHP as Behavioral Health Services.

The QIC committee is responsible for reviewing and recommending to the BHS director/ADS Administrator new and updated policies, discussing urgent QI issues including critical incidents and client complaints, monitoring audit results and information, recommending QI actions, ensuring follow up of QI processes and obtaining input from standing or ad hoc subcommittees. On a quarterly basis the QIC also reviews the Benchmark Status Report which includes data on all activities in the QI Work Plan.

The Quality Management Program Manager leads the QI committee which meets monthly. QI committee meeting minutes document decisions and actions taken by the QI committee. Minutes are reviewed and approved at each meeting as a standing agenda item.

The current composition of the QIC committee is listed below and will be expanded to include additional SUD partners consistent with participation as required in the MHP.

NAME	ROLE
Alex Rechs	Quality Management/Compliance Manager
Andrea Crook	Adult Consumer Advocate
Ann Arneill	Mental Health Board Representative
Ann Mitchell	Avatar/Fiscal Manager
Anthony Madariaga	Division Manager – Mental Health Treatment Center
Blia Cha	Adult Family Advocate
Chris McCarty	Children’s Contracted Provider Representative
Dawn Williams	Research, Evaluation, and Performance Outcomes - Program Manager
Ed Dziuk	Alcohol and Drug Services – Program Planner
Jane Ann LeBlanc	Mental Health Services Act Program Manager
JoAnn Johnson	Ethnic Services/Cultural Competence Program Manager
Kelli Weaver	Adult Services Division Manager
Lisa Sabillo	Division Manager, Research and Evaluation, Information Technology, Quality Management
Lori Miller	Alcohol and Drug Treatment Services Program Manager
Lynn Place	Adult Mental Health Contracted Provider Representative
Mary-Ann Asare	Sacramento County Pharmacy
Matt Quinley	County Operated Program Manager
Robert Hales	Medical Director – Sacramento County Adult Psychiatry
Robert Horst	Medical Director – Sacramento County Children’s Psychiatry
Sandena Bader	Children/Youth Family Advocate
Sheri Green	Adult Service Program Manager
Stephanie Kelly	Children’s Services Program Manager
Uma Zykofsky	Behavioral Health Services Director

Subcommittees are part of the QIC structure, with some meeting on a regular basis, while others meet as needed depending on the charge of the committee. Subcommittee chairs attend the monthly QIC to report out on subcommittee activities, issues to be addressed or discussed at the QIC level, to acknowledge successes and to provide feedback from stakeholders regarding future performance improvement ideas. SUD representatives will be integrated into current subcommittee membership and additional subcommittees will be added when and if the need is determined by the QIC. Subcommittees include, but are not limited to:

1. Cultural Competence Committee
2. Utilization Review Committee
3. Research and Evaluation Committee (ad hoc)
4. Grievance Committee (ad hoc)
5. Education and Training Committee (ad hoc)
6. Medication Monitoring Committee
7. Pharmacy and Therapeutics Committee
8. Credentialing Committee (ad hoc)
9. Executive Committee (ad hoc)

A special SUD Implementation Subcommittee will be developed to problem solve implementation issues relating to the ODS waiver.

Utilization Management and Review

Utilization management for substance use disorder services will be a collaborative effort between QM and ADS staff. QM will work with ADS to build on existing ADS utilization processes to assure clients have appropriate access to substance use disorder service; medical necessity has been established and the client is at the appropriate ASAM level of care and that the interventions are appropriate for the diagnosis and level of care.

Utilization Management:

ADS currently authorizes admissions to substance use treatment and extensions of lengths of stay in residential treatment and transitional housing clients. Consistent with MHP processes ADS will utilize the electronic health record to centralize and track all authorizations in a consistent manner across all service modalities, monitor and track waiting lists and types and amounts of services provided.

Utilization Review:

The established MHP utilization review process will be leveraged to enhance the existing ADS utilization review process. A separate utilization review process for monitoring the unique aspects related to the delivery of substance use disorder services will encompass:

1. A formal utilization review process that occurs on at least a quarterly basis with mechanisms in place to track number of cases reviewed and types and frequency of non-compliance items.
2. A tool based on DHCS compliance protocol (authorization, level of care determination, medical necessity, assessments, diagnosis, client plan, consistent with treatment in progress notes, evidence of coordination of care, discharge planning) (consent to treat, medication consents, HIPAA (42 CFR), ROIs) will be created as a guideline to monitor provider performance and compliance.
3. A to be determined minimum percentage of substance use client records that will be required to go through the utilization review process based on the annual number of clients served.
4. A provider peer review process and will consist of both internal provider reviews and county review processes.
5. Provisions for monitoring of billing corrections and plans of correction that result from the utilization review.

Contract Monitoring/ Compliance Review:

An additional aspect of utilization management involving programmatic reviews which look primarily at contractual and system-wide provider operational requirements are currently completed on an annual basis. Elements of expected program performance, such as the interfaces with psychiatry and primary care, are included in these reviews.

These reviews included site reviews to each provider site to determine whether services are provided in accordance with the contract and state regulations. Site reviews are facilitated by ADS and involve specific assessment tools for each level of care and include: a walk-through of the facility, comprehensive on-site evaluation and review of program policies/procedures, client file documentation, personnel files, adherence to Title 22, California Code of Regulations, and interviews with administrators, program managers, counseling and clerical staff.

Upon completion of the review, a written report is submitted to the subcontracting provider documenting the findings of the review and instructions for completing and submitting a corrective action plan when necessary. Corrective Action is required for outstanding issues of non-compliance or areas determined to need improvement.

Problem Resolution Process:

The MHP currently has a robust Beneficiary Protection program that encompasses the

problem resolution process and is staffed by 2 clinically licensed staff. The ADS problem resolution process will be integrated into the current DBHS problem resolution process and will adhere to the established policy and procedures set forth in the MHP Beneficiary Protection program and distributed to all service providers. The DBHS problem resolution process currently complies with all State and Federal regulations and will be updated as needed to comply with the new Managed Care Rule that goes into effect July, 1, 2017, CFR42 Part 438.402, as well as any new DHCS requirements.

DBHS is committed to providing solutions to problems and concerns that clients may encounter during the course of receiving treatment. Clients will not be subjected to discrimination, intimidation or any other retaliation for expressing concerns, filing a Grievance or Appeal. Clients who are dissatisfied with any issue related to the behavioral health services may submit a grievance or appeal to QM Beneficiary Protection Member Services. Clients may contact Patients' Rights or Member Services for assistance in completing forms and resolving a grievance, appeal, and State Fair Hearing. With written consent of the client, a provider or authorized representative may request an appeal, file a grievance or request a state fair hearing on the client's behalf. All providers are given information about the grievance and appeal process when they enter into a contract with the County and providers are expected to be knowledgeable about the problem resolution process and have materials on the problem resolution process easily accessible to clients. Clients will receive information upon intake and annually thereafter of the process for reporting and resolving grievances and appeals. All problem resolution informing materials are available in threshold languages and are available on the County website.

Grievance

A client or their authorized representative may file a grievance at any time either orally, by calling Member Services, or in writing, by completing a grievance form. The client will receive a written acknowledgment that the grievance was received and will receive a written resolution within (90) ninety calendar days. The written resolution will include the grievance findings.

Standard Appeal

A client or their authorized representative may submit an appeal orally or in writing but the submission must be within 60 calendar days from the date of the adverse benefit determination notice. Oral appeals must be followed up with a written, signed appeal. Clients will receive a written acknowledgement of receipt of the appeal and the client will receive written resolution within 30 days. The written resolution provided to the client will contain the results of the appeal resolution process and the date that the appeal decision was made. If the appeal is not resolved wholly in favor of the client the notice will also contain information on the client's right to a State fair hearing and the procedure for filing a State Fair hearing, including the right to continued benefits.

Expedited Appeal

An expedited appeal is filed when the client's life, health, or ability to have or maintain

maximum function is at risk. The client will receive a written resolution within 72 hours after the appeal is received. If the expedited appeal is denied a written notice will be sent to the client and the standard appeal process will begin.

Notification of resolution timelines for standard and expedited appeals can be extended up to 14 calendar days if the client requests it or if there is a justified need for additional information and the extension is in the client's best interest.

State Fair Hearing

A client may request a State Fair Hearing following the receipt of an adverse benefit determination if the client has exhausted the Problem Resolution Process. A request for a State Fair Hearing must be made in writing and sent to the State Hearing Division of the California Department of Social Services. Once the Problem Resolution staff have been notified by DHCS of a client request for a state hearing the request will be logged. Prior to each hearing Problem Resolution staff will prepare a Statement of Position and provide a copy to the client and his/her authorized representative not less than two working days prior to the schedule date of the hearing. The State Fair Hearing decision is final.

Continuation of benefits

For clients that file a grievance or appeal the County will continue to provide the client with the level of services the client currently receives until a final decision is reached. For clients that file a State Fair Hearing, the client must request continuation of behavioral health services within 10 days of the postmark date of the notice of adverse resolution or before the effective date of the change, whichever is later in order for services to continue at the same level while the hearing is pending.

Problem resolution staff maintains a Grievance/Appeal log documenting privacy issues, grievances, appeals, change of provider requests and requests for State hearings. Information logged includes the name of the beneficiary, date of receipt of the grievance/appeal, nature of the problem, disposition, the date of decision is sent to the client, and when there has not been a decision rendered documentation of the reason(s) that there has not been final disposition of the grievance. Reports have been built to monitor the number, types, frequency, and resolution relating to appeals, grievances and State Fair Hearings. This data is reviewed by QM management on a monthly basis to ensure resolution and compliance with timelines.

The problem resolution process is included in the QI Work Plan and data on grievances, appeals, and State Fair Hearings is reviewed quarterly at the QI Committee.

Adverse Incidence Reporting:

Currently contract providers throughout the mental health system submit Adverse Incident Reports (AIR) to the MHP, both to Program Monitors and to Quality Management, whenever a sentinel incident occurs. A sentinel incident involves a client

or a staff person and includes: death (for e.g. suicide or homicide), suicidal attempt, sexual harassment, infractions of patient's rights, serious medication side effects, likelihood of litigation, possibility of media coverage, falsification of professional credentials, and facility fire. Quality Management reviews all these reports. The QIC Executive Committee reviews reports that suggest a trend or pattern of issues of concern and all reports of death when the cause is undetermined. If, at any level of review, there is noted a need for improvement, feedback is given to the provider either through phone contact, a face-to-face meeting and/or in writing with a request for a plan of correction. All actions are tracked, reviewed and monitored by the Manager of Quality Management on behalf of the Executive Committee of the Quality Improvement Committee. The AIR P&P will be updated to include the requirements and standards for SUD providers and will be incorporated into the current tracking and monitoring process.

Data Collection & Performance Measurement Monitoring:

Program data for the ADS System of Care is currently entered into the California Outcomes Measurement System database and Sacramento County's electronic health record (EHR), Avatar. At present, county and contract providers enter data into Avatar within a common timeframe, as specified in policy and procedures for system operations and contracts between the county and community based organizations. Routine reports are available for all providers to manage their operations. County ADS and provider staff run multiple reports on a regular basis and monitors both provider and system performance. Independent review of performance measures will also be conducted by the REPO unit within the department.

Data support staff within ADS are also responsible for uploading CalOMS data from all providers in the system on a monthly basis. CalOMS error and rejection rates are monitored and training is provided to contracted providers who require technical assistance to meet their corrective action objectives. CalOMS data are used to establish outcomes and system monitoring reports, ad hoc management and policy reports, specialized reports by department's analysts, and system and performance improvement projects. Consumer satisfaction surveys will be collected on a bi-annual basis to measure consumer perception of services and quality of life

Sacramento County will ensure compliance with DHCS performance standards as they relate to the ODS Waiver. Performance standards will be integrated into the QI Work Plan and will be monitored on a quarterly basis by BHS Management and the QI Committee.

Performance Improvement Projects:

DBHS will comply with all requirements related to substance use disorder related Performance Improvement Projects (PIP) and will leverage the current MHP process for the development and implementation of required PIPs.

External Quality Review (EQR):

DBHS will immediately review EQR requirements under the ODS Waiver and will phase in all EQR requirements within the first 12 months of having an approved implementation plan. The experience of the Support Services QM, REPO and EHR teams will be leveraged to assist prepare DBHS for the annual ODS Waiver EQRO review.

13. Evidence Based Practices. How will the counties ensure that providers are implementing at least two of the identified evidence based practices? What action will the county take if the provider is found to be in non-compliance?

Sacramento County will ensure that contract providers are implementing evidence based practices from the National Registry of Evidence-based Programs and Practices (NREPP). Contracts will be amended to include a requirement that each contract provider will provide at least two of the following EBPs:

- Cognitive Behavioral Therapy
- Relapse Prevention
- Psycho-Education
- Motivational Interviewing
- Trauma Informed Treatment

When the DMC-ODS is implemented, providers in the current ADS System of Care will be required to attest that they are trained in the ASAM and providing at least two EBPs in the treatment program. ADS will provide training and technical assistance to provider staff to ensure consistent use and fidelity to EBPs. Specific protocol and procedure will be developed so that this standard of care can be monitored during compliance reviews. Treatment provider use of EBPs will be reviewed by the contract monitor staff during annual reviews. Non-compliance will result in the issuance of a corrective action plan (CAP).

Alcohol and Drug Services contracted providers have been trained in a number of Evidence Based Practices (EBP's). County and Provider staff have been trained or offered training in Motivational Interviewing, Cognitive Behavioral Therapy, Stages of Change, Trauma Informed Care, Seeking Safety, Gorski's Relapse Prevention and 12 Step Facilitation. During the first year of the Waiver, the substance use treatment system will provide further training in ASAM, Peer Support Services, and other Evidence Based Practices.

All programs in the Adult and Youth System of Care will need to be determined as co-occurring capable per the Dual Diagnosis Capability in Addiction Treatment (DDCAT) with score of 3 or above. A DDCAT assessment of MAT programs will also be scheduled.

Actions for non-compliance:

Annual compliance reviews will be the primary mechanism used to determine compliance with the requirement for using EBPs. Providers who are out of compliance will be given direction as to the necessary training required to meet standards of care for the system. Providers will be required to submit a plan of correction to the County.

14. Regional Model. If the county is implementing a regional model, describe the components of the model. Include service modalities, participating counties, and identify any barriers and solutions for beneficiaries. How will the county ensure access to services in a regional model (refer to question 7)?

Sacramento County is not currently proposing to participate in a regional delivery system.

15. Memorandum of Understanding. Submit a signed copy of each Memorandum of Understanding (MOU) between the county and the managed care plans. The MOU must outline the mechanism for sharing information and coordination of service delivery as described in Section 152 “Care Coordination” of the STCs. If upon submission of an implementation plan, the managed care plan(s) has not signed the MOU(s), the county may explain to the State the efforts undertaken to have the MOU(s) signed and the expected timeline for receipt of the signed MOU(s).

16. Review Note: The following elements in the MOU should be implemented at the point of care to ensure clinical integration between DMC-ODS and managed care providers:

- Comprehensive substance use, physical, and mental health screening, including ASAM Level 0.5 SBIRT services;
- Beneficiary engagement and participation in an integrated care program as needed;
- Shared development of care plans by the beneficiary, caregivers and all providers;
- Collaborative treatment planning with managed care;
- Delineation of case management responsibilities;
- A process for resolving disputes between the county and the Medi-Cal managed care plan that includes a means for beneficiaries to receive medically necessary services while the dispute is being resolved;
- Availability of clinical consultation, including consultation on medications;
- Care coordination and effective communication among providers including procedures for exchanges of medical information;
- Navigation support for patients and caregivers; and
- Facilitation and tracking of referrals.

As a Geographic Managed Care (GMC) county, Sacramento County has Memorandums of Understanding (MOU) with all its Managed Care Plans. Sacramento County Alcohol and Drug Services is coordinating with GMCs to develop a process for SUD to be included in County MOUs, including the required policies and procedures with the following Medi-Cal Managed Care Plans in Sacramento County: Anthem Blue Cross, Health Net, Kaiser Health Plan, and Molina Healthcare. It is anticipated that when, United Healthcare and Aetna Better Health become active plans in Sacramento, these plans will follow the same GMC MOU structure. The MOU will outline mechanisms for sharing information and coordination of service delivery.

Elements to be covered in the MOU include the following components:

- Comprehensive substance use, physical, and mental health screening;
- Beneficiary engagement and participation in an integrated care program as needed;
- Shared development of care plans by the beneficiary, caregivers and all providers;
- Collaborative treatment planning with managed care;
- Care coordination and effective communication among providers;
- Navigation support for patients and caregivers; and
- Facilitation and tracking of referrals between systems.

Policies and procedures:

- Information sharing policies and procedures;
- Agreed upon roles and responsibilities for sharing personal health information (PHI) for the purposes of medical and behavioral health care coordination; and
- Coordinating medical and behavioral health care for beneficiaries enrolled in Medi-Cal Managed Care Plans that are receiving Medi-Cal specialty mental health or Drug Medi-Cal services through the Department.

Additional provisions for compliance with 42 CFR Section 438:

The MOUs with health plans will contain language that covers:

- Plan for a fair hearing for denial of service
- Provisions for a protocol to resolve issues related to denial of coverage or payment of services rendered.
- The grievance system will include required elements such as:
 - Procedures for clients, providers and MCOs to file and appeal grievances
 - Time frames for reasonable action
 - Fair hearing procedures
 - Protocols for filing grievances

The Memorandum of Understanding with managed care organizations must be approved by county counsel. The template for future agreements will also be reviewed and approved by counsel review. The MOU and affiliated policies and procedures are targeted to be complete prior to implementation.

17. Telehealth Services. If a county chooses to utilize telehealth services, how will telehealth services be structured for providers and how will the county ensure confidentiality? (Please note: group counseling services cannot be conducted through telehealth).

Tele-health services will be explored for the Medi-Cal Waiver demonstration. However, a number of issues related to electronic transmission of Personal Health Information (PHI), confidentiality of tele-health sessions and client privacy need to be explored, and policy and procedures developed. As the Behavioral Health Services Division is located within Sacramento County's Health Services Department, policies and procedures must be aligned to the technological capacity and requirements of the county departmental system. A working committee composed of representatives from the Sacramento County Compliance Office and County Counsel's Office has been reviewing procedures for tele-health modalities to ensure that all programs comply with confidentiality regulations.

18. Contracting. Describe the county's selective provider contracting process. What length of time is the contract term? Describe the local appeal process for providers that do not receive a contract. If current DMC providers do not receive a DMC-ODS contract, how will the county ensure beneficiaries will continue receiving treatment services?

Selection of provider contracting process:

The Sacramento County Department of General Services (DGS) is the designated County agency that oversees procurement policy and procedure. In compliance with DGS and the Board of Supervisors (BOS), DHS/BHS has been given authority to conduct procurement for Health Services. BHS complies with the County Competitive Solicitations policy and procedure for the selection and retention of service providers. Sacramento County Charter (Section 45) and the Sacramento County Purchasing Code (Section 2.56 states: Except as authorized by Section 2.56.250, all purchases or annual contracts by the Purchasing Agent exceeding \$100,000 shall be made pursuant to formal competitive solicitation (bids, proposals, reverse auctions, etc.) and shall be let to the party whose offer provides the greatest value to the County.

The Sacramento County Department of Health Services administers a competitive Request for Proposal process under the direction of the DHS Director. The main stages of the competitive bid process are:

1. Development of procurement request and approval of funding by DHS Director
2. RFP Development
3. RFP Release
4. Bidder's Conference
5. Bid Submission

6. County Evaluation Team Orientation (includes panelist confidentiality and conflict of interest statements)
7. Evaluation of written proposal by County Evaluation Team
8. Award/notification letters sent to all bidders
9. Formal bid protest/appeal process
10. Contract development/negotiation
11. Presentation of DHS recommendation to the BOS for approval

Length of term of contract:

Services will be re-bid every 5 years through a competitive procurement process that involves publishing Request for Proposals (RFP). Contract awards from RFPs are renewed every fiscal year and are in effect for a maximum of 5 years. Under specific circumstances, the Board of Supervisors may allow a contract to be extended beyond the prescribed period.

Local appeals process:

Sacramento County Charter (Section 45) and the Sacramento County Purchasing Code (Section 2.56) provides vendors an opportunity to submit a protest to a contract award. Additionally, the protest procedure is explained in detail as part of all DHS Request for Proposals, to allow non-selected contractors a process to appeal.

DHS protest/appeal language is as follows:

1. Any proposer wishing to protest disqualification in the screening process or the proposed award recommendation(s) must submit a written letter of protest to the DHS director. Submit such a letter by the date shown in the RFP timeline. Any protest shall be limited to the following grounds:
 - a. The County failed to include in the RFP a clear, precise description of the format which proposals shall follow and elements they shall contain, the standards to be used in screening and evaluating proposals, the date on which proposals are due, and the timetable the County will follow in reviewing and evaluating them: and/or
 - b. Proposals were not evaluated and/or recommendation(s) for award were not made in the following manner:
 - i. All timely proposals were reviewed to determine which ones met the screening requirements specified in the RFP; and/or
 - ii. All proposals meeting the screening requirements were submitted to an Evaluation Committee, which evaluated the proposals using the criteria specified in the RFP; and/or
 - iii. The proposer(s) judged best qualified by the Evaluation Committee was recommended to the Director of DHS for award; and/or

- iv. The County correctly applied the standards for reviewing the format requirements or evaluating the proposals as specified in the RFP.

Options for continuing service for beneficiaries if a particular contractor is not selected:

If current DMC providers are not awarded a DMC-ODS contract, the County will ensure that beneficiaries are referred to other DMC-ODS contract providers that provide comparable services. Sacramento County will assume the responsibility to ensure continued care and will develop a transition plan between providers to decrease any gaps in service that may arise in this type of situation.

19. Additional Medication Assisted Treatment (MAT). If the county chooses to implement additional MAT beyond the requirement for NTP services, describe the MAT and delivery system.

Sacramento County will explore the implications and feasibility for adding additional Medication Assisted Treatment services to the continuum of care, with a specific focus on Vivitrol.

20. Residential Authorization. Describe the county's authorization process for residential services. Prior authorization requests for residential services must be addressed within 24 hours.

Residential capacity in the Alcohol and Drug Services system is managed by the County System of Care. When clients enter the System of Care, they are triaged to the most appropriate modality using an ASAM screening tool. A decision is then made by the County counseling staff member referring the client to the most effective service modality (Detoxification, Residential Treatment, Outpatient Treatment, MAT services). The triage determination at the System of Care constitutes an authorization for Residential Treatment and the client is referred to treatment within 24 hours. In the case of all system beds being at full capacity, the client is placed on the Residential Placement list. All clients on the Placement list are offered treatment on demand through Intensive Outpatient services and/or provided with interim group education options. The County will explore contracts with out of network residential facilities as needed. County staff are responsible for matching clients on the list to appropriate residential beds as soon as possible. Current placement data indicate that the overwhelming majority of clients are placed into residential treatment during the first 27 days following the initial assessment at System of Care. Placement times in residential treatment depend on capacity and client choice.

With the implementation of the Waiver, Sacramento County will move to placement within 21 days. This will be accomplished through the development of additional residential capacity within the existing network. Sacramento County will also be pursuing the possible capability of creating an electronic bed census management tool within its EHR system to manage residential bed capacity with greater efficiency.

Referrals for residential treatment from the call-center and post-authorization sites are maintained centrally by System of Care staff, which manages a placement process following SAPT standards for prioritizing residential admissions. The System of Care proposes to increase the timeliness to service by retooling the residential placement process and other tools used for system improvement.

Beneficiaries will be offered same day admissions if beds are available. Some beneficiaries prefer the convenience of an appointment and choose to schedule their admission day up to a few weeks in advance.

The System of Care coordinates placement of clients in residential treatment when the initial assessment requires it. If the recommendation involves an “upgrade” to a more intensive level of care, then the provider obtains authorization through the System of Care. In instances where transfer cannot be arranged on the same day, the first provider is required to admit the client and provide them with the intensity of services necessary to prevent their condition from deteriorating until the transfer can be arranged. Upgrades from outpatient to residential are given a high priority and these transfers are routinely coordinated by the System of Care. Transfers between levels of care are documented.

The ODS Waiver has created the opportunity for the System of Care to revise the residential placement process. In the future, authorization will occur following a face to face session in which an ASAM six-dimension assessment is conducted (at the referred treatment site). Providers will contact the County System of Care after completing a standardized intake assessment and request a formal authorization. In the Adult system, the current 90-day residential length of stay benchmark for an initial authorization will continue. At present, residential treatment is initially authorized for 90 days (120 days for opioid treatment). Stays beyond the initial authorization period must be authorized by the System of Care. This protocol will continue under the demonstration project. The same full six- dimensional ASAM assessment used at intake will be used to determine re-authorizations for stays anticipated beyond 90 days. Extensions will be granted by System of Care consultation based on a beneficiary’s current clinical needs and ASAM assessment in keeping with a chronic care management philosophy where clients are stabilized at higher levels of care and then moved to lower levels of care within the community. The Sacramento County Organized Delivery System will manage client benefits by using authorizations, utilization management and data reporting.

The length of residential services range from 1 to 90 days with a 90-day maximum for adults, unless medical necessity requires a one-time extension of up to 30 days on an annual basis. Only two non-continuous 90-day regimens will be authorized in a one-year period. Perinatal and criminal justice clients may receive a longer length of stay based on medical necessity. If longer lengths of stay are needed, other non-Medi-Cal funds can be used. The authorization and preliminary payment source will be entered into the System of Care Residential placement list.

21. One Year Provisional Period. For counties unable to meet all the mandatory requirements upon implementation, describe the strategy for coming into full compliance with the required provisions in the DMC-ODS. Include in the description the phase-in plan by service or DMC- ODS requirement that the county cannot begin upon implementation of their Pilot. Also include a timeline with deliverables.

Sacramento County is in the process of acquiring a youth residential contracted provider. If DHCS is able to review and approve DMC certification applications in a timely manner, the County anticipates being able to come into full compliance with the required provisions of the DMC-ODS Waiver within one year of State, Federal and County approval of the State/County contract for DMC-ODS services. The County is exploring contracting options with out of network providers in order to provide youth residential treatment services. The County is also exploring contracts with local providers for the provision of Residential 3.7 and 4.0 services.

County Authorization

Authorization of County Director of Behavioral Health Services:

_____	<u>Sacramento</u>	_____
Uma K. Zykofsky, LCSW Behavioral Health Services Director Alcohol and Drug Administrator Department of Health Services	County	Date