NOTE: Given the continual evolution of the field of Substance Use Disorder treatment, the SUDPOH is a living document and will evolve with the availability of new information and research, or changes in policy, regulatory mandates, or contractual agreements. As a result, this document is subject to ongoing review and revision at the discretion of the County of San Diego HHSA Behavioral Health Services.
COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY, BEHAVIORAL HEALTH SERVICES
Drug Medi-Cal Organized Delivery System (DMC-ODS)

SUDPOH
Substance Use Disorder Provider Operations Handbook

Note:
- Reminder – DHCS is the DMC Authority. Always check DHCS’s website to ensure access to the most current information included in MHSUDS Information Notices, FAQs, and other DMC-ODS related regulations and guidance.

- The Program contract, including the Service Template and Statement of Work, takes precedence over the SUDPOH. If any element of the contract is in conflict with the SUDPOH, contact the program’s COR.

- All Forms and Manuals referenced in the SUDPOH can be found on the Optum website. Documents are located under the County Staff & Providers tab, and then under the Drug-Medi-Cal Organized Delivery System link.
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A. THE COUNTY OF SAN DIEGO DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM (DMC-ODS)

In 2015, the California Department of Health Care Services (DHCS) received approval from the Center for Medicare & Medicaid Services (CMS) for an 1115 waiver amendment which is referred to as the Drug Medi-Cal Organized Delivery System (DMC-ODS). This allowed for improvements to provision of substance use disorder services by providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for SUD treatment services. Additionally, it enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidence-based practices in substance use disorder treatment, and coordinates with other systems of care. This approach provides Drug Medi-Cal beneficiaries with access to the care and system interaction needed in order to achieve sustainable recovery.

After a process of planning and collaboration with community partners and recipients of SUD services, the County of San Diego submitted their DMC-ODS Implementation Plan to DHCS in 2017. The plan was approved, and implementation began in 2018.

The DMC-ODS expands the standard Drug Medi-Cal (DMC) substance use disorder service benefits package in the following ways:

<table>
<thead>
<tr>
<th>Standard Drug Medi-Cal Benefits</th>
<th>DMC-ODS Benefits</th>
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<tbody>
<tr>
<td>Outpatient Services</td>
<td>Outpatient Services</td>
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<tr>
<td>Intensive Outpatient Services</td>
<td>Intensive Outpatient Services</td>
</tr>
<tr>
<td>Perinatal Residential Treatment (perinatal only and 16 bed limitation)</td>
<td>Residential Treatment (multiple levels of care for all beneficiaries and no bed limitation)</td>
</tr>
<tr>
<td>Inpatient Hospital Detoxification</td>
<td>Withdrawal Management (continuum)</td>
</tr>
<tr>
<td>Narcotic Treatment Program Services</td>
<td>Narcotic Treatment Program Services</td>
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<tr>
<td></td>
<td>Recovery Services</td>
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<td>Case Management</td>
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<td>Physician Consultation</td>
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<td></td>
<td>Additional Medication Assisted Treatment</td>
</tr>
<tr>
<td></td>
<td>Partial Hospitalization</td>
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</tbody>
</table>

DHCS remains responsible for administering SUD treatment in California, and the County of San Diego Behavioral Health Services (COSDBHS) contracts with DHCS to fund local SUD services. As a part of the contract with DHCS, COSDBHS ensures that state SUD treatment requirements and standards are met by maintaining fiscal management systems, monitoring provider billing, conducting compliance visits, processing claims for reimbursement, and offering training and technical assistance to SUD treatment providers.

Mission of the County of San Diego Drug Medi-Cal Organized Delivery System Service Programs

The County of San Diego Behavioral Health Services (COSDBHS) Division provides a continuum of Behavioral Health Services (mental health and substance use disorder services) for children, youth, families, adults, and older adults. The Division embraces Live Well San Diego: The County’s over-arching vision to promote healthy, safe and thriving communities throughout the County of San Diego. It promotes recovery and well-being through prevention, treatment, and intervention, as well as integrated services for clients experiencing co-occurring mental illness and substance use disorders. The Behavioral Health
Services Division provides services under two systems of care: Adult/Older Adult Services and Children, Youth, and Family Services.

Substance use disorders are a major public health and safety problem impacting adults with diverse treatment needs, children, youth, families, and communities. Substance Use Disorder (SUD) programs provide an integrated system of community-based substance use prevention, intervention, treatment, and recovery services throughout San Diego County via contracts with local service providers. SUD program contractors should be relational and strength-based, trauma-informed, culturally competent and involve healing of the family unit in a safe and sober environment. It is the mission of the County of San Diego Behavioral Health Services to deliver these services at the highest level of quality, ensuring that clients are given the necessary tools and support to become productive citizens. Services are delivered under contracts managed by a BHS Contracting Officer’s Representative (COR).

The Drug Medi-Cal Organized Delivery System Substance Use Disorder Provider Operations Handbook (DMC-ODS SUDPOH) is specifically designed to be used by all administrative and direct service staff to ensure understanding of core values and principles for the SUD system of care and adherence to the clinical and business expectations meant to ensure delivery of quality and outcome based services.

The DMC-ODS SUDPOH, along with other federal, state and local regulations, governs delivery of SUD treatment services in the County of San Diego. A partial list is as follows (see the Resources section for a more comprehensive listing):

- Health Insurance Portability and Accountability Act (HIPAA);
- California Code of Regulations (CCR) Title 9 Counselor Certification the California Code of Regulations;
- CCR Title 22 Drug Medi-Cal;
- Drug Medi-Cal Organized Delivery System Special Terms and Conditions; (note, in the event of conflicts between Title 22 Drug Medi-Cal provisions and the DMC-ODS Special Terms and Conditions, the provisions of Title 22 shall control if they are more stringent);
- Department of Health Care Services Perinatal Practice Guidelines and Youth Treatment Guidelines;
- County of San Diego DMC-ODS Implementation Plan and Finance and Rates Plan;
- The DHCS & County of San Diego Intergovernmental Agreement (IA);
- State Department of Health Care Services (DHCS) Letters and Information Notices
- State mandated Performance Improvement Projects (PIP) – the State has mandated that each county undertake one administrative and one clinical improvement plan yearly.
- The Contract Template and Statement of Work for each Program including but not limited to the Specific Services to be provided.

Additionally, The Federal Managed Care Regulations, specifically part 438 of title 42 Code of Federal Regulations applies to the provision of Medicaid Managed Care (MMC) programs and managed care organizations (MCOs), Pre-Paid Inpatient Health Plans (PIHPs), and Pre-Paid Ambulatory Health Plans (PAHPs). Counties opting-in to the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver are considered PIHPs. Key goals of the final rule are:
• To support State efforts to advance delivery system reform and improve the quality of care
• To strengthen the beneficiary experience of care and key beneficiary protections
• To strengthen program integrity by improving accountability and transparency
• To align key Medicaid and CHIP managed care requirements with other health coverage programs

All providers shall adhere to the rules and regulations as stipulated in the Medicaid and CHIP Managed Care Final Rules.

System of Care Principles

Substance Use Disorders as a Chronic Disease
Substance use disorders (SUD) are often chronic, relapsing conditions of the brain that cause compulsive drug seeking and use, despite harmful consequences. They are considered a brain disease because substances change the brain; they change its structure and how it works. These brain changes can be long lasting and can lead to many harmful, often self-destructive, behaviors. (National Institute on Drug Abuse).

A chronic disease is one that cannot be easily or simply cured, but instead must be treated, managed, and monitored over time. Like heart disease, diabetes and asthma, SUD exhibits a chronic course that requires treatment and management over a longer period, and at times over the course of a lifetime. While some individuals may develop a SUD and achieve recovery after minimal intervention and over brief period of time, the majority of individuals will exhibit a more chronic and relapsing course.

With this in mind, the County of San Diego has chosen to participate in the Drug Medi-Cal Organized Delivery System (DMC-ODS) continuum of service model of SUD treatment. This perspective values the individualized needs of the person with a SUD, and tailors services to meet these unique needs. SUD services from this perspective are not “one size fits all,” but based on an individual’s needs at a specific point in time. As an individual advances along their recovery journey, the type and intensity of treatment services they receive should change and reflect the severity and nature of the client’s SUD. This approach emphasizes care coordination and ensuring a full continuum of care that offers varying levels of care to best tailor service delivery to client need. As a result, a key goal of SUD treatment is to provide the right service, at the right time, for the right duration, in the right setting.

Accessing Service: “No Wrong Door”
Consistent with the Health and Human Services Agency’s “No Wrong Door” philosophy, clients may access SUD services through multiple points of entry. Clients who are residents of San Diego County may call the Access and Crisis Line (ACL), call or walk into a program directly, or be referred to a program by community partners.

Client-Centered Care
The County of San Diego Behavioral Health Services (COSDBHS) embraces a philosophy of client-centered care. In order to engage and retain a client in treatment, providers must work collaboratively with clients, respecting an individual’s preferences, needs, well-being and values. Client-centered care is not the same thing as “always doing what the client wants,” as there will be times when clinical judgment does not align with a client’s desires, but is deemed in the best interest of the client; however, client preferences and values need to be considered as part of that decision-making process.
Customer Service
The County of San Diego Behavioral Health Services (COSDBHS) recognizes that its greatest strength lies in the talent of its providers and expects them to always treat clients, families and other consumers with respect, dignity and courtesy. Clients/families shall be treated equally regardless of race, religion, creed, color, gender, economic status, sexual orientation, and age, as well as source of payment or any other non-treatment or non-service-related characteristic.

Clients and families deserve high-quality customer service, which includes:

- Treating customers with courtesy, respect, professionalism and a positive attitude
- Responding to customers in a timely manner whether in person, by phone, in writing or via e-mail
- Being aware of cultural diversity and focusing on understanding customer differences
- Providing complete, accurate and reliable information and feedback

SUD providers are expected to ensure that they have a customer-first attitude which is instilled throughout their operations. Systems should be in place to enable customers to voice any grievances or problems, and if needed, may be done anonymously. Review Section G: Quality Management for SUD program requirements regarding reporting grievances.

The following are the basic expectation that COSDBHS has for all County and contracted programs:

1. Establish Customer Service Standards. For example, the County of San Diego Customer Experience Initiative has set a standard of using a positive approach to provide customers with a positive experience. This commitment is summarized in the acronym HEART:
   - Helpfulness: going out of our way to find answers
   - Expertise: being knowledgeable
   - Attentiveness: being ready to meet customer needs
   - Respect: Treating customers with dignity and courtesy
   - Timeliness: being efficient with customer time

2. Ensure that all staff members are aware of these standards and are clear that adhering to Customer Service Standards is an expectation of the program.

3. Ensure clients and families that no form of retaliation will come from any grievances or suggestions for improvement made to the program.

4. Enhance program services based on input received from customers to demonstrate receiving and accepting feedback from customers.

5. Make Customer Service Standards training available to all staff.

Ensuring a Standard Quality of Service
The DMC-ODS is a core component of the larger healthcare system and, as such, needs to maintain minimum standards and expectations to ensure high quality services for the clients it serves. Similar to the management of other chronic conditions, these minimum standards for SUD ensure a reasonable degree of
consistency across service providers, while also allowing sufficient flexibility to provide services that are tailored to the individual needs of clients. For example, an individual with diabetes may receive slightly different services depending on the provider (e.g. one doctor may suggest a different medication or dietary/lifestyle change than another), but the treatment and management approach should be guided by certain best practice and clinical standards.

Similarly, SUD services need to be guided by best practice and clinical standards, which include the use of evidence-based practices (EBPs). Motivational Interviewing (MI) and Relapse Prevention are required EBPs in the County of San Diego DMC-ODS.

It is important to note that standards-based care and individualized care are not mutually exclusive. Service providers can offer individual and client-centered care that also meets certain minimum best practices and clinical standards.

This provider manual describes a framework of standards that involve client services, clinical and business processes, and pertains to all providers within the County of San Diego Drug Medi-Cal Organized Delivery System. In outlining these minimum expectations, this provider manual establishes an infrastructure of qualify for SUD treatment throughout San Diego County.

County of San Diego Drug Medi-Cal Organized Delivery System Regions

The County of San Diego is divided into six Health and Human Services Agency regions by zip code. The following list presents the regions and the communities contained therein.
### General Practice Guidelines

The County of San Diego Behavioral Health Services (COSDBHS) recognizes that clinical care needs to be an individualized process that balances client needs, established clinical standards, and available resources. Each clinical case is unique and there are many variables that impact care; however, care guidelines can be helpful to outline generally accepted clinical standards.

The guidelines outlined below are not intended to be a comprehensive overview of all aspects of clinically appropriate substance use care. It is strongly recommended that one refer to more detailed clinical guidelines provided through SAMHSA and other respected resources for additional information. (SAMHSA publications can be found [here](https://www.samhsa.gov).)

#### Medical Necessity and Assessment

Medical necessity refers to the applicable evidence-based standards applied to justify the level of services provided to a client, so the services can be deemed reasonable, necessary and/or appropriate. It refers to those SUD treatment services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness or injury consistent with 42 CFR 438.201(a)(4) or, in the case of EPSDT, services that meet the criteria specified in Title 22, Sections 51303 and 51340.1.

It is imperative that medical necessity standards be consistently and universally applied to all clients to ensure equal and appropriate access and service delivery, and is established to demonstrate and maintain eligibility for services delivered.

Medical necessity for an adult (an individual age 18 and over) is determined using both of the following criteria:

- The individual shall have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance Related Disorders
• The individual shall meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria (i.e. meet criteria for a specific level of care).

Individuals under age 21 are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, clients under the age of 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority. Regulations under DMC-ODS do not override any EPSDT requirements. Medical necessity for an adolescent (age 12 to 20) is determined using the following criteria:

• The adolescent shall be assessed to be at risk for developing a SUD*
• The adolescent shall meet the ASAM adolescent treatment criteria.

*Per DHCS, the Intergovernmental Agreement between the County of San Diego and the State allows at-risk youth (individuals under the age of 21) to be served at the ASAM Level 0.5 (Early Intervention) level of care. At-risk youth (those without a DSM-5 SUD diagnosis) would not meet medical necessity criteria for Outpatient Services (OS - also known as ASAM Level 1) or any other levels of care in the continuum.

There are various types of assessments focusing on medical necessity and clinical care, including level of care determinations. Assessments, and the corresponding documentation, serve as the foundation of high-quality care. Assessment is also an important aspect of client engagement and treatment planning and is generally performed in the initial phases of treatment, though not necessarily during the initial visit.

In the treatment of persons with SUD, ongoing assessment is an expected process and is essential in order to identify client needs and help the provider focus their services to best meet those needs.

In certain situations, brief and focused assessments may be more appropriate than more extensive assessments. However, the comprehensive treatment of addictions requires a comprehensive assessment to be conducted in the initial phases of treatment. An important competency of counselors/clinicians is to discern when a brief assessment versus a comprehensive assessment is needed. Additionally, collaborative and coordinated care is a key characteristic of quality care and is based on the ability to perform appropriately comprehensive assessments in order to determine the most suitable referral or linkage.

Staff and professionals who possess the appropriate training perform assessments within their scope of practice. Comprehensive clinical assessments are performed by appropriately trained Licensed Practitioners of the Healing Arts (LPHAs) and SUD counselors.

Clinical assessments are based on the ASAM Criteria, which includes multidimensional assessments comprised of six dimensions:

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications
3. Emotional, behavioral, or cognitive conditions and complications
4. Readiness to change
5. Relapse, continued use, or continued problem potential
6. Recovery/living environment
The multidimensional ASAM assessment provides a common language to describe holistic, biopsychosocial assessment and treatment across addiction, physical health, and mental health services. At a minimum, comprehensive assessments include the following elements:

- History of the present episode
- Substance use and addictive behavior history
- Developmental history (as appropriate)
- Family history
- Medical history
- Psychiatric history
- Social history
- Spiritual history
- Physical and mental status examinations, as needed
- Comprehensive assessment of the diagnose(s) and pertinent details of the case
- Survey of assets, vulnerabilities, and supports
- Client strengths
- Treatment recommendations

Assessments based on the ASAM Criteria ensure that necessary clinical information is obtained in order to make appropriate level of care determinations. Assessments must be appropriately documented (see the Documentation section for specifics), reviewed, and updated on a regular basis, including at every care transition, in order to promote engagement and meet the client’s needs and preferences. If during the course of assessment, the client and provider(s) determine that adequate progress toward treatment goals has been made, plans to build upon these achievements must be made, which may include transitions to other services and recovery-focused strategies. Similarly, reassessments of the diagnosis, treatment modalities/intensity/goals must be performed if progress toward agreed upon goals is not being made within a reasonable time. See Appendix A.1 for ASAM Criteria Dimensions at a Glance.

Clients who prematurely exit the SUD system of care should receive case management services, with the goal of re-engagement, during the established period prior to Administrative Discharge. (See Section D: Service Delivery for additional information).

**Drug Testing**
Drug testing is often a useful tool to monitor engagement and provide an objective measure of treatment efficacy and progress to inform treatment decisions. In general, the frequency of drug testing should be based on the client’s progress in treatment, and the frequency of testing should be higher during the initial phases of treatment when continued drug use has been identified to be more common.

A punitive approach to drug testing does not facilitate a productive and therapeutic relationship with clients and should be avoided. Consequences to drug testing should be communicated in a therapeutic manner and the communication of these consequences does not need to adversely affect the therapeutic alliance. Decisions about appropriate responses to positive drug tests and relapses should consider the chronic nature of addiction, recognize that relapse is a manifestation of the condition for which people are seeking SUD treatment, and recognize instances in which medications or other factors may lead to false or appropriately positive drug test results.
Evidence Based Practices (EBPs)
Research and innovations have yielded significant progress in the development, standardization, and empirical evaluation of psychosocial treatments for SUD. This has resulted in a wide range of effective programs for SUD that differ in both theoretical orientation and treatment technique. While a number of approaches and techniques are effective depending on the clinical situation, certain treatment approaches have a stronger evidence base and therefore must serve as the foundation of a high-quality system of SUD care.

In San Diego County, although other psychosocial approaches may be used, SUD providers are at a minimum expected to implement the two evidence-based psychosocial interventions of Motivational Interviewing (MI) and Relapse Prevention. Below are brief descriptions of these and other evidence-based psychosocial interventions:

- **Motivational Interviewing (MI)** - A client-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment by paying particular attention to the language of change. This approach frequently includes other problem solving or solution-focused strategies that build on clients' past successes. According to the Motivational Interviewing Network of Trainers, MI “is designed to strengthen an individual's motivation for and movement toward a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion.”

- **Relapse Prevention** - According to SAMHSA’s National Registry of Evidence-Based Programs and Practices, relapse prevention is “a behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment. Coping skills training strategies include both cognitive and behavioral techniques. Cognitive techniques provide clients with ways to reframe the habit change process as a learning experience with errors and setbacks expected as mastery develops. Behavioral techniques include the use of lifestyle modifications such as meditation, exercise, and spiritual practices to strengthen a client's overall coping capacity.”

In addition to these two required EBPs, programs may choose to also include EBPs such as:

- **Cognitive-Behavioral Therapy (CBT)** - According to the National Institute of Drug Abuse’s Principles of Drug Addiction Treatment: A Research-Based Guide, “Cognitive-behavioral strategies are based on the theory that in the development of maladaptive behavioral patterns like substance abuse, learning processes play a critical role. Individuals in CBT learn to identify and correct problematic behaviors by applying a range of different skills that can be used to stop drug abuse and to address a range of other problems that often co-occur with it. A central element of CBT is anticipating likely problems and enhancing clients’ self-control by helping them develop effective coping strategies. Specific techniques include exploring the positive and negative consequences of continued drug use, self-monitoring to recognize cravings early and identify situations that might put one at risk for use and developing strategies for coping with cravings and avoiding those high-risk situations.” The Matrix Model is an example of an integrated therapeutic approach that incorporates CBT techniques and has been empirically shown to be effective for the treatment of stimulant use.
- **Trauma-Informed Treatment** - According to SAMHSA’s concept of a trauma-informed approach, “a program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization.” Seeking Safety is an example of an evidence-based trauma-informed practice.

- **Psychoeducation** - Psychoeducational interventions educate clients about substance abuse and related behaviors and consequences. The information provided may be broad but are intended to lead to specific objectives. Psychoeducation about substance abuse is designed to have a direct application to clients’ lives, to instill self-awareness, suggest options for growth and change, identify community resources that can assist clients in recovery, develop an understanding of the process of recovery, and prompt people using substances to act on their own behalf.

Elements of these practices may be used in any type of service setting and must be performed by trained providers within their scope of practice. Of note, the descriptions of the evidence-based psychosocial interventions above are simply summaries and providers are encouraged to refer to other available resources and manuals for more detailed guidance as to the effective clinical application of these approaches. Implementation of Motivational Interviewing and Relapse Prevention will be a contract requirement and monitored through the contract compliance monitoring process.

**Medication-Assisted Treatments (MAT)**

Research has shown that for the treatment of addiction, a combination of medications and behavioral therapies is more successful than either intervention alone. Subsequently, medication-assisted treatments (MAT) must be part of a comprehensive, whole-person approach to the treatment of SUD that includes psychosocial interventions like counseling, behavioral therapies, case management, and care coordination. The use of FDA approved addiction medications as part of this comprehensive, whole-person approach to the treatment of SUD shall not be discouraged in any way. Similarly, clients shall not be denied services based solely on the fact that they are taking prescribed medication, regardless of the type of medication.

For those programs providing MAT services, required elements of service include obtaining informed consent, ordering, prescribing, administering, and monitoring of all medications for SUD. Given the biopsychosocial nature of addiction, all available clinically indicated psychosocial and pharmacological therapies must be discussed and offered as a concurrent treatment option for appropriate individuals with an alcohol and/or opioid related SUD condition at all levels of care. When MAT is part of the treatment plan, licensed prescribers operating within their scope of practice should assist the client to collaborate in clinical decision-making, assuring that the client is aware of all appropriate therapeutic alternatives. Informed consent for all pharmacotherapies must be obtained, including discussion about the advantages and disadvantages of MAT, taking into consideration the benefits, side effects, alternatives, cost, availability, and potential for diversion, among other factors.

Clients receiving MAT in OTP settings must receive a minimum of 50 minutes of counseling sessions with a therapist or counselor, not to exceed 200 minutes per calendar month, although additional services may be provided based on medical necessity. All prescribed MAT should be consistent with generally accepted standards of medical practice and best practice guidelines for the condition being treated.
There are currently several FDA-approved medications for the treatment of various types of addiction in adults:

**Opioid Use Disorder**
- Methadone
- Buprenorphine
- Naltrexone (oral and long-acting injectable formulation)

Note: In addition to the above medications for opioid use disorder treatment, Naloxone is an FDA-approved medication used to prevent opioid overdose deaths.

**Alcohol Use Disorder**
- Naltrexone (oral and long-acting injectable formulation)
- Disulfiram
- Acamprosate

Details regarding the availability, pharmacology, and appropriate prescribing of FDA-approved medications for addiction are beyond the scope of this section. However, providers are encouraged to reference published prescribing guidelines and other available resources for additional information regarding medication-assisted treatments. The prescribing of MAT must be in compliance with all federal, state, and local laws and regulations.

**Physician Consultation**
A physician consultation is a correspondence in which one physician is seeking advice, opinion, or recommendation from another physician, usually a specialist with expertise in a specific area of medicine. Based on the information provided, the consultant physician provides his/her recommendations regarding the question asked by the requesting physician. In conjunction with the consultant’s expert opinion, the requesting physician utilizes his/her own professional judgment and other considerations (e.g., client preferences, family concerns, other comorbid health conditions and psychosocial factors) to provide comprehensive client treatment.

Given the shortage of medically trained addiction specialists in the SUD workforce, the physician consultation is designed to help facilitate the exchange and dissemination of addiction expertise between physician providers and within the COSD adult and youth systems of care. Under the DMC-ODS, physician consultation is a county billable service.

The Clinician Consultation Center Substance Use Management team at UCSF provides free peer-to-peer consultation from physicians, clinical pharmacists, and nurses with special experts in substance use evaluation and management. Advice on all aspects of substance use management is provided, including:

- Assessment and treatment of opioid, alcohol, and other substance use disorders
- Approaches to suspected misuse, abuse, or diversion of prescribed opioids
- Methods to simplify opioid-based pain regimens to reduce risk of misuse and toxicity
- Urine toxicology testing – when to use it and what it means
- Use of buprenorphine and the role of methadone maintenance
- Withdrawal management for opioids, alcohol, and other CNS depressants
- Harm reduction strategies and overdose prevention
Managing substance use in special populations (pregnancy, HIV, hepatitis)
Productive ways of discussing known or suspected addiction with clients

This service does not occur in real-time, so is not appropriate for emergent and/or urgent consultation needs. Cases may be submitted for consultation via internet at the UCSF Clinical Consultation Center website http://nccc.ucsf.edu/clinician-consultation/substance-use-management/ or by calling Monday-Friday, 9 a.m. – 8 p.m. EST at 855-300-3595. Physician Consultation requests are intended for DMC physicians within COSD’s network of providers only and should not be initiated by non-physicians or clients. COSD will continue to explore opportunities to expand this service, according to community need.

Referring Physicians – physicians who are based at provider sites and seeking consultation – are responsible for initiating the consultation by either submitting a case electronically via the link above, or by calling 855-300-3595. All consultation requests must include a clear explanation as to the reason for the consultation and include any relevant history and clinical details that help to inform and provide context for the concern/question.

Physician consultation services are strictly limited to routine consultation requests. Emergent and urgent consultation needs should be directed to more appropriate resources (e.g., emergency department, psychiatric emergency services, etc.).

All local, state, and federal confidentiality requirements involving HIPAA and 42 CFR Part 2 will be followed during the Physician Consultation process.

As the County is utilizing this free resource for physician consultation, the service is a not billable to Drug Medi-Cal. Providers may be reimbursed for calls made by Physicians to UCSF for physician consultations. Physician consultations are a County billable service; providers will need to use the County-billable cost center on its monthly invoice to claim this cost.

Recovery Services
Recovery Services are aftercare support services designed to help individuals become and stay engaged in the recovery process and reduce the likelihood of relapse. Recovery Services emphasize the client’s central role in managing their health and recovery and promotes the use of effective self-management and coping strategies, as well as internal and community resources to support ongoing self-management. Medical necessity is considered established for any individual transitioning directly into Recovery Services from treatment. If there is a lapse between treatment discharge and receipt of Recovery Services, or if Recovery Services are discontinued, a screening needs to occur to determine if Recovery Services are still an appropriate service level (see Section D: Service Delivery for more details on Recovery Services.)

Recovery Services are available for all clients who have completed treatment or left treatment with satisfactory progress and are in recovery. The last treatment provider of care will serve as the default provider of Recovery services, unless necessary services are not offered, or the client prefers a change in provider. These services can be delivered by either a SUD counselor or LPHA and will be offered after completion of a treatment episode.
Culturally Appropriate Services
Culturally competent care is critical in providing high quality SUD services. Research indicates that lack of cultural competency in the design and delivery of services can result in poor outcomes in areas such as access, engagement, receptivity to treatment, help-seeking behaviors, treatment goals, and family response.

Core practices that address cultural competency include:
- Attitudes, beliefs, values, and skills at the provider level.
- Policies and procedures that clearly state and outline the requirements for the quality and consistency of care.
- Readiness and availability of administrative structures and procedures to support such commitments.

Providers are required to adhere to CLAS standards and are responsible for providing services that are developmentally, culturally, and linguistically appropriate, and must ensure that their policies, procedures, and practices are consistent with this requirement. Providers must also ensure that these principles are embedded in the organizational structure of their agency, as well as being upheld in day-to-day operations.

The COSD will promote cultural competency by coordinating trainings designed to educate providers and administrators about various aspects of cultural sensitivity, with the goal of better engaging clients of diverse backgrounds and needs.

Case Management and Care Coordination
Case management and care coordination are collaborative and coordinated approaches to the delivery of health and social services, linking clients with appropriate services to address specific needs and achieve treatment goals. Case management and care coordination are intended to complement and integrate with existing systems and community resources while avoiding duplication or replacement of existing services and supports. Case management and care coordination services are available to all clients who enter the County’s DMC-ODS treatment system, are available throughout the treatment episode, and may be continued during recovery services as allowed by COSD.

Care coordination is meant to provide seamless transitions of care for clients within the DMC-ODS, to ensure that clients successfully transition between levels of SUD care (i.e. withdrawal management, residential, outpatient, etc.) without disruption to services. This includes access to recovery services immediately after discharge or upon completion of an acute care stay, with the goal of sustained engagement and long-term retention in SUD and behavioral health treatment.

In the DMC-ODS, care coordination is also meant to ensure that each client has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the client. The client shall be provided information on how to contact their designated person or entity (for more information, see the Care Coordination portion of SUDPOH Section D: Service Delivery).

The primary role of the staff providing care coordination or case management services is to coordinate client services:
- Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays.
- With the services the beneficiary receives from any other managed care organization.
With the services the beneficiary receives in FFS Medicaid.
With the services the beneficiary receives from community and social support providers.

Additionally, staff providing care coordination or case management services shall make a best effort to conduct an initial screening of each beneficiary’s needs, within 90 calendar days of the effective date of enrollment for all new beneficiaries, including subsequent attempts if the initial attempt to contact the beneficiary is unsuccessful (see Substance Use Disorder Uniform Record Manual, also known as the SUDURM, Initial Level of Care assessment forms and instructions for additional information.)

Successful care coordination requires documentation to be maintained and shared, as appropriate. The County DMC-ODS has created the SUDURM which details the requirements for maintaining a client health record in accordance with DMC-ODS and other professional standards. Written records, and the sharing of written and other types of communications, must be done in a way that maintains client confidentiality and privacy; thus, programs are to ensure that in the process of coordinating care, each client’s privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E and 42 CFR Part 2, to the extent that they are applicable.

Finally, as part of care coordination, programs shall share with DHCS or other managed care organizations serving the client the results of any identification and assessment of that beneficiary’s needs to prevent duplication of those activities.

Description of Case Management Services
Case management services are available to clients in the DMC-ODS based on the frequency documented in the individualized treatment plan. As documented on the treatment plan, case management shall provide advocacy and care coordination to physical health and mental health, transportation, housing, vocational, educational, and transition services for reintegration into the community.

Case management is a client-centered, collaborative approach to the delivery of health and social services that focuses on reducing barriers to treatment and linking clients with necessary and appropriate services including medical, mental health, educational, social, prevocational, vocational, rehabilitative, or other community services while the client is receiving SUD treatment. The primary goal of case management services is to ensure clients in the SUD System of Care receive all the necessary support and services available to be successful at meeting their treatment goals.

Case management is effective in keeping individuals engaged in treatment and moving toward recovery and helps an individual address other problem concurrently with substance use. Case management services are especially important among clients with chronic health problems, co-occurring disorders, or are involved with the justice system.

Case management services can often start during the intake and assessment process and continue to be provided to the client throughout SUD treatment and in recovery services (formerly known as “aftercare.”) As clients move through the system of care, case management assessments and reassessments can support different needs from initial service engagement (pre-treatment), treatment, and recovery services. Case management services may be provided face-to-face, by telephone, or by telehealth with the client and may be provided in the community as appropriate.
In order to successfully link clients with services and resources (e.g., financial, medical, or community services), case managers must have a working knowledge of the appropriate resources, both at the system and the service levels that are needed for the client to optimize care through effective and relevant networks of support. Services provided through case management are thus tailored to facilitate continuity of care across all systems of care and provide extensive assessment and documentation of the client’s progress toward self-management and autonomy.

Although an important component of case management in the SUD population is linking clients to outside systems of care, such as physical and mental health systems, case management is equally important in navigating clients through the SUD system of care. Comprehensive SUD treatment often requires that clients move to different levels of care within the SUD continuum, and case managers and care coordinators help to facilitate those transitions. See Section D: Service Delivery for more information.

**Description of Care Coordination Services**

Care coordination is the deliberate organization of client care activities, including appropriate information sharing, between two or more services and/or providers (e.g. SUD provider, primary care physician, psychiatrist, housing resources) involved in the client’s care. The primary goal of care coordination efforts is to produce a system of integrated care with high quality referral and transition of care. Care coordination services are best delivered with a team of interdisciplinary staff who are capable of effectively advocating for the client by communicating and consulting among the network of providers across multiple disciplines. Traditionally, coordination of services is often arranged through written formal agreements (e.g. Memorandum of understanding) or protocols and provided at separate locations; however, care coordination services may also be delivered through co-locating services where clients are being served or through alternative modalities such as telehealth.

There is not a separate billing code for care coordination services, so these types of activities are billed to “Case Management.”

Note: Both case management and care coordination services may involve handling of private and protected health information. Case management shall be consistent with and shall not violate confidentiality of alcohol or drug clients’ disclosure laws set forth in the 42 CFR Part 2, and California law.

The following are key care coordination service components:

1) **Referrals and linkages**: Providing high quality referrals and linkages for clients to necessary resources and services as identified on the treatment plan, which includes case management needs. High quality referrals and linkages differ from a simple referral as the case manager or care coordinator plays an active role to reduce access barriers to ensure clients have ‘actual’ access to needed services (e.g. establishing relationships and protocols with external providers to ensure clients will be served upon referral).

2) **Navigation**: Facilitating the navigation of client SUD treatment services with medical, mental health, social, legal, financial and other needed services, including helping clients set up appointment connections and transportation arrangements, and ensuring contacts with a primary care provider. Following-up with clients in service transition or notable events is also key. For example, care coordinator should follow up with client within a few days of an emergency room visit, hospital discharge, or discharge from a residential facility. Reducing barriers into care delivery by arranging for or providing clients with linkages to health, mental health, specialty care and others through co-location of services.
3) Monitoring client’s progress: Tracking client progress through SUD treatment services and coordinate client’s transition through the SUD provider network.

4) Client education and advocacy: Helping client (and their families/care-givers) understand and navigate the SUD treatment system including SUD diagnosis, availability of treatment options and services, and case management options, including coaching, educating, and mentoring clients (and caregivers) on how to self-manage their care and access needed services; Promoting the individual’s self-management and autonomy through access of community resources.

Case Management and Care Coordination for Populations with Special Needs

More intensive case management and care coordination activities will be required for populations with special needs. These populations may include clients with HIV/AIDS; clients with mental illness; homeless; women perinatal; adolescents, and justice involved. Each population will require care coordination activities to help an individual effectively navigate, access, and participate in an appropriate level of care for SUD services; access health and mental health services; secure housing; and obtain other supportive services.

Field-Based Services

Case management services, including care coordination activities, may be appropriate for clients served in field-based settings that may include, but are not limited to homeless encampments, runaway shelters, interim housing, permanent supportive housing, probation camps or other facilities. When services are provided in the field, providers must ensure confidentiality and document where in the community services were provided (as well as how confidentiality was maintained). See Section D: Service Delivery for more details on documentation.

Eligibility Criteria for Case Management Services

Case management services are available to all clients who are enrolled in all levels of care under DMC-ODS. Reimbursement eligibility criteria for case management services are the same as DMC-ODS enrollment criteria, the beneficiary must:

- Have Medi-Cal or be Medi-Cal eligible (or EPSDT if under age 21)
- Reside within SD County
- Meet medical necessity criteria
- Be enrolled in a treatment level of care or recovery support services

Staffing Requirement

Various members of the treatment team can function as the case manager, including registered/certified SUD counselors and LPHAs.

Housing Referrals

Housing and an individual’s living environment are oftentimes a critical component to the ability to achieve and maintain recovery from SUD. Before being admitted to treatment, all SUD clients must be assessed on all six (6) ASAM dimensions of care, including ASAM Dimension 6 – Recovery/Living Environment. This intake assessment should reveal potential concerns regarding housing and living situations that may warrant further follow.
Continued Service and Discharge Criteria

After the admission criteria for a given level of care have been met, the criteria for continued service, discharge or transfer from that level of care are as follows:

Continued Service Criteria:
It is appropriate to retain the client at the present level of care if:

1. The client is making progress but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the client to continue to work toward his or her treatment goals;

   Or

2. The client is not yet making progress but has the capacity to address his or her problems. He or she is actively working on the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the client to continue to work toward his or her treatment goals;

   and/or

3. New problems have been identified that are appropriately treated at the present level of care. This level is the least intensive at which the client’s new problems can be addressed effectively. To document and communicate the client’s readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the client’s existing or new problem(s), the client should continue in treatment at the present level of care. If not, refer the Discharge/Transfer Criteria, below.

Discharge/Transfer Criteria:
It is appropriate to transfer or discharge the client from the present level of care if he or she meets the following criteria:

1. The client has achieved the goals articulated in his or her individualized treatment plan, thus resolving the need(s) that justified admission to the current level of care;

   Or

2. The client has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service therefore is indicated;

   Or

3. The client has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service therefore is indicated;

   Or

4. The client has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

To document and communicate the client’s readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the existing or new problem(s), the client should be discharged or transferred, as appropriate. If not, refer to the Continued Service criteria.
Coordination of Transitions in Care (Step-Up/Down within SUD System and between Health Systems)

Coordinating transitions in client care is foundational to clients benefiting from a full SUD continuum with various levels of care to continuously meet their needs as they progress through treatment and ultimately toward recovery.

In all cases of care transitions (both when the transition occurs along the SUD care continuum and when the transition occurs between other health systems), the last treating SUD provider is responsible for and must coordinate transitions in care. Case management is a billable service that needs to be used to support these care transition responsibilities.

Important Components of Successful Transitions in Care

- Having established policies and procedures for standardizing the care transition process
- Ensuring sufficient training for case managers and staff who are responsible for managing transition in care to ensure understanding of the various levels of care in the DMC-ODS and other service delivery systems
- Clear and thorough treatment and discharge planning so the goals of treatment are clear, such as when transitions may be necessary and the goals of transition
- Client and family preparation and education about transitions in care (i.e. Why they are necessary, what to expect, how to seek help if the need arises, etc.)
- Warm handoffs that involve interpersonal communication and ideally physically accompanying the client during the transition, rather than solely relying on written or electronic communication
- Ensuring that the receiving provider receives necessary information to all of a smooth transition in care
- Interdisciplinary team involvement with assigned accountability for transition-related tasks and outcomes
- Follow up and tracking of referrals to ensure smooth and completed transitions in care
- Positive relationships between the sending and receiving providers
- Medication reconciliation, as needed
- Establishing a quality and process improvement process to identify and ultimately address obstacles (like transportation) to care transitions, both at individual and systemic levels.
- Maintaining client engagement throughout the transition process.

Special Populations

Prevention

San Diego County's substance use prevention strategy primarily utilizes environmental prevention, a federally approved community-change model to prevent substance use problems throughout the region. Providing a targeted focus on these issues allows the County to develop long term, strategic, cost effective and sustainable prevention plans for each initiative, provides coordination and shared resources where possible, and provides flexible prioritization in each region regarding how each initiative will be tailored to individual community needs.
Primary Prevention
Since the inception of the San Diego County Prevention Framework in 1997, the County has initiated four regional substance use disorder prevention initiatives that are aligned with the County of San Diego’s Strategic Initiatives:
- Binge and Underage Drinking initiative (1996)
- Methamphetamine Strike Force (1996)
- Marijuana Initiative (2005)

Adult Services
Clients who are age 18 or older with substance use and/or co-occurring disorders receive services through Adult SUD programs. These services include:
- Outpatient and Residential Treatment
- Withdrawal Management
- Case Management
- Justice Programs
- Ancillary services (i.e. TB testing)
- Opioid Treatment Programs (OTP)

Co-Occurring Disorder Population
Co-occurring disorders (COD) are defined as the occurrence of a combination of any SUD with a mental health condition. The COD must meet the diagnostic criteria independently from the other condition and cannot simply be a cluster of symptoms resulting from a single disorder. The significant co-morbidity of SUD and mental illness (typically reported as 40% - 80% depending on study characteristics and population) and the growing body of research associating poorer outcomes with a lack of targeted treatment efforts have highlighted the importance of addressing the unique needs of this population.

Integrated treatment coordinates substance use and mental health interventions to treat the whole person more effectively. As such, integrated care broadly refers to the process of ensuring that treatment interventions for COD are combined within a primary treatment relationship or service setting. Research has generally supported that the ideal approach toward treatment for CODs is to address all conditions simultaneously, as opposed to addressing the SUD and mental health condition separately and in a silo of separate treatment approaches. When providers have staff who possess the skills and training to adequately address the needs of the COD population within their scope of practice, integrated care is best provided in-house. It is the expectation that all programs be, at a minimum, Co-Occurring Capable with the goal of becoming Co-Occurring Enhanced.

To aid in serving the needs of the COD population in San Diego County, programs are required to participate in the Comprehensive, Continuous, integrated System of Care (CCISC) CADRE.

Perinatal Services for Women and Girls
Perinatal services (from age 15+) are gender-specific, trauma informed SUD treatment and recovery services provided to pregnant and new mothers and their dependent minor children, from birth through 17 years of age. Childcare service is provided for participants while on-site receiving services. Issues specific to perinatal clients include substance use while pregnant, pre-natal care, parenting, and family violence.
All Perinatal Programs, regardless of funding source, are required to comply with the Perinatal Practice Guidelines FY 2018-19 (PPG).

Women who are pregnant and/or parenting with substance abuse and/or co-occurring disorders receive SUD services through the Perinatal Services Network. The mothers are the clients, but their children are the motivating factor behind these services. Health and safety of both the mother and her child/children are key. The following are essential service elements:

- Trauma Informed, gender specific, and culturally competent treatment
- Residential, Outpatient and Perinatal Detox treatment
- Child Care on site
- Incredible Years Parenting curriculum and Infant Massage
- Transportation
- Registered/certified SUD counselors and Mental Health clinicians
- Therapeutic services such as behavioral and developmental therapies for children on site
- Teen perinatal SUD treatment
- Homeless Outreach Workers
- Dependency Drug Court

Gender Responsive Treatment
Contractor’s systems and services shall recognize the importance of the histories, life circumstances, and behaviors of women and men with substance use disorders and take these into account when providing SUD treatment with the goal of producing the best possible treatment outcomes. Contractor shall ensure that the program addresses gender-specific issues in determining individual treatment needs and therapeutic approaches.

As outlined in the SAMHSA TIP 51: Substance Abuse Treatment: Addressing the Specific Needs of Women, core principles for gender responsive treatment include:

- Acknowledging the importance as well as the role of the socioeconomic issues and differences among women.
- Promoting cultural competence specific to women.
- Recognizing the role as well as the significance of relationships in women’s lives.
- Addressing women’s unique health concerns.
- Endorsing a developmental perspective.
- Attending to the relevance and influence of various caregiver roles that women often assume throughout the course of their lives.
- Recognizing that ascribed roles and gender expectations across cultures affect societal attitudes toward women who abuse substances.
- Adopting a trauma-informed perspective.
- Using a strengths-based model for women’s treatment.
- Incorporating an integrated and multidisciplinary approach to women’s treatment.
- Maintaining a gender responsive treatment environment across settings.
- Supporting the development of gender competency specific to women’s issues.
Additionally, in SAMHSA TIP 56: Addressing the Specific Behavioral Health Needs of Men, particular factors impacting men are addressed, such as barriers to engagement and ways to engage men in SUD treatment.

**Deaf and Hard of Hearing (DHH) Clients**

For persons who are deaf or hard of hearing, the principles of addiction are the same as they are for hearing people, yet these individuals are currently unable to fully access the resources available to hearing individuals. DHH individuals are at a severe disadvantage in receiving and realizing long-term benefits from treatment for substance abuse, since treatment efforts are typically not focused on culturally specific information. During treatment, the majority of the therapeutic benefit comes from being involved with the counselor on a 1:1 basis, with peers in group and the interactions that occur during non-structured periods of the day. Without the availability of communication during program hours, a deaf person does not benefit from substance abuse treatment in the same way and to the same extent as their hearing peers. Ideally, individuals who successfully complete an alcohol/drug treatment program should be able to return to the environment that they lived in prior to entering a treatment program. However, that environment must include a sober living option, family/friend support, professionals trained to work with clients on aftercare issues and accessible support group meetings. This kind of environment is unavailable for the majority of deaf and hard of hearing individuals. Currently, there are only a handful drug and alcohol recovery programs for DHH people in the United States and less who have a full continuum of treatment and recovery options such as residential treatment and sober living homes.

While the County of San Diego explores treatment options for this special population, the following practice guidelines are recommended:

- Client records should reflect the client’s hearing status, use of personal hearing assistive technology, preferred method of communication (including language and hearing assistive technology needs), preferred language for care and for written materials, presence of interpreters/communication service providers during any service delivery, preferred method(s) of contact, and communication method used to secure informed consent;
- Intake and assessment should include gathering information about cultural identification and hearing acuity, age of onset of hearing loss, etiological components, and language proficiencies;
- Treatment plans for each DHH client shall include services necessary to meet the client’s needs, including interpreters, technology support, other services to ensure full linguistic access, and culturally accessible services;
- For clients whose preferred communication method is sign language, access to sign-fluent staff and/or an interpreter shall be utilized for all services.

**Adolescent Services**

As documented in the State of California’s Youth Treatment Guidelines (2002), substance abuse and dependence among youth is a complex problem, resulting from multiple factors including biological predisposition, psychological factors, adolescent development, and social factors. Adolescents have added social factors such as bullying, peer pressure, and low self-esteem that have led to gang activity,
prostitution, and depression on top of their substance use. Therefore, the biopsychosocial approach will aid in understanding and treating these disorders.

In San Diego County, the drug of choice for adolescents upon admission into substance use disorder programs is marijuana. With recent legalization of marijuana for adults, this will further add to the appeal of marijuana use.

Teen Recovery Centers (TRCs) are specialty population outpatient programs for adolescents that experience many of the complex issues paired with substance use. TRCs provide substance abuse treatment for adolescents age 12-17 and their families. Outpatient services, crisis intervention, and residential treatment services are offered in our urban and rural communities. In addition to their main clinics in the regional communities of San Diego, TRCs are also located within school sites to increase access and coordination with school personnel. The goals of BHS TRC services are as follows:

- Provide developmentally and culturally appropriate substance abuse treatment services for adolescents throughout the County
- Increase access to care by reducing access times to entering programs
- Improve capability and functioning for youth and their families
- Decrease the incidence of crime
- Support the youth in becoming self-supporting through education/employment
- Provide Family Counseling
- Provide Co-occurring disorder treatment
- Increase prosocial skills and eliminate illicit substance use

Contracted providers are to follow the Youth Treatment Guidelines in developing and implementing youth treatment programs/services.

Teen Recovery Centers (TRCs) have been designed to include one TRC primary site, and at least two TRC school or ancillary sites within each regionally based TRC contract. Although it may be convenient for a TRC to serve clients at multiple locations within the TRC contract, this is not allowed. Please see Appendix A.2 for specific guidelines.

Additionally, it is a requirement for all CYF DMC-ODS Teen Recovery Centers to utilize SchooLink and all required forms. SchooLink is a collaborative training program and tool kit for County-funded behavioral health providers and school staff in the County of San Diego. It provides successful strategies for linking eligible children and youth to on-campus, County-funded behavioral health services. The project launched for the 2018/2019 school year, and provides strategies and specific tools, based on best practices in the field, for a collaborative process to ensure student access to behavioral health services is used to its full capacity. Focus areas include:

- **Provider Orientation/Annual Meeting**
  Set the stage for schools and behavioral health providers to work together throughout the school year.
- **School Outreach**
  Identify and establish school outreach strategies. Communication and connection of behavioral health staff to school staff to understand behavioral health services available on-campus.
• **Parent Outreach**
  Identification of parent outreach strategies. Informing parents about on-campus behavioral health services and encourage distribution of parent brochure.

• **Eligibility**
  Informing parents/guardians of behavioral health service providers and eligibility. Describe the many ways for parents/guardians to access behavioral health services for their student.

• **Referral and Assessment**
  Create a standardized referral process. Describe the standardized referral process, introduce the referral form and first contact procedures.

• **Treatment**
  Best practices to access students for treatment. Gain an understanding of best practices for summoning students and for sending monthly status reports via the Monthly Referral Communication Log.

• **Confidentiality**
  Understand confidentiality standards and limitations. Strategies for how behavioral health providers can respond within confidentiality limitations when school staff express caring and concern about how a student is responding to therapy.

• **Suicide/Self-Harm Procedures**
  Understand roles and responsibilities when responding to threats of suicide or evidence of self-harm.
  Clarify that the Principal or designee takes responsibility for suicide/self-harm concerns and the behavioral health provider follows school policy.

• **Special Education**
  Understand how to help parents who inquire about special education services.
  Provide best practices for behavioral health staff to respond to parent questions related to special education resources.

Children, Youth, and Family Services
These services focus on a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

• **Relapse Prevention.** Relapse Prevention education and activities shall be available to help the client maintain sobriety over time. Example activities include:
  o Use relapse prevention workbooks and journals
  o Develop skills to reinforce sobriety and relapse prevention
  o Organize physical activities (individuals or teams) on site or off-site
  o Conduct meditation and relaxation activities
  o Cooking classes, food preparation, and nutrition education
  o Music appreciation sessions and/or learning to play a musical instrument
  o Organize outings to demonstrate drug free lifestyle changes
  o Communication building sessions/activities
  o Parent training on relapse prevention
  o Youth Leadership Group development/activities

• **Recovery Planning Groups.** Recovery planning groups shall be available and provide strategies to achieve abstinence, physical and mental health, financial, employment, educational, and spiritual goals. Example activities include:
Recovery services workbook exercises
- Journaling
- Conduct meditation and relaxation activities
- Invite Guest Speakers in recovery (community leaders, parents or motivational speakers)
- Jobs and career development activities with presentation from groups like Workforce Partnerships or Jobing.com
- Host financial literacy and credit building sessions with groups like Money Management International
- Aftercare recovery groups

- Community-based Self-Help Group Participation. Clients shall be referred to one community peer group per week. Example activities include:
  - Educate and introduce the concept of self-help and its strategy in maintaining sobriety and recovery.
  - Coordinate client attendance at women- or youth-oriented self-help group meeting off-site
  - Invite guest speakers to promote the benefits from self-help processed that support recovery
  - Host a women- or youth-oriented self-group meeting on site

Clients Involved with the Justice System
The justice system includes accused or adjudicated clients who require various SUD services. Parole and probation status is not a barrier to SUD treatment services provided that the parolees and probationers meet the DMC eligibility verification and medical necessity criteria. For many people in need of alcohol and drug treatment, contact with the justice system is their first opportunity for treatment. Services can be provided through courts, probation or parole agencies, community-based or institutional settings, or in sex offender programs. In each of these situations, the individual is accountable to comply with a criminal justice sanction. Legal incentives to enter SUD treatment at times motivate individuals to pursue recovery, whereas for other offenders, arrest and incarceration are part of a recurring cycle of drug abuse and crime.

Ingrained patterns of maladaptive coping skills, criminal values and beliefs, and a lack of job skills may require a more intensive treatment approach for the justice population, particularly among offenders with a prolonged history of substance abuse and crime. However, strong empirical evidence over the past several decades has consistently shown that the justice population can be effectively treated, and that SUD treatment can reduce crime.

Best practice is that staff working with justice populations receive specific training in working with criminogenic risk, need, and responsivity (RNR), as well as SUD and CODs. Staff also must be capable of integrating identified treatment goals with the goals of the involved agencies. As a result, it is critical for treatment providers to have a strong working relationship with probation and parole officers, judges, the court, and other legal entities involved in the client’s care.

The first step in providing SUD treatment to people under justice supervision is to identify offenders in need of treatment. Comprehensive assessments incorporate issues relevant to justice involved individuals, such as assessment of criminogenic RNR, anger management, impulse control, values and behaviors, family structure and functioning, criminal lifestyle, and antisocial peer relationships. Assessments also pay particular attention to CODs, developmental and cognitive disorders, and traumatic brain injury.
In general, clinical approaches and the use of medication-assisted treatments must parallel those used with individuals who are not involved with the justice system, and a qualified counselor/clinician should determine the appropriate level of placement and interventions rather than court/probation requirements. Treatment interventions must be based on a multidimensional assessment and individualized needs. However, working with the justice population does have unique requirements that necessitate modified treatment approaches in order to meet their specific needs. Additionally, it is essential to collaborate with correctional staff to ensure that the treatment goals align with correctional and supervision case planning and/or release conditions (particularly involving the prescription of certain MAT).

Clinical strategies for working with justice clients may include interventions to address criminal thinking and provide basic problem-solving skills. Providers must be capable of using evidence-based practices designed to address SUD, mental health, and criminogenic needs. For example, motivational interviewing, cognitive behavioral therapy that focuses on both substance use and antisocial behaviors that lead to recidivism, trauma-informed care, and contingency management therapies.

Due to court mandates, classification policies and procedures, various security issues, and differences in available programming, one of the challenges of working with the justice population is determining when the ASAM Criteria can be meaningfully applied. The ideal scenario is for the level of care setting to match the severity of illness and functional impairment, similar to the general population. However, there are instances in working with offenders that necessitate close collaboration with correctional staff to provide services that are clinically appropriate and that also align with correctional and supervision case planning and/or release conditions. When skillfully applied, the ASAM Criteria can be used to access the full continuum of care in a clinically appropriate manner for the justice population.

Similar to other groups, treatment of offenders needs to be regarded as a dynamic, longitudinal process that is consistent with the chronic disease model of addiction. As such, effective treatment is expected to continue even after the legal issues for justice clients are resolved.

**Homeless Population**

There is wide recognition that substance use in the homeless population cannot be treated apart from addressing the needs of the whole person in the context of his or her environment. A continuum of comprehensive services is needed to address the various safety, health, social and material needs of homeless clients. Common examples include assistance with accessing food, clothing, shelter/housing, identification papers, financial assistance and entitlements, legal aid, medical and mental health care, dental care, job training, and employment services. These services may be provided within the SUD program itself or through linkages with existing community resources. Proactive outreach, addressing needs in a non-judgmental and non-threatening environment, and addressing the various identified needs early in treatment may help to better engage this population.

On the whole, research demonstrates that effective programs for homeless clients address their substance use as well as their tangible needs (e.g., housing, employment, food, clothing, finances); are flexible and non-demanding; target the specific needs of subpopulations, such as gender, age, or diagnoses (e.g., COD/TAY/older adult populations); and provide longer-term, continuous interventions. As a result of these diverse needs, effective treatment for homeless clients must involve various disciplines and collaboration across agencies and organizations.
Stable housing is often critical to attaining treatment goals and is an important component of necessary services. Services that link clients to secure housing early in treatment tend to produce better outcomes, emphasizing the importance of case management in order to meet the varied needs of homeless clients.

Psychosocial interventions and MAT for homeless clients must mirror the approaches that are successfully used in other populations, with modifications to meet the unique needs of this population. Mobile outreach services are ideal, along with motivational enhancement interventions, in order to encourage continued treatment engagement. As a whole, the homeless population tends to be less responsive to confrontational approaches to treatment. Counselors and clinicians also must be mindful of the physical and mental health needs of this population, given high rates of co-morbidity for many homeless individuals. Medications should be used when clinically indicated, with prescribing practices that take into consideration the environment in which these medications will be used and stored (for example, care is to be taken to ensure that medications that require refrigeration are not prescribed when the client has no way to store such medications). Integrated interventions that concurrently address the multitude of medical, psychiatric, substance use, and psychosocial needs of homeless persons tend to produce improved outcomes compared to interventions that are provided sequentially or in parallel with other services.

In general, treatment for homeless clients with SUD is challenging, but successful outcomes can be achieved by prioritizing access to appropriate housing and providing comprehensive, well-integrated, client-centered services with uniquely qualified staff.

For these reasons, designated Recovery Centers and Perinatal programs throughout the county will provide Homeless Outreach Worker (HOW) services to assist with outreach and engagement in the community. Potential clients will be screened and then provided short-term case management and referral services as needed.

Lesbian, Gay, Bisexual, Transgender, Questioning Population

Lesbian, gay, bisexual, transgender, questioning (LGBTQ) populations tend to experience higher rates of substance use than the general population. The stigma and discrimination of being a member of a marginalized community such as the LGBTQ community causes some individuals to cope with these additional stressors by using substances. Furthermore, research has also shown that once LGBTQ clients do meet the criteria for a diagnosable SUD, they are less likely to seek help. These findings may be due to the various barriers the LGBTQ population faces in seeking treatment, and unique needs LGBTQ clients have that may not be addressed by SUD programs.

In many ways, psychosocial and pharmacologic interventions (medication-assisted treatment) geared toward LGBTQ clients are similar to those for other groups. An integrated biopsychosocial approach considers the various individualized needs of the client, including the societal effects on the client and his/her substance use. Unless SUD providers carefully explore each client’s individual situation and experiences, they may miss important aspects of the client’s life that may affect recovery (e.g., social scenes that may contribute to substance use, prior experiences being discriminated against, a history of antigay violence and hate crimes such as verbal and physical attacks, etc.).

As with any client, substance use providers must screen for physical and mental health conditions in LGBTQ persons due to the risk of co-morbid health conditions. As a result of previously discussed challenges confronted by the LGBTQ community, members of this group do have higher rates of certain mental health conditions and are also at greater risk for certain medical conditions. Comprehensive
screening and assessments can assist LGBTQ clients in accessing appropriate care for their physical and mental health concerns.

The methods of best practice outlined in counseling competency literature apply to all populations, particularly in working with LGBTQ clients. From this perspective, a counselor respects the client’s frame of reference; recognizes the importance of cooperation and collaboration with the client; maintains professional objectivity; recognizes the need for flexibility; is willing to adjust strategies in accordance with client characteristics; appreciates the role and power of a counselor; appreciates the appropriate use of content and process therapeutic interventions; and is non-judgmental, respectfully accepting of the client’s cultural, behavioral, and value differences.

There are also some unique aspects of treating LGBTQ clients that providers must be aware of. For example, while group therapies should be as inclusive as possible and should encourage each member to discuss relevant treatment issues or concerns, some group members may have negative attitudes toward LGBTQ clients. Staff members must ensure that LGBTQ clients are treated in a therapeutic manner and group rules should make clear that homophobia is not to be tolerated. The LGBTQ client (and not the other group members) is solely responsible for deciding whether to discuss issues relating to his/her sexual orientation and/or gender identity in mixed groups. Although providing individual services decreases the likelihood that heterosexism/homophobia/transphobia will become an issue in the group setting, there is also an opportunity for powerful healing experiences in the group setting when LGBTQ clients experience acceptance and support from non-LGBTQ peers.

Elements of treatment that promote successful treatment experiences for the LGBTQ client include cultural sensitivity, an awareness of the impact of cultural victimization, and addressing issues of internalized shame and negative self-acceptance. Cognitive-behavioral therapies challenge internalized negative beliefs and promote emotional regulation, which can be helpful for relapse prevention. Motivational enhancement techniques may also encourage treatment engagement in this population.

Veterans

Although veterans share commonalities, their experiences are as varied and unique as their needs. Some veterans may have experienced combat in one or more wars, while others may have served in non-combat roles. Likewise, some veterans may have experienced injury, including traumatic brain injuries (TBI), loss of limb, or other physical injury, while others may have emotional scars. In particular, gender may also influence veteran experiences, as reports of women veterans who have experienced sexual harassment and/or physical and sexual trauma are becoming more common. As a result of the cumulative effects of these events and experiences, veterans and family members may develop SUD and present to treatment with a unique set of needs and circumstances that must be addressed.

Under certain circumstances, veterans may be ineligible for Veteran’s Administration (VA) benefits due to a dishonorable discharge or discharge “under other than honorable conditions,” among other circumstances. Additionally, some veterans and family members may attempt to secure services from SUD treatment programs due to the long wait times at the VA. Regardless of the situation, SUD treatment providers should work to ensure that the services provided address the varied and unique needs of individuals.

While substances of abuse vary, veterans may abuse sedating substances such as prescription drugs in efforts to address untreated/under-treated anxiety or other mental health conditions. Additionally, co-occurring physical health conditions and injury may increase rates of prescription drug and opioid abuse,
including the use of heroin, and thus certain veterans may be at higher risk for fatal overdoses and may be appropriate candidates for medication-assisted treatments.

Given the higher likelihood of trauma, physical and behavioral health complications of the veteran population, SUD providers perform thorough assessments that encompass the full range of complications that may be present. For example, assessments may include questions concerning trauma, combat or war experiences, or injuries that may impact the client’s participation in SUD treatment. If the client reports (or it is determined that) injuries exist that may impact treatment, the SUD treatment provider is should work with other providers (e.g., medical, mental health) to coordinate care, which is often particularly critical in this population.

Veterans may also have different reasons for their substance use, such as untreated/under-treated physical injury or mental health issue. Stigma is often an additional complicating issue. Although stigma exists around substance use, within the military stigma often also exists for seeking help for any health condition. Anger or personality disorders may also be present, further making treatment engagement difficult. In these instances, effectively engaging veterans and utilizing evidence-based techniques, such as motivational interviewing, will be critical to treatment success.

In summary, treatment providers may need additional training to fully understand the nuances of the veteran population and how their experiences impact their behaviors in order to adequately treat veterans and their families.

(See Appendix A.3 for a Glossary of Common Terms).
B. CONTINUUM OF CARE & SERVICES

The County of San Diego Drug Medi-Cal Organized Delivery System (DMC-ODS) provides access to a full continuum of SUD benefits modeled after the American Society of Addiction Medicine (ASAM) Criteria. This approach is expected to provide clients with access to the care and services they need for a sustainable and successful recovery.

The goal of the ASAM Criteria is to improve assessment and outcomes-driven treatment and recovery services. It is also used to match clients to appropriate types and levels of care.

Generally speaking, ASAM criteria are used to ensure the client receives the appropriate level of care in the correct program at the right time. The guiding principles of ASAM criteria are:

- Moving from one-dimensional to multi-dimensional assessments
- Moving from program-driven to clinical-driven and outcomes-driven treatment
- Moving from fixed length of service to variable length of service
- Moving from a limited number of discrete levels of care to a broad and flexible continuum of care
- Identifying adolescent-specific needs
- Clarifying the goals of treatment
- Not using previous “treatment failure” as an admission prerequisite
- Moving toward an interdisciplinary approach to care

The complete continuum is as follows:

Levels of Care

**Early Intervention (ASAM Level 0.5)**
Clients determined to be at risk of developing a substance use disorder or with an existing substance use disorder are identified and provided screening and brief treatment. This level of care is done outside of SUD treatment programs in the system (for example, in primary care settings).

**Outpatient Services, OS (ASAM Level 1)**
In this level of care, clients receive up to nine hours a week for adults and less than six hours a week for adolescents when determined by a Medical Director or LPHA to be medically necessary and in accordance with an individualized treatment plan. These services shall include intake, individual counseling, group counseling, family therapy, patient education, medication services, collateral services, crisis intervention services, treatment planning, discharge services and case management.

**Intensive Outpatient Services, IOS (ASAM Level 2.1)**
In IOS, adult clients receive a minimum of nine hours up to a maximum of 19 hours per week, when determined by a Medical Director or LPHA to be medically necessary, and in accordance with an individualized treatment plan. Adolescents receive a minimum of six hours up to a maximum of nineteen hours a week when determined by a Medical Director or LPHA to be medically necessary, and in accordance with an individualized treatment plan. Intensive outpatient services shall include counseling and education about addiction-related problems with specific components including intake, individual counseling, group counseling, family therapy, patient education, medication services, collateral services, crisis intervention services, treatment planning, discharge services and case management services.
Residential Services (ASAM Level 3.1, 3.5)
Level 3.1 clinically managed, low-intensity residential services are designed to prepare clients for a successful transfer to outpatient treatment services. Clients meeting criteria for Level 3.1 have an impaired ability to practice recovery skills and sustain change behaviors outside of a 24-hour structured setting. Clients are open to recovery and may have some knowledge of relapse prevention, however their ability to structure daily life in an outside environment requires additional skill building and the development of community supports to prevent relapse. Treatment goals for a client meeting criteria for 3.1 may include learning and practicing coping skills, building community connections, relapse prevention, self-efficacy, and an improved ability to structure and organize tasks of daily living.

In a Level 3.1 program, clients must receive 20 hours a week of structured activities. Of those 20 hours, 5 of them must be clinical services (defined as individual counseling, group counseling, family therapy, collateral services, crisis intervention, treatment planning, or discharge services).

In order for residential treatment to be reimbursed on a daily basis, the service provided must include one of these clinical activities on the date of billing – or one of two other structured activities: client education or transportation (which is defined as provision of or arrangement for transportation to and from medically necessary treatment).

Level 3.5 clinically managed, high-intensity residential services are designed to prepare clients for a successful transfer to lower intensity treatment services. Clients meeting criteria for Level 3.5 have severe, unstable SUD symptoms, functional impairments, demonstrate a repeated inability to control impulses, and are in imminent danger of substance use outside of a 24-hour structured setting. Level 3.5 services sufficiently address complex needs, including significant emotional, behavioral, or cognitive conditions related to a mental health disorder. Clients receiving level 3.5 services have limited coping skills and an outside living environment that is highly conducive to substance use. Treatment services are comprehensive and address severe instability as a result of an SUD, and contributing issues which may include justice-involvement, a personality disorder, antisocial values and other maladaptive behaviors. Treatment goals include stabilization, the development of prosocial behaviors, and relapse prevention skills.

Like a Level 3.1 program, clients in a Level 3.5 residential program must receive 20 hours a week of structured activities. However, of those 20 hours, 10 hours must be clinical services (defined as individual counseling, group counseling, family therapy, collateral services, crisis intervention, treatment planning, or discharge services).

Like a level 3.1 program, in order for residential treatment to be reimbursed on a daily basis, the service provided must include one of these clinical activities on the date of billing – or one of two other structured activities: client education or transportation (which is defined as provision of or arrangement for transportation to and from medically necessary treatment).

Withdrawal Management
Withdrawal management services are also provided on a continuum, based on client specific needs, and are provided in either an ambulatory or non-ambulatory setting consistent with ASAM level of care. See Appendix B.1 for the Withdrawal Management (WM) Standards.

The levels of Withdrawal Management are as follows:

Ambulatory Withdrawal Management (ASAM Level 1-WM)
Provides Outpatient services for withdrawal management and staffed with available physicians, and nurses.
Counselors, psychologists and social workers may be available through the program or may be accessed through affiliation with other entities. Therapies include individual assessment, medication or non-medication methods of withdrawal management, patient education, non-pharmacological clinical support, involvement of family member’s significant others in the withdrawal management process, and discharge or transfer/referral planning.

Ambulatory Withdrawal Management with extended on-site monitoring (ASAM Level 2-WM)
This level of withdrawal management is an organized outpatient service, which may be delivered in an office setting, a health care or mental health care facility, or an addiction treatment facility by medical and nursing professionals who provide evaluation, withdrawal management and referral services. Services are provided in regularly scheduled sessions and under a defined set of physician approved polices and physician monitored procedures or clinical protocols. Assessment of progress through withdrawal management, education, services to families and significant others, as well as referrals for ongoing support or transfer planning are integral aspects of care.

Clinically Managed Residential Withdrawal Management (ASAM Level 3.2-WM)
This is an organized service delivered by an appropriately trained staff member who provides 24-hour supervision, observation, and support for clients who are intoxicated or experiencing withdrawal. Programs providing ASAM 3.2 – WM are strongly encouraged to obtain an Incidental Medical Service (IMS) license through DHCS. This level provides services for client’s whose intoxication/withdrawal signs and symptoms are sufficiently severe to require 24-hour structure and support. The clinical components of this level of care include the necessary services for assessment and medication or non-medication withdrawal management, support, services to families and significant others and referrals for ongoing support or transfer planning.

Medically Managed Intensive Inpatient Withdrawal Management (ASAM Level 4-WM)
This level of detoxification is provided to clients whose withdrawal symptoms are sufficiently severe to require 24-hour inpatient care and medical management. This level is an organized service delivered by medical and nursing professionals that provide 24 hour medically directed evaluation and withdrawal management. Services are delivered under a defined set of physicians approved polices and physician managed procedures or medical providers. This included 24-hour observation, monitoring, cognitive, behavioral, medical, mental health and other therapies designed to enhance the client’s understanding of addiction and completion of the withdrawal. Services for families and significant others, and appropriate referral for ongoing support of transfer planning are also included.

Opioid Treatment Program (OTP)-ASAM level 1.0
OTP is an organized, ambulatory, addiction treatment service for clients with an opioid use disorder. It is delivered by a team of personnel trained in the treatment of opioid use disorder which includes physicians, nurses, licensed or certified addiction counselors and mental health therapists who provide client centered and recovery oriented individualized treatment, case management, and health education (including education about HIV, tuberculosis, hepatitis C, and sexually transmitted diseases). OTP services are considered appropriate for clients with an opioid use disorder that require methadone or other medication assisted treatment. This level of care is heavily regulated by federal agencies and involve the direct administration of medications on a daily basis without prescribing medication.

In accordance with CCR Title 9 10270(c)(3), clients under the age of 18 years can enter detoxification treatment if they have the written consent of their parent(s) or guardian prior to the administration of the first medication dose. In accordance with CCR Title 9 10270(d)(3), the client would need to be 18 years of age to receive maintenance treatment. A licensed NTP does have the option of submitting a SMA-168
Exception Request through the SAMHSA/CSAT Opioid Treatment Program Extranet if a client under 18 years is in need of maintenance treatment. When serving a minor, the contractor shall provide a written summary, guardian consent, and SMA-168 Exception Request and results to the Children Youth and Families Supervising Psychiatrist and the COR.

The components of OTPs shall include intake, individual and group counseling, patient education, transportation services, medication services, collateral services, crisis intervention services, treatment planning, medical psychotherapy and discharge services.

OTP provides, at minimum, 50 minutes of counseling sessions with a therapist or counselor for up to 200 minutes per calendar month, although additional services may be provided based on medical necessity.

For additional information regarding Withdrawal Management and ASAM Levels of Care, please see the ASAM Level of Care (LOC) Determination Guidelines in Appendix B.2. See Appendix B.1 for Withdrawal Management standards.

Medication Assisted Treatment (MAT)
Research has shown that for the treatment of addiction, a combination of medications and behavioral therapies is more successful than either intervention alone. Subsequently, medication-assisted treatments (MAT) must be part of a comprehensive, whole-person approach to the treatment of a SUD that includes psychosocial interventions like counseling, behavioral therapies, case management, and care coordination. The use of FDA approved addiction medications as part of this comprehensive, whole-person approach to the treatment of a SUD shall not be discouraged in any way. Similarly, clients shall not be denied services based solely on the fact that they are taking prescribed medication, regardless of the type of medication.

Additional MAT
Additional MAT services may include the ordering, prescribing, administering, and monitoring of all medications for substance use disorders. Medically necessary services are provided in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber.

Service Descriptions
Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. For example, DHCS has clarified that although RNs are considered LPHAs, they are not permitted to determine a SUD diagnosis because it is not within their scope of practice. Therefore, programs shall not use a RN as a LPHA to complete the diagnosis on the DDN (Diagnosis Determination Note) or the diagnosis on the Initial LOC Assessment (Note: A provisional diagnosis is required on the Initial LOC Assessment for all programs). See Appendix B.3 DMC-ODS Staff Services Categories for more information.

Intake/Assessment
An intake/assessment session is the process of admitting a client into substance use disorder treatment program. The intake/assessment includes the evaluation of the cause and nature of mental, emotional, psychological, behavioral, and substance use disorders. Intake occurs upon admission to the program on the first day of treatment. The assessment continues the process of the intake to further evaluate the client to determine the diagnoses and individual service needs utilizing the ASI or YAI and the ASAM criteria. In the treatment of persons with a SUD, assessments are an essential and ongoing process in order to help the provider focus their service delivery to best meet the individual client needs.
Treatment Planning
Treatment planning is the process of identifying the individual needs of the client and determining appropriate goals and interventions to alleviate the symptoms and problems associated with their SUD diagnosis. The SUD counselor or LPHA prepares the initial treatment plan, ideally with the client, based upon information obtained in the intake and assessment process. Subsequent treatment plans are written as needed when there are significant changes in the client’s life (e.g., pregnancy) and at a minimum within required timeframes for the client’s level of care (e.g., every 90 days for outpatient programs).

Group Counseling
Group counseling sessions are designed to support discussion among clients with guidance from the facilitator to support understanding and encourage participation on psychosocial issues related to substance use. Group counseling sessions need to utilize evidence-based practices.

Group can be facilitated in the field. In order to do so, each program must have policy and procedures in place to specify the following: that staff providing services in the field are linked to the contracted DMC Certified program claiming the service; ensure that confidentiality is maintained; that progress notes for these services must include the location services were provided and document steps taken to ensure confidentiality; and that the field location cannot be a regular site for groups (i.e. services in the field can never be used in lieu of obtaining DMC Certification). For outpatient programs, a separate individualized progress note must be documented for each participant. Outpatient groups can consist of both OS and IOS clients. For residential programs, groups will be documented in a weekly note. Group size must be 2-12 participants to be billable except education groups in residential treatment which may be more than 12 participants. For mother/child habilitative and rehabilitative services (development of parenting skills, training in child development, which may include the provision of cooperative childcare pursuant to Health and Safety Code Section 1596.792), children do not count toward the group size. These types of groups must have progress notes completed with all documentation standards and within timelines, and group sign-in sheets that meet all requirements as for all other group services. Note: Recovery Services groups shall consist only of clients receiving Recovery Services and shall not be included in group with client’s receiving treatment. For more information on group sign-in sheet standards, see Group Sign-In Sheets in Section D.

Individual Counseling
Individual counseling by definition is face to face or telephone contact between a client and LPHA or SUD counselor and focus on psychosocial issues related to substance use and goals identified in the client’s treatment plan. A progress note is required to document the session in the client’s chart.

Family Therapy
Family therapy is a form of psychotherapy that involves both the client and their family members to improve the psychosocial impact of substance use and the dynamics of the social/family unit. Family members may provide social support to clients, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well. Progress note documenting the session is required in the client’s chart.

Collateral Services
Collateral services are sessions between significant persons in the life of the client and SUD counselors or LPHA’s. Significant persons are individuals that have a personal, not official or professional relationship (e.g. teachers or probation officers) with the client. These sessions are used to obtain useful information regarding the client to support their recovery. The client may be present, but it is not a requirement that the client is present. A progress note must document each session in the client’s chart.
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CONTINUUM OF CARE & SERVICES

Crisis Intervention
A contact between a LPHA or SUD counselor and a client in crisis. These services focus on alleviating crisis problems, where crisis is defined as an actual relapse or an unforeseen event that presents imminent threat of relapse. This type of service is limited to stabilization of the client’s emergency situation.

Case Management
Case management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet the client’s needs. This includes coordination of care and collaboration with other providers and other professionals (e.g. teachers, probation officers, psychiatrists) as needed. Clients are guided through the system of care and assisted with linkages through ancillary services and the next needed ASAM level of care from withdrawal management through recovery services (aftercare). When a client is transitioning from one level of care to another (or to an ancillary service), consider care coordination concepts. Care coordination should be based on warm handoff principles: carefully coordinated transfer or linkage of a client to another provider, entity, agency, or organization who will continue, add, or enhance services. For additional information, refer to Section D: Service Delivery. For both residential and outpatient programs, a progress note is required for each case management interaction in the client’s chart.

Discharge
Discharge planning is the process of preparing the client to transition from the current services to another level of care or out to return to the Community. Discharge planning should begin at the onset of treatment services. This ensures sufficient time to plan and prepare the client for change. It also assists in conveying the concept that recovery is an ongoing life process and not a single event or service. Discharge planning sessions are defined as face to face contact between one SUD counselor, or LPHA and one client at the same time. The Discharge Summary is a narrative summary that summarizes the treatment experience. Note: For details on documentation requirements for these services, please refer to the section on Documentation.

Recovery Services
Recovery Services are only available after the client has completed a course of treatment (for example, at an IOS program) and there is not a clinical indication for step-down to another level of care. Recovery Services emphasize the patient’s central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to clients. Recovery Services cannot be provided by one program when a client is receiving SUD treatment services at another program.

Recovery Services include outpatient individual or group counseling (relapse prevention), recovery monitoring/coaching, care coordination/linkages to education and job skills services, family support (i.e. childcare, parent education, etc.), support groups, and other linkages (such as to housing, transportation, etc.) Recovery services are provided either face-to-face, by telephone, or by telehealth, and in any appropriate setting in the community with the beneficiary. Providers may accept Recovery Service clients from other treatment programs. See Appendix B.4 – Recovery Services Transition Flowchart for more information. If a client is accessing Recovery Services within 90 days of concluding their treatment phase, the Initial LOC Assessment form is not required. If a client is accessing Recovery Services more than 90 days after concluding their treatment phase, the Initial LOC Assessment form shall be completed.

Recovery services shall be utilized when the beneficiary is triggered, when the beneficiary has relapsed, or simply as a preventative measure to prevent relapse. At the completion of a course of treatment and as part of the assessment and treatment needs of Dimension 6 of the ASAM criteria (Recovery Environment) during the transfer/transition planning process, programs shall provide beneficiaries with recovery services.
Additionally, recovery services are provided based on medical necessity. Refer to the section on Care Coordination for expectations for offering Recovery Services to clients. (See Section D: Service Delivery for more details on Recovery Services.)

**Housing Needs & DMC-ODS**

**Recovery Residences**

Recovery Residences (also known as Sober Livings) are privately-owned homes or complexes that provide transitional housing for adults actively receiving SUD Outpatient Treatment Services or Recovery Services. (On rare occasions, clients actively receiving SUD Residential Recovery Services that do not meet ASAM criteria for Residential or Outpatient Services or who decline Outpatient Services may also be referred to Recovery Residences). Recovery Residences serve residents who are in need of a recovery oriented, supportive housing environment. Recovery Residences serve as a housing option for clients who are homeless and/or in unsafe living environments.

The County has contracted with CHIP (Community Health Improvement Partners) to develop a Recovery Residence Association (RRA) to provide oversight and support for our local Recovery Residences, their proprietors, owners, and clients to ensure the highest quality of living environment and to address any issues that may arise. They will identify and implement a training curriculum and a set of quality standards and best practices for Recovery Residences that are part of RRA. BHS Providers are encouraged to use Recovery Residences that are part of the RRA.

Recovery Residence supplemental funding is an option for clients who are receiving treatment at a DMC-ODS outpatient or residential program. Refer to Appendix B.5 Recovery Residences – Supplemental Funding Guidelines or more details on the requirements and maximum costs. County reimbursement is only available for daily utilized beds. It is important to note supplemental funding for Recovery Residences should only be utilized when other safe housing options (e.g., supportive family residence) are not readily available for the client. Recovery Residence funding can also be used on a case-by-case basis for immediate short-term/time limited housing (e.g., motel) needs when a client is at risk and there is a delay in transitioning them to a stable long-term recovery residence. Programs should contact their COR for approval in these circumstances.

Please note: treatment services are not provided in Recovery Residences. Clients in Recovery Residences must be actively receiving Outpatient Treatment or Recovery Services under BHS SUD contract.
C. PREVENTION SERVICES & SPECIALTY PROGRAMS

San Diego County's substance use prevention strategy primarily utilizes environmental prevention, a federally approved community-change model to prevent substance use problems throughout the region. Providing a targeted focus on these issues allows the County to develop long term, strategic, cost effective and sustainable prevention plans for each initiative, provides coordination and shared resources where possible, and provides flexible prioritization in each region regarding how each initiative will be tailored to individual community needs.

Primary Prevention
Since the inception of the San Diego County Prevention Framework in 1997, the County has initiated four regional substance use disorder prevention initiatives that are aligned with the County of San Diego’s Strategic Initiatives:

- Binge and Underage Drinking Initiative (1996)
- Methamphetamine Strike Force (1996)
- Marijuana Initiative (2005)
- Prescription Drug Abuse Task Force (2008)

Each of the four County Initiatives has a subject matter expert facilitator who provides leadership and expertise on the specific Initiative, its goals and work plans, and actively engages stakeholders and community throughout the region for each effort.

The County of San Diego’s prevention system is implemented through a broad array of contracted community-based prevention service providers. The providers incorporate the activities of the County Prevention Plan to ensure full coordination and continuation of efforts by working together in focused workgroups for each initiative.

The San Diego Prevention system includes a substance use disorder prevention provider located in each of the six HHSA Regions to implement the State approved County Prevention Plan.

A key component to the San Diego Prevention system is a commitment to continuous improvement and professional development in the prevention arena by working closely with the community to mitigate issues they are concerned about. As such, each prevention contract requires a designated position for a media advocacy specialist, a community organizer and a prevention specialist to assure capacity and expertise at service delivery.

A countywide media advocacy project provides technical expertise training and facilitates a monthly media advocate’s meeting to share expertise, resources and experiences conducting media advocacy efforts.

To evaluate and measure the impact of prevention services, all prevention service providers are required to work with the evaluation provider and to provide working documents to the “Prevention Information and Resource Library” (PIRL) portal, which is accessible to County SUD prevention providers. Information includes meeting agendas, sign in sheets, media advocacy calendar, notes and other relevant information. Each County Initiative has an evaluation plan designed to measure the impact of each activity and progress is reviewed annually and over time. Access to PIRL is controlled by the evaluation contractor.
Each substance use disorder prevention provider is required to develop an implementation manual that describes how the Statement of Work will be implemented which is updated as needed.

**Incredible Families**

The Incredible Families Program (IFP) was designed to consolidate needed services, and improve outcomes for children and their families involved with Child Welfare Services (CWS), in three (3) service areas of San Diego County: 1) Central/North Central regions, 2) East/South regions and 3) North Coastal/North Inland regions. Utilizing proven methods from the evidence-based Incredible Years model, the goal of the program is safe and successful family reunification (for families of children in foster care), improved family functioning, and improved mental health functioning for referred children.

The target population includes children ages 2-14, who meet medical necessity diagnostic and impairment criteria in accordance with California Code of Regulations Title 9 and who are dependents of Juvenile Dependency Court due to abuse and/or neglect, and their families. Most of the participating children reside in foster homes, with a smaller portion residing with relatives and/or parents under CWS supervision. In order for these families to safely reunify, parenting skills education, consistent and meaningful family visitation and mental health treatment are typically among the most critical (and often court-ordered) service needs. In collaboration with CWS and Behavioral Health Services, Children Youth and Families (CYF), the Incredible Families Program seeks to combine these elements under one organizational umbrella, with one primary clinician assigned to each family, thus providing maximum efficiency and effectiveness for the families as well as the supervising CWS worker.

Specific service components include a weekly multi-family parent-child visitation event and meal for all family members. Immediately following the family visitation, a 15-week parenting group, utilizing the Incredible Years evidenced-based curriculum, is provided to parents. Their children, ages 2 to 14 are provided a full range of Title 9 outpatient-based services as an entitled Medi-Cal beneficiary. Services are focused on alleviating trauma and strengthening parent-child relationships. Evidence-based therapeutic interventions offered include Trauma Focused Cognitive Behavioral Therapy (TF-CBT) and Eye-Movement De-sensitization and Reprocessing (EMDR). Additional interventions will include clinical support and facilitation of visitation events and individual therapeutic contacts with parents to address specific problems and further support their attainment of effective parenting skills.

A primary therapist is assigned to each family and is responsible for implementing all program components: Parent group, clinical support during family visitation events and individual/family therapy. All family members (parents and children) are also assessed and referred for additionally needed services, including further mental health treatment, substance use disorder services, and if needed, ancillary services. The primary therapist will be responsible for documenting all services in CCBH.

**Credentials**

- All IF staff must attend a three-day Incredible Years parenting training session
- Therapists are to be licensed or registered associates working toward their licensure
- Therapists are also required to attend ongoing Trauma Focused trainings
- Parent Partners attend Youth and Family Roundtable

**Services for Children of Parents Receiving SUD Services**

Embedded in each of the Perinatal Outpatient and Residential treatment programs is a mental health clinician who is designated to work directly with the children of mothers receiving SUD services. The purpose is to:
• screen children to determine need for mental health services, to include but not limited to, parent-child bonding
• provide assessment and therapeutic interventions for children screened to have emotional, developmental, behavioral, or attachment needs
• identify and link children with higher level needs to specialty behavioral health services
• collaborate with County-designated contractors offering therapeutic services for children, to include but not limited to, Healthy Development Services (HDS) and Developmental Screening and Enhancement Program (DSEP)

Justice-Involved SUD Services
For many people in need of alcohol and drug services, contact with the criminal justice system is their first opportunity for treatment. Outlined below are specific requirements for providers to follow and utilize in serving the specific needs of this population. Note: Providers will not be reimbursed for report writing at this time. The County will revisit this decision within one year of implementation.

PC 1210/Prop 36
Providers who receive clients referred to SUD services by the Court under PC 1210/Prop 36, shall provide reports and communication to the Court regarding client treatment status as directed by Program COR.

Community Resource Directory (CRD)
The Probation Department Community Resource Directory (CRD) is a web-based catalog of countywide services to which adults and youth can be referred. It assists in linking individuals on probation to appropriate community-based intervention services based on the individual’s assessed needs. Service providers receive probation referrals through the CRD and utilize the CRD as a mechanism to report back to probation officers on an individual’s progress toward meeting their program goals.

As directed by COR, Contractor shall enroll in and utilize the CRD to include referral management and weekly status updates, as one route to work closely with the case-carrying Probation Officer.

Communication with Probation
As directed by program COR, Program staff will contact Probation within 24 hours whenever noteworthy incidents arise involving a Probationer. (Noteworthy incidents include but are not limited to: Program enrollment/exit; violent behavior; positive drug test; law enforcement contact; and change in program location.) Providers shall work closely with and be available to meet monthly with case carrying Probation Officers to discuss client progress in treatment. Contractors shall provide pertinent treatment information received from Recovery Residences to the assigned case-carrying Probation Officer to include providing information about noteworthy incidents within 24 hours of receiving the information. Providers shall be available to meet quarterly with Probation representatives to discussed systemic improvements and collaboration.

Correctional Program Checklist (CPC)
As directed by COR, Contractor will fully participate in the Corrections Program Checklist (CPC) to improve treatment quality for clients who are assessed to be moderate to high risk for recidivism. Additional information regarding the CPC is found in the Technical Resource Library.

High Risk Services
As directed by COR, contractor shall utilize criminogenic risk and need assessment results (i.e. COMPAS) to inform individualized treatment planning and to develop specific “treatment tracks” for clients who are
assessed at medium to high criminogenic risk. These treatment tracks will include evidence base practices with a target of reducing recidivism as a focus of treatment.

**Criminal Offender Record Information (CORI)**
Please refer to the Staffing and Training Section.

**Justice Overrides**
While in residential treatment, clients on “justice overrides” may be allowed to get back to work and/or receive vocational activity in lieu of a structured activity. The vocational activities would be okay to replace “program structure activity hours” but minimums of 3.1 clinical hours would still be in place. County recommends clients to be referred to programs directly whenever possible.

- Provider would need to utilize a DMC-billable cost center when a court-ordered client is a Medi-Cal beneficiary, meets the Program LOC, and is opened to the Program.
- Provider would need to utilize a County-billable cost center to claim the cost of screening a court-ordered client but not opened to the Program and/or the client is opened to the program but is not a Medi-Cal beneficiary.

**County of San Diego Justice-Related SUD Programs**

**Driving Under the Influence (DUI) Programs**
The Driving Under the Influence (DUI) programs are licensed by the California Department of Health Care Services and administered locally by BHS. Services are designed to meet the requirements of the Department of Motor Vehicles (DMV) and courts as stipulated for individuals who have been arrested for driving under the influence. Available services include: 3, 6, 9, 12, and 18-month programs and education only. This program is completely funded by participant fees. Spanish services are available at all locations. All facilities are wheelchair accessible.

**Penal Code Section 1000 (PC 1000)**
California Penal Code Section 1000 (PC 1000) establishes the authority for counties to create drug diversion programs for eligible participants who are referred from a court. A referral will be made to a County certified PC 1000 Drug Diversion program when a participant is eligible and suitable for the PC 1000 program. Persons who have a need for Substance Use Disorder (SUD) treatment, and who have private insurance, will be referred to their healthcare provider. The criminal charge is dismissed, pursuant to statute, if the participant successfully completes the program and complies with the conditions established by the court.

PC 1000 Two-Track Drug Diversion Program is intended to provide participants with either education on substance use or treatment for a diagnosed substance use disorder (SUD). The Drug Medi-Cal Organized Delivery System, and changes in state law, bring about the following changes to providers: 1) elimination of the AIDS education component, 2) maintenance of the education track, and 3) addition of a treatment track. The education track will continue at the existing sites, and on September 1, 2019, the new treatment track will be available at the six Regional Recovery Centers. All participants will be assessed SUD need through the American Society for Addiction Medicine (ASAM) criteria. If participant is assessed as having a need for treatment, they will only participate in the treatment track. Please see Appendix C.1 for service and program requirements, including communication with court requirements.

**Drug Court and Re-entry Court**
Drug Court Programs shall establish and maintain a program to provide non-residential substance use disorders (SUD) treatment and testing program services to serve non-violent adult male and female
offenders who have been referred to Adult Drug Court. Members of the Adult Drug Court Team, which include the Adult Drug Court Judge, District Attorney, law enforcement, Public Defender, and Programs shall participate in case conferencing and Adult Drug Court sessions.

Dependency Drug Court (DDC)
The Dependency Drug Court Program provides screenings and referrals for drug and/or alcohol treatment to families that are involved in Child Welfare Services (CWS). Substance Abuse Specialists (SAS) are stationed at the Dependency Courts located at County of San Diego Superior Court buildings. In Level 2 Drug Court, the role of the SAS is to provide support, collaboration between the client, treatment program, Courts, and CWS, and to give updates to the Court on the client’s status/progress in treatment.

Note: Contact your COR for questions related to any justice-involved clients.
D. SERVICE DELIVERY

In order to receive SUD services within the County of San Diego Drug Medi-Cal Organized Delivery System (DMC-ODS), clients must be a resident of San Diego County.

Access

In our commitment to providing excellent customer service, timely access is emphasized. Consistent with the County of San Diego’s Health and Human Services Agency’s “No Wrong Door” philosophy, Behavioral Health Services clients are able to access DMC-ODS services by directly contacting DMS-ODS providers or via the Access and Crisis line. County of San Diego DMC-ODS providers will maintain hours of operation during which services are provided to clients in an equal capacity to all clients regardless of funding source (e.g. Medi-Cal).

County of San Diego DMC-ODS providers will post the Access and Crisis Line (ACL), 888 724-7240, to assist clients with after hour’s access. This line includes language translations in the client’s preferred language via Language Line which has 150 languages. The ACL uses the California Relay Service (711) for TTY. The ACL maintains policies and procedures to screen for emergency medical and behavioral conditions as well as general screenings to assist with appropriate referrals to access services. Contact information for the Access and Crisis Line is also available on the County of San Diego Behavioral Health Services website and on printed materials as well as Optum San Diego’s website.

County of San Diego DMC-ODS providers will ensure a face to face appointment within ten (10) business days of the request for Outpatient and Intensive Outpatient Services. Opioid Treatment Programs will ensure a face to face appointment within three (3) business days of the request for services. Residential program will ensure intakes will be conducted 24 hours a day/7 days a week. All programs will ensure to not have standard wait lists. Programs are required to contact other appropriate level programs within the provider network if they do not have capacity, to ensure warm handoffs as needed. Providers shall have policies and procedures in place to screen for emergency medical conditions and immediately refer beneficiaries to emergency medical care. Time and distance for Outpatient, Intensive Outpatient Services, and Opioid Treatment Programs shall be within thirty (30) minutes from the client’s place of residence or up to fifteen (15) miles, unless an alternate access standard has been approved by the Department of Health Care Services (DHCS).

Network Adequacy

On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) published the Medicaid Managed Care Final Rule (Mega Regs), which aimed to align Medicaid managed care regulations with requirements of other major sources of coverage. Mega Regs require states to establish and implement standards for network adequacy, including time and distance standards and timely access requirements. In addition, states must submit annual network certifications to CMS demonstrating compliance with such established standards.

The Department of Health Care Services (DHCS) issued a Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice (IN) (Information Notice 18-011) to set forth federal network adequacy requirements for Drug Medi-Cal Organized Delivery System (DMC-ODS) pilot counties. The IN also specifies reporting responsibilities related to federal and state network adequacy requirements. Each DMC-ODS pilot county must complete the Network Adequacy Certification Tool (NACT) for all network providers at the organizational (Exhibit A-1), site (Exhibit A-2) and rendering provider (Exhibit A-3) level. The organizational level refers to the provider’s legal entity. The site level refers to the physical location of the provider. The rendering provider refers to the individual practitioner,
acting within his or her scope of practice, who is rendering services directly to the Medicaid beneficiaries. Each DMC-ODS provider will collaborate with the Quality Improvement Team (QI) to provide this information based on the submission requirements of DHCS. DHCS will use this information to ensure compliance with CMS network adequacy requirements.

System requirements include that the County of San Diego comply with time and distance standards. The availability of services must either be within 15 miles from the beneficiary’s residence or be within a 30-minute drive from the beneficiary’s residence. Refer to the Access section for timely access to care standards.

In addition, the County of San Diego will monitor Network Adequacy to ensure service capacity by assessing the range of services available and the capacity to serve the anticipated number of beneficiaries. Monitoring will occur by reviewing the range of services provided, the geographic distribution of providers in the network, the current number of clients served, and client access times. This analysis will be summarized and submitted to DHCS through the required documentation that includes:

- Network Adequacy Certification Tool (NACT)
- Geographic access maps
- Actual grievances and appeals
- Provider agreement boilerplates
- Provider directory
- Beneficiary satisfaction survey results
- Specific policies and procedures

**Out-of-Network Access**

Providers are expected to direct beneficiaries of San Diego County to in-network providers when arranging for services related to the residents’ care. If required treatment services are not available with the County of San Diego provider network, the beneficiary may access required services from an out-of-network provider.

The County of San Diego DMC-ODS plan will adequately and timely cover services out-of-network for beneficiaries if medically necessary services are not available in the network for as long as the network is unable to provide them.

The County of San Diego contracts with an Administrative Services Organization (ASO) for the execution of out-of-network accommodation agreements.

**Process**

1. Accommodation Agreements with out-of-network providers are executed when one or more of the following criteria are met:
2. There are no San Diego County network providers within a reasonable geographic range who meet the cultural, ethnic, and clinical needs of the beneficiary;
3. Treatment by an out-of-network provider is within the clinical best interest of the beneficiary as determined by County of San Diego Behavioral Health Services (BHS);
4. Special requests made by designated County BHS staff, which may include reimbursement of providers with non-Medi-Cal funds.
5. Providers who determine medically necessary SUD treatment and cannot provide the indicated level of care shall provide case management services and assist the beneficiary in contacting the
ASO’s Access and Crisis Line at 888-724-7240 (TTYL 711) for information/referral to an out-of-network SUD provider.

6. On behalf of the County of San Diego DMC-ODS, the ASO will manage the out-of-network request service approvals. Upon receipt of the request, the ASO shall send the beneficiary written acknowledgement of receipt of the request and begin to process the request within three (3) working days.

7. ASO staff contact the professional out-of-network provider identified, or who is requesting accommodation, and arranges for the Accommodation Agreement in which the professional provider:

8. Agrees to follow County of San Diego standard care procedures;
9. Accepts standard San Diego County Medi-Cal rates, unless otherwise negotiated;
10. Meets the following criteria and submits supporting documentation, as applicable:
11. A copy of the provider’s current state license to practice at the independent level,
12. A copy of proof of professional liability coverage, and
13. DEA certificate (MDs only).
14. Primary Source Verification process does not occur, but staff can confirm the active license online. The provider is not presented to the San Diego Credentialing Committee for approval.
15. The Provider receives two original Accommodation Agreements for the out-of-network provider to sign and return if no fax machine is available. If using a fax machine, only one Accommodation Agreement is faxed to the provider. The signed agreement may be faxed back to the ASO.
16. The ASO sets up the provider in the Designated Database (DDS) so that authorizations and payment can occur.
17. If the County of San Diego DMC-ODS and out-of-network provider are able to enter into a suitable arrangement, then the County shall allow a beneficiary to have access to that provider as long as deemed medically necessary, unless the out-of-network provider is only willing to provide services to the beneficiary for a shorter timeframe. In this case, the County of San Diego DMC-ODS shall allow the beneficiary to have access to that provider for the shorter period, as established by the out-of-network provider.
18. Within seven (7) calendar days of approving the out-of-network service request, the ASO shall notify the beneficiary of the following in writing:
19. The request approval;
20. The duration of services arrangement;
21. The process that will occur to transition the beneficiary’s care at the end of the service arrangement; and
22. The beneficiary’s right to choose a different provider from the DMC-ODS County’s provider network.
23. At any time, beneficiaries may change their provider to an in-network provider. When the Accommodation Agreement has been established, the County shall work with the provider to establish a care plan for the beneficiary.
24. Each request for out-of-network services shall be completed within thirty (30) calendar days from the date that the ASO, on behalf of the County of San Diego DMC-ODS, received the request.
25. The ASO shall notify the beneficiary in writing thirty (30) calendar days before the end of the Accommodation Agreement period about the process that will occur to transition the beneficiary’s care to an in-network provider. This process includes engaging with the beneficiary and affected provider(s) before the end of the agreement period to ensure continuity of services through the transition to an in-network provider.
Telehealth
Under the County of San Diego DMC-ODS, telehealth is an option for most services as a means of increasing accessibility to SUD services. BHS is responsible for ensuring that SUD providers who are part of the County of San Diego DMC-ODS Network follow standard telehealth protocols for protecting beneficiary confidentiality. Contracted organizational providers in the County of San Diego DMC-ODS shall:

- Verify in the County of San Diego DMC-ODS Provider Services Guide which services are allowed to be provided via telehealth prior to service delivery utilizing this technology.
- Use a secure, trusted platform for videoconferencing.
- Verify devices and software use the latest security patches and updates.
- Install the latest antivirus, anti-malware, and firewall software to devices. The underlying network must provide security.
- Verify devices use security features such as passphrases and two-factor authentication. Devices preferably will not store any patient data locally, but if it must, it should be encrypted.
- Verify audio and video transmission is encrypted. The Federal Information Processing Standard (FIPS) 140-2 is used by the United States government to accredit encryption standards. Encryption strengths and types can change. When partnering with 3rd party telehealth vendors, verify if their encryption meets the FIPS 140-2 certified 256 bit standard; that any peer-to-peer videoconferencing (streamed endpoint-to-endpoint) is not stored or intercepted by the company in any way; and that any recorded videoconferences or—if available—text-based chat sessions near the chat window are stored locally, on the program’s own HIPAA-compliant device or electronic record keeping system, in order to safeguard any electronic protected health information or PHI.
- Choose a software solution that is HIPAA-compliant, as many popular, free products are not. Compliance with HIPAA (Health Insurance Portability and Accountability Act of 1996) and 42 CFR Part 2 is essential. HIPAA sets a minimum federal standard for the security of health information. States may also set privacy laws that can be even more strict, so programs must be sure to check any relevant statute for California. Just because software says its HIPAA-compliant isn’t enough. HIPAA compliance may also be dependent on the interface of your videoconferencing software with other aspects of the program’s practice, such as EHRs, so it is best to think about HIPAA and telehealth from a global, “all technologies” perspective.
- It is recommended to use a broadband internet connection that, at minimum, has a transmission speed of at least 5 MB upload/download to avoid pixilation, frequent buffering, and other video and audio difficulties associated with slow and insufficient transmission. Higher speeds might be required for newer technologies that use HD capabilities.
- When reviewing software options, many vendors require a “business associate agreement,” or a BAA, to ensure HIPAA compliance. Contact the vendor and confirm what such an agreement entails.

Compliance will these requirements will be monitored through annual BHS SUD QM site visits.

Referral Resource
SUD programs shall serve as a community referral resource, directing individuals in need of other services beyond the scope of the program. The program shall maintain and make available to participants a current list of resources within the community that offer services that are not provided within the program. At a minimum the list of resources shall include medical, dental, mental health, public health, social services and where to apply for the determination of eligibility for State, Federal, or County entitlement programs.
Release of Information to Referrals
In order to facilitate linkage and care coordination, providers shall report all required client information to identified referral source according to specified format and established timelines, providing there is current written consent to release information contained in the client file.

Programs shall have written policy and procedures regarding their role as a community referral resource. Program policy and procedure will identify conditions under which referrals are made, details of the referrals, and additional follow-up services as documented within the client record. Programs will offer individuals either requesting, or in need of services not otherwise offered by the program, resource options/referrals from an updated list of community service resources available within San Diego County.

Missed Scheduled Appointments
All providers shall have policies and procedures in place regarding the monitoring of missed scheduled appointments for clients (and/or caregivers, if applicable). These policies and procedures shall cover both new referrals and existing clients, and at minimum, include the following standards:

- **For new referrals:** When a new client (and/or caregiver, if applicable) is scheduled for their first appointment and does not show up or call to reschedule, they will be contacted within 1 business day by clinical staff. If the client has been identified as being at an elevated risk, the client (or caregiver, if applicable) will be contacted by clinical staff on the same day as the missed appointment. Additionally, the referral source, if available, should be informed.

- **For current clients:** When a client (and/or caregiver, if applicable) is scheduled for an appointment and does not show up or call to reschedule, they will be contacted within 1 business day by clinical staff. If the client has been identified as being at an elevated risk the client (or caregiver, if applicable) will be contacted by clinical staff the same day as the missed appointment. For clients who are at an elevated risk and are unable to be reached on the same day, the program policy needs to document next steps, which may include consultation with a supervisor, contacting the client’s emergency contact, or initiating a welfare check. Additionally, the policy shall outline how the program will continue to follow up with the client (or caregiver, if applicable) to re-engage them in services, and should include specific timeframes and specific types of contact (e.g., phone calls, letters).

All attempts to contact a new referral and/or a current client (or caregiver, if applicable) in response to a missed scheduled appointment must be documented by the program.

Note: Elevated risk is to be defined by the program and/or referral source.

Crisis Intervention Protocol
SUD programs are to have a protocol in place to address client crises and emergency situations. These protocols shall be available to all program staff and staffs are to be trained in crisis intervention procedures. Phone numbers for the Programs’ local police, PERT team, fire department, and other emergency services shall be readily available to all staff members.

Access and Crisis Line: 1-888-724-7240 (TTY: 711)
Optum Health operates the Access and Crisis Line (ACL) on behalf of the County of San Diego Behavioral Health Services (COSDBHHS). The ACL, which is staffed by licensed and master’s level clinicians, provides telephone crisis intervention, suicide prevention services, and behavioral health information and referral 24
hours a day, seven days a week. The ACL may be the client or the family’s initial access point into the system of care for routine, urgent or emergency situations.

All ACL clinicians are trained in crisis intervention, with client safety as the primary concern. ACL Counselors evaluate the degree of immediate danger and determine the most appropriate intervention (e.g., immediate transportation to an appropriate treatment facility for evaluation, or notification of Child or Adult Protective Services or law enforcement in a dangerous situation). In an emergency situation, ACL counselors make direct contact with an appropriate emergency services provider to request immediate evaluation and/or admission for the client at risk. The ACL counselor makes a follow-up call to that provider to ensure that the client was evaluated and that appropriate crisis services were provided.

If the client’s mental health condition is serious but does not warrant immediate admission to a facility, the ACL counselor performs a telephone risk screening and contacts an SUD provider directly to ensure that the provider is available to assess the client within 72 hours.

Additionally, the ACL conducts a Brief Level of Care Screening Tool in order to determine a provisional level of care recommendation to guide linkage to an appropriate referral to SUD services. During business hours, the ACL will offer the client the opportunity for a warm handoff to a SUD program best aligned with the client’s provisional level of care need.

The ACL has Spanish-speaking counselors on staff. Other language needs are met through the Language Line, which provides telephonic interpreter services for approximately 140 languages at the point of an initial ACL screening. Persons who have hearing impairment may contact the ACL via the California Relay Service 711.

**Eligibility Determination**

County of San Diego Substance Use Disorder services offer a comprehensive continuum of care to better meet the unique recovery needs of adults, adolescents, and specific subset populations (probation, perinatal), including those struggling with co-occurring disorders.

SUD programs within the County of San Diego system of care are required to develop and maintain written program eligibility, admission, and readmission policy, procedure, and protocols to include non-discriminatory eligibility and admission practices compatible with [42 CFR 438.3](#), Title VI of the Civil Rights Act of 1964, The Age Discrimination Act of 1975, The Rehabilitation Act of 1973, The Americans with Disabilities Act, and Title IX of the Education Amendments of 1972 to include:

- Enrollment discrimination is prohibited ([42 CFR Title 438.3](#))
- Enrollment is voluntary, except in the case of mandatory enrollment programs that meet the conditions set forth in ([42 CFR § 438.50 (c)](#))
- Prohibit discrimination in enrollment, disenrollment, and re-enrollment, based on the client’s health status or need for health care services ([42 CFR 438.3](#))
- The Provider accepts individuals eligible for enrollment in the order in which they apply without restriction ([42 CFR Title 438.3](#))
- The provider will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation gender identity, or disability ([42 CFR 438.3](#))
- Eligible individuals may not be denied services pending establishment of Medi-Cal
Eligible Populations
Program policies will include a description of “target populations” eligible to receive SUD services within their programs as defined within their contracts. Eligibility may include one or any combination of:

- Adolescents age 12 – 17
- Adults age 18 and over
- Clients self-referred or referred by another person or organization
- Geographical Service Area: Residents of San Diego County (North Coastal, North Inland, North Central, Central, East, South)
- Persons with Medi-Cal or are Medi-Cal eligible (regardless of % FPL and regardless if they have additional insurance), including those served by local Medi-Cal managed care plans and their plan partners. Note: Clients who are at or under 138% of FPL are eligible for Medi-Cal.
- Special populations based on: disabilities, cultural, linguistic, and sexual orientation (DHCS AOD Certification Standards, Sec. 7000)
- No DMC/Low Income or no insurance:
  - Clients within 138% to 200% FPL without insurance (and not Medi-Cal eligible). Note: sliding scale would apply. Please refer to Section F, Provider Contracting, for more information.
  - Clients under 200% FPL with health coverage other than Medi-Cal may be invoiced to the County BHS contract.
  - Clients above the 200% FPL are outside of the BHS target population may not be invoiced to the County BHS contract.
  - Optum will require a denial or Assignment of Benefits (AOB). Check with Optum for requirements.
- Under-insured – only for existing or pre-ODS clients with no coverage for SUD services. The County is willing to have these current clients as County billable on a case by case basis. (Contact SUD QM at QIMatters.HHSA@sdcounty.ca.gov.)
- Persons meeting DMC-ODS medical necessity criteria
- Justice Overrides
- Individuals under age 21 are eligible to receive Early Periodic Screening, Diagnostic and Treatment (EPSDT) services. They are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority.

(See Section A: County of San Diego DMC-ODS for more information.) For more information on the current FPL, see the Poverty Guidelines at US Department of Health & Human Services website.

Assisting Clients with Medi-Cal
Providers shall make every effort to assist clients with applying for and maintaining eligibility for Medi-Cal and attempt to maintain a minimum of 80% Medi-Cal enrollment of its total program population. Programs will assess the client’s insurance status during the initial assessment and throughout treatment. Programs must check clients’ Medi-Cal status monthly, including Share of Cost, to verify DMC eligibility. Refer to the County of San Diego Drug Medi-Cal Financial Eligibility and Billing Procedures Manual for more details.

Medi-Cal Enrollment
For clients who are currently uninsured and eligible for Medi-Cal, programs will offer assistance to obtain Medi-Cal and/or maintain their benefits, by connecting them with a Medi-Cal enrollment entity and/or
assisting with the Medi-Cal application process. Medi-Cal applications can be completed throughout the year. For additional Medi-Cal qualifying information, please visit the DHCS website.

There are several ways to assist clients in the Medi-Cal enrollment process:

- Clients may complete or SUD providers may assist clients in completing an online application at:
  - MyBenefits CalWIN
  - Covered California
- Clients may make an appointment or walk-in to a Federally Qualified Health Center (FQHC) where dedicated enrollment staff will assist them with the application process
- Clients may make an appointment or walk-in to a County of San Diego operated Family Resource Center or Live Well Center where dedicated eligibility staff will assist the client with the application process
- The SUD program may partner with local FQHC to host a Medi-Cal enrollment event at the program site
- The SUD program may partner with the County of San Diego Eligibility staff to host a Medi-Cal enrollment event at the program site
- To find a Federally Qualified Health Center or County of San Diego Family Resource Center located near your program, please visit the 2-1-1 San Diego website.

Residential Service Authorization
An Administrative Services Organization (ASO) provides customized administrative services to the County, clients and providers and is responsible for residential placement authorization and coordinating intakes to SUD providers. Optum acts as the ASO for County Behavioral Health Services. While there is no “wrong door” for clients to enter the SUD treatment system, the two most frequently used portals are the Optum Access and Crisis Line (ACL) and direct referrals. Clients seeking residential SUD services in the County may go directly to a SUD residential treatment provider or contact them by telephone to initiate services. Less frequently, clients are referred to SUD services by physical and mental health providers, law enforcement, and County agencies. All requests for authorization must be entered in SanWITS (see SanWITS User Guide for data entry of this process). For assistance with SanWITS during normal business hours (7:00 am to 4:30 pm, M-F), contact the SUD_MIS_Support.HHSA@sdcounty.ca.gov. For assistance with SanWITS after normal business hours and on weekends, contact the Optum Support Desk at 800-834-3792.

Residential providers are expected to have established workflow processes in place to meet submission of complete information in authorization requests, and to meet the timelines as described below. The date the authorization request is considered received is the date complete information for the request has been received. Incomplete authorization requests received by Optum that require additional follow-up for information may not meet required timelines. Residential days covered by late authorization requests will require entry into SanWITS as non-billable

Initial Authorization
The SUD Provider begins the authorization process by checking the client’s Medi-Cal eligibility, which is not a requirement for services, and by completing the required intake/admission documentation (See the SUDURM for further details). If the client meets criteria for admission, the SUD Program will complete the Initial Level of Care Assessment form to establish medical necessity and submit it to Optum within 24 hours of the client’s admission to the program. The Optum SUD Care Advocates are available for consultation by telephone at 800-798-2254 (select option 3, and then option 2) at any time before or during
the authorization process. Residential programs are encouraged to consult should they have questions regarding a client’s needs, documentation, or other questions related to authorization.

The SUD Program will notify the Optum SUD Care Advocate of the initial authorization request via telephone and will provide demographic information. The SUD Provider will then fax the Optum fax coversheet with the Initial Level of Care Assessment Form to Optum at 855-244-9359. If the ASAM Dimension 2 has a risk rating of greater than zero (0), the Health Questionnaire must also be faxed. Upon receipt of the authorization request, an Optum clinician will verify Medi-Cal eligibility, review the clinical documentation for an approved DSM-5 diagnosis and ASAM Level of Care 3.1, 3.3, or 3.5, and enter the information into the designated data system. The Optum clinician will make a clinical determination within twenty-four (24 hours) of receipt of the initial authorization request and will notify the SUD Provider. (See Appendix D.1 for the Optum SUD Residential Clinical Documentation and Authorization Request Timelines Quick Guide.)

Approved Request
If the initial authorization request is approved, the SUD Provider will be given an initial authorization for fifteen (15) days. Optum will notify the provider of authorization via a telephone call, and the SUD Provider will begin the continued authorization request process.

Denied Request
If the initial authorization request is denied, then the client receives a Notice of Adverse Benefit Determination (NOABD “denial” letter). The Optum clinician will verbally notify the SUD Provider of the denial and fax the Notice of Adverse Benefit Determination (NOABD) - Denial Notice along with the additional following documents: Your Rights Under Medi-Cal, Language Assistance, and the Nondiscrimination Notice. The SUD Provider will provide the client with the NOABD and Client Rights. Clients may appeal the denial through the Grievance and Appeal Process (for more information on the Grievance and Appeal Process, please see Section G: Quality Management).

Continuing Authorization
After the initial authorization request is approved, the SUD Provider will submit via fax within ten (10) days of admission a Continuing Authorization Request. The minimum documents to submit are:

- Optum RSUD Fax Cover Sheet
- Initial Treatment Plan
- ASAM Level of Care Recommendation Form
- ASI/YAI
- Diagnosis Determination Note (DDN)

The Optum clinician will review the clinical documentation for Medical Necessity and enter the submitted information in the designated data system. The Optum clinician will make a clinical determination within five (5) calendar days of receipt of the continuing authorization request. The SUD Provider may request an expedited authorization when the clinical determination process could jeopardize a client’s life, health or functioning. The expedited authorization process timeframe is seventy-two (72) hours after receiving the request.

Approved Continuing Authorization
If continuing authorization request is approved, the Optum clinician will provide a continuing authorization of seventy-five (75) days and will notify the SUD Provider by telephone. For adolescent programs, a continuing authorization of fifteen (15) days will be provided.
Denied Continuation Request
If an authorization request is denied, the Optum clinician will verbally notify the SUD Provider of the denial and fax to the program the Notice of Adverse Benefit Determination (NOABD) – Denial Notice along with the additional following documents: Your Rights Under Medi-Cal, Language Assistance, and the Nondiscrimination Notice. The program will provide the notice and other documents to the client. Clients may appeal the denial through the Grievance and Appeal Process (for more information on the Grievance and Appeal Process, please see Section 4: Quality Management).

Extension Authorization Request
If the SUD Provider determines that a client needs residential treatment services beyond ninety (90) days, the SUD Provider will submit an extension request for continuing authorization for thirty (30) more days no later than day eighty (80). Perinatal SUD programs may request authorization beyond ninety (90) days and will submit continuing authorization requests in thirty (30) day increments until the client discharges or has reached sixty (60) days postpartum. Adolescent SUD Provider may request an extension request for thirty (30) more days and must be submitted to Optum by day thirty (30).

The Extension Authorization Request may include any documentation that indicates ASAM Medical Necessity. The continuing authorization request documentation will be faxed and include at a minimum:

- Optum RSUD Fax Cover Sheet
- Updated Treatment Plan
- ASAM Level of Care Recommendation Form
- Diagnosis Determination Note (DDN)

The Optum clinician will review all submitted clinical documentation for Medical Necessity and document in the designated data system. The Optum clinician will make a clinical determination within five (5) calendar days of receipt of the continuing authorization request. The SUD Provider may request an expedited authorization when the clinical determination process could jeopardize a client’s life, health or functioning. The expedited authorization process timeframe is seventy-two (72) hours after receiving the request.

Residential Level of Care Changes
If the client’s assessed level of care changes and the client needs to be moved to another residential level of care (e.g. 3.1 to 3.5), the SUD Provider will submit a request to change the level of care via fax that will include:

- Optum Fax Cover Sheet (Note: specify the change in level of care and start date of the new level of care)
- Updated Treatment Plan
- Level of Care Recommendation Form

The Optum clinician will review all submitted clinical documentation for Medical Necessity and document in the designated data system. The Optum clinician will make a clinical determination within five (5) calendar days of receipt of the continuing authorization request. The SUD Provider may request an expedited authorization when the clinical determination process could jeopardize a client’s life, health or functioning. The expedited authorization process timeframe is seventy-two (72) hours after receiving the request.
Discharge
When medical necessity is no longer met for residential treatment during an authorized stay, the SUD Provider shall recommend a change in level of care and transfer or discharge the client. The SUD Program will notify the Optum SUD Care Advocate via telephone (800-798-2254) the day of transfer or discharge. The SUD Provider will submit to Optum via fax the discharge plan and the discharge summary for a planned discharge or the discharge summary only for an unplanned discharge (e.g. client leaves the program without prior notice) within thirty (30) days of the last face-to-face with the client (please see “Timelines” under “Discharge Summary” further in this section for more information).

Retrospective Authorization Request Requirements
Residential providers are expected to submit all authorization requests within prescribed timelines. There are limited circumstances in which retrospective authorizations may be conducted, including:

- Retroactive Medi-Cal eligibility determinations;
- Inaccuracies in the Medi-Cal Eligibility Data System;
- Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dual-eligible beneficiaries;
- Circumstances beyond the program’s control (such as natural disaster. This does not include negligence, misunderstanding of requirements, illness or absences of staff), and/or,
- Beneficiary’s failure to identify payer/concealed Medi-Cal eligibility at the time of admission.

The residential program shall be required to send copies of the entire client chart and documentation as to why an authorization request is being sent retrospectively.

All Retrospective Authorization Requests must be submitted within four (4) months from the date of the client’s retrospective eligibility. Retrospective Authorization Requests which are not submitted timely will be administratively denied.

In cases where the review is retrospective, the ASO, on behalf of the DMC-ODS, will communicate the decision to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall communicate to the provider in a manner that is consistent with state requirements.

Required Relapse Plan for Licensed Residential SUD Treatment Facilities
Per SB992, a licensed residential treatment facility must develop and maintain a written plan to address resident relapses. A relapse plan is a written plan that addresses:

- Resident relapse including when a resident is on the licensed premises after consuming alcohol or using illicit drugs;
- How the treatment stay and treatment plan of the resident will be adjusted to address the relapse episode;
- How the resident will be treated and supervised while under the influence of alcohol or illicit drugs; and
- Resident discharge and continuing care plan, including when a residential facility determines that a resident requires services beyond the scope of their license.

Initial applicants for residential treatment facility licensure must submit a relapse plan with the Initial Treatment Provider Application (DHCS 6002). Applicants that submitted an application for licensure prior to January 1, 2019 but have not been approved for licensure will be required to submit a relapse plan prior to licensure. Existing licensees must submit a relapse plan to their assigned DHCS analyst no later than
April 1, 2019. DHCS will review the submitted relapse plan to determine compliance with the statutory requirements. DHCS will notify the licensee within 30 working days whether the relapse plan is complete or incomplete. A copy of the relapse plan must be kept onsite, or at a central administrative location, provided that the plan is readily available to staff and DHCS upon request.

For more information, refer to DHCS Information Notice 19-003. If you have questions about the relapse plan or Information Notice 19-003, contact Nadalie Meadows-Martin by email at Nadalie.Meadows-Martin@dhcs.ca.gov or Pelumi Abimbola at Pelumi.Abimbola@dhcs.ca.gov.

Residential: Bed Holds and Weekend Passes
Providers may be reimbursed room and board for up to 7 days when a client is hospitalized, AWOL or incarcerated while in residential treatment. COR preapproval is required if a client is in need of a bed hold beyond 7 days (e.g. client at crisis residential). As soon as client returns to the program, the provider shall consider any revisions to the ASAM level of care determination, risk assessments and/or medical information to incorporate into the chart and/or treatment plan. Provider would not need to discharge/readmit client. The number of days in the hospital or AWOL or incarceration counts toward the client’s 90-day DMC reimbursable period.

Providers may allow a client a weekend pass when client is in 3.1 LOC with a planned discharge. Providers may be reimbursed for treatment as long as one hour of service is provided daily (e.g., 1 hour of structured daily activity on Saturday before they leave and also when they come back on Sunday evening.) Otherwise, the provider would be reimbursed for room and board only. As soon as client comes back to the program, the provider shall consider conducting a level of care assessment. The number of days a client is on a “weekend pass” counts toward the client’s 90-day DMC reimbursable period.

Non-Residential Service Access
There is no “wrong door” in which individuals, and/or organizations, providers, family, or law enforcement, can access specialty SUD services for themselves or on behalf of someone else within San Diego County. Main entry methods are:

- Direct-to-provider self-referrals (client walk-ins, client direct provider calls);
- Client call to the Access and Crisis Line (ACL) toll free number: 1-800-724-7240 (TTY: 711). A 24 hour/7 day a week access number for information/referral and crisis/behavioral health/SUD screening as provided by master level, licensed providers;
- Provider to Provider on behalf of client (referrals from medical partners, SUD Dependency Drug Court or CalWORKs Case Management);

In person or telephonic screenings are often considered first points of entry into the SUD system of care. To ensure the customer experience is viewed as both professional and helpful, Access and Crisis Line screeners are master level, licensed providers with advance clinical and client engagement skills. SUD programs are required by contract to provide trained staff for screening purpose should an individual call or walk in expressing interest in and/or have been referred for services.

Screening Process
The screening process functions to:

- Determine an appropriate provisional level of care for an individual
- Connect with emergency services if at any point during the call or in-person screen, it is determined that emergency services are required. At such times, providers are to follow written program crisis...
Facilitate a “warm handoff” of the client to the identified provider capable of meeting the individualized need(s) of the individual, including programs that specialized in treatment of special populations or specific cultural groups.

Respect individual rights and choice/preference.

Offer service recommendations to include an appointment for a comprehensive assessment for possible admission into a SUD treatment program.

Obtain client personal demographic and identifying information to assist for the establishment of eligibility for SUD treatment services.

Should a service/level of care recommendation not be agreed upon by the individual and/or SUD provider that matches the individual’s needs and preferences as determined by the screen, or, should the individual not have a readily available appointment date, and/or the provisional recommended level of care provider not have openings, the screener will provide the individual with additional provider options and continue to work with the individual and provider to secure a “warm hand off” linkage of client to provider for a scheduled appointment. See SUDURM for the optional Brief Level of Care Screening Tool.

**Intake/Admission Process**

SUD providers within the County of San Diego system of care are required to include within their program policies, procedures, and practice, written admission and readmission criteria for determining client eligibility and medical necessity treatment per Federal, State, and County, and contractual regulations, obligations. Program admission and readmission policy and procedure will ensure services are offered to the target population to include special populations and comply with all non-discrimination and related clauses in Article 8, Compliance with Laws and Regulations.

An Intake/Admission appointment is considered the clients first treatment episode and is a billable service. The client admission to treatment date is considered the date on which any face-to-face treatment service is provided to a client. An individual becomes a client of the program once intake, assessment process, and verification of eligibility Section 51341.1(b)(13), Title 22, CCR, Federal, State, County, and program regulations, policy and procedure, is completed. Programs will ensure via policy and procedure that anticipated treatment outcome will not impact admission of an eligible client.

**Daily Admissions**

Outpatient and Residential programs shall have capacity to conduct daily admissions and level of care determinations for the days they are open. Outpatient programs are expected to be open five (5) days a week at minimum, and to complete the Initial Level of Care Assessment upon admission. At residential programs, the LPHA initial level of care face-to-face determinations are expected to be completed within the same day of admission and no more than 24 hours after the client admission. Doing so ensures that clients staying overnight receive an initial assessment. Each residential program shall have Daily Admission Policy & Procedure developed with, and approved by, Medical Director, regarding client safety.

**Policies & Procedures**

Programs will have written policy and procedure to reflect adherence to Federal and State Health and Human Services priority and entry criteria:

- Pregnant Injection Drug Users (IDU)
- Pregnant Substance Users
- Parenting Injection Drug Users
- All other IDU
• Parenting Substance Users
• All other County Health and Human Services (HHSA) referrals

All clients are to receive a face-to-face Initial Level of Care Assessment prior to a scheduled assessment appointment. Documentation requirements may vary by program. Please refer to the SUDURM for more details on documentation. Documentation to be completed at intake/admission may include:

• Initial Level of Care Assessment Form
• TB Screening Questionnaire
• Health Questionnaire
• Proof of Pregnancy and the last day of pregnancy (for Perinatal programs if applicable)
• Financial Responsibility and Information Form
• CalOMS Profile Form Instruction (if client is not already in SanWITS)
• CalOMS Admission Form
• Consent for Treatment
• Notice of Privacy Practices
• Written Summary Outlining Federal Confidentiality Requirements (per 42 CFR)
• Your Personal Rights at an AOD Certified Program (required for all programs as part of compliance with the “Alcohol and/or Other Drug (AOD) Program Certification Standards” of DHCS)
• Acknowledgement of DMC-ODS Beneficiary Handbook and BHS Provider Directory Form
• Grievance and Appeal Process is explained, and brochure with envelope is offered
• Provider Directory is explained and offered
• Language/interpretation service availability reviewed and offered, as applicable
• Voter Registration material is offered
• Consent for Release of Information, as applicable
• Release of Information to primary care physician (PCP), or to assist linkage with one if the client does not have a PCP
• Consent for Photo, TV, Video (if applicable)
• Risk Assessment and Safety Management Plan
• High Risk Assessment (optional)
• Community Resource List

Per AOD Certification Standards (Section 7010(d)), client is to be provided an introduction and overview to describe the functions and requirements of the program within seventy-two (72) hours of admission.

National Voter Registration Act (NVRA)
Per the National Voter Registration Act of 1993, providers are required to offer voter registration materials at intake (except in a crisis situation), at renewal and anytime a change of address is reported. A NVRA Voter Preference Form shall be included in all intake/admission packets. This form is available in English and 9 other languages, including the required languages of Spanish, Chinese, Vietnamese, and Tagalog at http://www.sos.ca.gov/elections/voter-registration/nvra/training/voter-preference-forms/.

When a client requests a form in a language other than those available, staff shall provide the client with the Secretary of State’s toll-free number: 1-800-345-VOTE. If a client reports a preference to register to vote, then they are to be provided with a paper voter registration form or be assisted with completing the registration form online (http://registertovote.ca.gov/). Voter registration forms are available for free from the Registrar of Voters and must be onsite at the program in English, Spanish, Chinese, Vietnamese, and Tagalog. The same level of assistance shall be provided to clients registering to vote as is provided for
completing other forms for SUD services. For youth programs, voter registration services shall be offered to parents/guardians of clients less than 18 years of age.

Training on the legal requirements and County expectations under this Act is required to be taken by provider staff annually. The NVRA training is available on the HHSA BHS webpage. Failure to implement the NVRA may subject the agency to legal liability. If you have additional questions about this requirement, please contact your Contracting Officer Representative (COR) and/or review chapter 4 from the California NVRA Manual.

Medical Necessity and SUD Diagnosis
Medical necessity refers to the applicable evidence-based standards applied to justify the level of services provided to a client for the services to be deemed reasonable, necessary and/or appropriate. It refers to those SUD treatment services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness or injury consistent with 42 CFR 438.201(a)(4) or, in the case of EPSDT, services that meet the criteria specified in Title 22, Sections 51303 and 51340.1.

It is imperative that medical necessity standards be consistently and universally applied to all clients to ensure equal and appropriate access and service delivery. Medical necessity is also established to demonstrate and maintain eligibility for services delivered.

Medical necessity for an adult (an individual age 18 and over) is determined using both of the following criteria:

- The individual shall have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance Related Disorders
- The individual shall meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria (i.e. meet criteria for a specific level of care).

Individuals under age 21 are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, clients under the age of 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority. Regulations under DMC-ODS do not override any EPSDT requirements. Medical necessity for an adolescent (age 12 to 20) is determined using the following criteria:

- The adolescent shall be assessed to be at risk for developing a SUD*
- The adolescent shall meet the ASAM adolescent treatment criteria.

*Per DHCS, the Intergovernmental Agreement between the County of San Diego and the State allows at-risk youth (individuals under the age of 21) to be served at the ASAM Level 0.5 (Early Intervention) level of care. At-risk youth (those without a DSM-5 SUD diagnosis) would not meet medical necessity criteria for Outpatient Services (OS - also known as ASAM Level 1) or any other levels of care in the continuum.

A SUD diagnosis can only be determined by a Medical Director or an LPHA. The Medical Director or LPHA shall document separately from the treatment plan the basis for the diagnosis in the beneficiary's record within timelines specified for the respective treatment modality (i.e. Within 30 calendar days of admission to outpatient services or within 10 calendar days of admission to residential services.) The basis...
for the diagnosis shall be a narrative summary based on DSM-5 criteria, demonstrating the Medical Director or LPHA evaluated each beneficiary’s assessment and intake information, including their personal, medical, and substance use history. ii. The Medical Director or LPHA shall type or legibly print their name, and sign and date the diagnosis narrative documentation. The signature shall be adjacent to the typed or legibly printed name.

To establish the ASAM level of care requirement for medical necessity, the Medical Director or LPHA shall review and evaluate the client’s assessment and intake information, if completed by a SUD counselor, and have a face-to-face or telehealth interaction with the counselor to verify the client meets medical necessity criteria (DHCS Information Notice 16-044). The initial medical necessity determination is documented using forms as described in the Substance Use Disorder Uniform Record Manual (SUDURM).

Initial medical necessity determination must clearly demonstrate use of the ASAM Criteria to determine placement into the appropriate assessed level of care for services. Medical necessity pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the client. It should not be restricted to acute care and narrow medical concerns (such as severity of withdrawal risk as in Dimension 1); acuity of physical health needs (as in Dimension 2); or Dimension 3 psychiatric issues (such as imminent suicidality). Rather, medical necessity encompasses all six ASAM dimensions for a more holistic concept of clinical necessity or clinical appropriateness for treatment.

In outpatient and residential programs, medical necessity must continue to be met through ongoing ASAM assessment and treatment plan updates, including utilizing County forms and demonstrating compliance with timelines as described in the SUDURM. The requirements for the Medical Director/LPHA and the SUD counselor, including a face-to-face review, apply to all ASAM assessments and treatment plan updates. In addition to the reassessment/treatment plan update process, continuing outpatient services shall be justified for each client no sooner than five months and no later than six months after the client’s admission to treatment date, or after the completion date of the most recent justification for continuing services. The SUD counselor or LPHA shall review the client’s progress and eligibility to continue to receive treatment services and recommend whether the client should or should not continue to receive treatment services at the same level of care. The Medical Director or LPHA shall determine and document the medical necessity for continued services meeting all documentation requirements as described in the SUDURM for continuing service justification (i.e. “Stay Review Justification”).

For an individual to receive ongoing Opioid Treatment Program (OTP) services, the Medical Director or LPHA shall reevaluate that individual’s medical necessity qualification at least annually through the reauthorization process to determine that the services are still clinically appropriate for that individual.

Assessment Process
Assessment is the in-depth evaluation and analysis of the cause or nature of mental, emotional, psychological, behavioral, and substance use disorders, to include identification of a client’s individual strengths and possible barriers to treatment success. Comprehensive, validated, and standardized assessment tools, and their corresponding documentation form the foundation of high-quality SUD services. Assessments based upon current DSM and ASAM Criteria, as approved by the program COR, ensure utilization of a standardized structure by which to collect necessary clinical information to establish medical necessity for admission, and appropriate SUD level of care determinations. The six (6) dimensions of the ASAM Criteria, with other elements, establish client specific; diagnosis, medical necessity, level of care needs, and other service needs. The assessment process also offers opportunities for provider-client
engagement and targeted treatment planning and is generally considered the initial phase of the treatment process.

**Medical Director or LPHA**
The Medical Director or LPHA shall evaluate each client assessment (personal, medical, and substance use history) and intake information, if completed by a SUD counselor, through a face-to-face review or telehealth with the SUD counselor to establish a client meets medical necessity criteria. It is highly recommended that LPHAs and SUD counselors have the appropriate experience and training before conducting assessment and medical necessity determinations.

**Documentation**
County of San Diego is resolute to facilitate SUD services that are; medically necessary, sufficient in amount, duration, and/or scope to reasonably achieve the purpose for which the services are meant. To that end, County of San Diego SUD providers have been provided with a required use, Intake/Assessment Form for Adults, Adolescents, and Parents (as appropriate), incorporating an ASAM multidimensional assessment which explores client risk, needs, strengths, skills, and resources. Documentation requirements may vary by program. Required documentation to be completed and/or offered at Assessment (see SUDURM for forms and instructions):

- ASI/YAI Assessments
- Diagnosis Determination Note
- ASAM Level of Care Recommendation Form

**ASI/YAI**
Providers are required to utilize the ASI for adults or the YAI for adolescents to complete the assessment process. SUD providers must ensure an SUD counselor and/or LPHA completes all fields of the assessment to include personal, medical (See SUDURM for Client Health Questionnaire) and substance use and other drug history for each client upon admission to treatment. As documented in the Initial Level of Care Assessment and the ASI/YAI, assessment elements include client personal identifying information and, at minimum, past and current:

- Alcohol and/or other drug usage
- Medical history (Client Health Questionnaire and/or physical exam)
- Family history
- Psychiatric/psychological treatment history
- Social/special needs/recreational history
- Financial status
- Education
- Employment history
- Criminal history, legal status
- Previous SUD treatment history

**Client Health Questionnaire**
All SUD programs will complete a Client Health Questionnaire Form for all clients during the - Intake or Assessment. The SUDURM offers a Client Health Questionnaire Form for use or programs may use the DHCS Form 5103.
Safety Management Plan Guidelines
Each program must develop internal guidelines for the risk assessment with regards to the Safety Management Plan as what will be the plan of action when someone is identified at the various levels of risk (e.g. low, moderate, high). If the risk assessment is completed by staff that is not licensed/licensed eligible and risk is identified, then a consultation with the supervisor must be included as part of the internal guidelines. The Safety Management Plan may include the following information:

- Documentation about consultation
- Considerations of higher level of services or additional services such as case management, more frequent sessions, and/or coordination for care with current mental health treatment providers
- Coordination with emergency contacts (e.g. client’s spouse or parents)
- Linkage to additional resources such as providing client with referrals to 211 or Access & Crisis Line (1-888-724-7240; TDD/TTY Dial 711)
- Referrals made to higher level of care such as a crisis house or psychiatric hospital
- Contacting Psychiatric Emergency Response Team (PERT) or the police
- If applicable, changes made to the client’s treatment plan
- Frequency of re-assessment for risk
- The documentation should also include how the use of Protective Factors and coping skills will be employed by the client

Physical Examination Requirements
Substance use often complicates and may lead to serious health conditions making it important to assess for medical illnesses that may affect SUD clients. Medical illness left untreated may lead to poor treatment outcomes and years of life lost. County of San Diego SUD system of care encourages providers to take a “whole person care” client treatment approach and consider all aspects of client care needs to include behavioral health, substance use, and primary care at each point of SUD service access. For more information on Physical Examinations, please see Page 119 of the County of San Diego Intergovernmental Agreement; Exhibit A, III, PP, 11.

Timeline
- If a client had a physical examination within the twelve (12) month period prior to the client’s admission to treatment date, the physician or registered nurse practitioner or physician’s assistant shall review documentation of the client’s most recent physical examination within 30 calendar days of the client’s admission to treatment date for outpatient treatment; within 10 calendar days for residential treatment
- If a provider is unable to obtain documentation of a client’s most recent physical examination, the provider shall describe the efforts made to obtain this documentation in the client’s individual record
- As an alternative to complying with above, or in addition to complying with above, the physician may perform a physical examination of the client within 30 calendar days of the client’s admission to treatment date within 10 days for residential treatment, if the program is able to provide IMS (See Section E: SUD Program Requirement for more information on IMS)
- If the physician, registered nurse practitioner, or physician’s assistant has not reviewed the documentation of the client’s physical examination within 30 days of client admission to treatment date, or the provider does not perform a physical examination of the client per above, then the LPHA or counselor shall include in the client’s initial and updated treatment plans the goal of obtaining a physical examination, until this goal has been met.
Documentation
A copy of the physical exam must be included in the client record. For significant medical illnesses, the client’s initial and updated treatment plans must incorporate a goal to obtain appropriate treatment for the illnesses. The physician shall type or legibly print their name, sign, and date documentation to support they have reviewed the physical examination results. The signature shall be adjacent to the typed or legibly printed name.

Referrals
When appropriate, a client shall be referred via consultation with medical staff to a licensed medical professional for physical, psychiatric, labs, and/or other examinations. When a client is referred to a licensed medical professional due to medical concerns, a medical clearance or release will be obtained prior to readmission. The referral and medical clearance shall be documented within the client’s file. Refer to AOD Certification Standards Section 7020. Appointments for residential clients with medical professionals in the community for examinations or due to medical concerns shall not be delayed arbitrarily based on routine program schedules or program rules, such as acclimation or “black-out” periods, and shall be based on an individualized assessment of the client’s medical and clinical risk clearly documented in the client record.

Admission
Documentation
If a client is admitted into treatment, the client will be given a consent for treatment form for review and signature. The client shall be provided with names and contact information for an assigned primary counselor and case manager. (Refer to Care Coordination for more information). The Medical Director or LPHA will document the basis for the diagnosis in the client record. For more information refer to the Medical Necessity and SUD Diagnosis section. All referrals made by the provider staff shall be documented in the client record. Copies of the following documents shall be provided to the client upon admission:

- Share of cost if applicable
- Notification of DMC funding accepted as payment in full
- Consent to treatment form
- Notice of Privacy Practices
- The County of San Diego DMC-ODS Beneficiary Handbook

Copies of the following shall be provided to the client or posted in a prominent place accessible to all clients:

- Statement of nondiscrimination by race, religion, sex, ethnicity, age, disability, sexual preference, and ability to pay, if the client meets the County’s eligibility population requirements
- Grievance and Appeals process
- Program rules and expectations
- Notice of Privacy Practices

In programs where drug screening by urinalysis is deemed medically appropriate, the program will have:

- Established procedures which protect against the falsification and/or contamination of any urine sample
- Document urinalysis results in the client’s file
Additional Program Specific Admission Criteria

Opioid Treatment Program (OTP), ASAM 1.0
- Medical necessary services shall be provided in accordance with an individualized plan determined by a licensed physician, and approved and authorized according to the State of California requirements

Outpatient Services (OS), ASAM 1.0
- This level of care is appropriate for clients who are stable with regard to acute intoxication/withdrawal potential, biomedical, and mental health conditions
- Must meet medical necessity criteria as determined by a Medical Director and/or LPHA working within their scope of practice
- Must meet level of care determinants as established by ASAM

Intensive Outpatient Treatment (IOS), ASAM 2.1
- This level of care is appropriate for clients (adults/adolescents) whom meet diagnostic criteria for a SUD with instabilities or complicating factors, often characterized by addiction and co-occurring conditions, which require high intensity, professionally directed SUD treatment
- Clients with more complex co-occurring mental health substance-related conditions
- Must meet medical necessity criteria as established by a Medical Director and/or LPHA
- For adolescent clients, medical necessity criteria must be met as determined by a Medical Director and/or LPHA working within their scope of practice
- Must meet level of care determinants as established by ASAM

Residential Programs (Res), ASAM 3.1 – 3.5
- This level encompasses residential services that are described as co-occurring capable, co-occurring enhanced, and complexity capable services staffed by designated addiction treatment, mental health, and general medical personnel who provide a range of services in a 24-hour treatment setting
- Must obtain authorization for residential services via Optum
- Must meet DSM and ASAM diagnostic and level of care criteria requirements
- Must meet medical necessity criteria as determined by a Medical Director and/or LPHA working within their scope of practice
- Residential services must be provided to non-perinatal and perinatal clients
- May be adult (over 18) and/or adolescent (Refer to Residential Programs section in SUDPOH for additional information regarding minor admission criteria)

Residential/Inpatient Withdrawal Management (WM), ASAM 3 – 4
- Otherwise known as “detoxification”, current withdrawal management can occur in various levels of care and concurrently with addiction management by same staff in the same treatment setting in an integrated manner. Features of a client’s clinical presentation must be examined to determine the specific interventions needed for withdrawal management
- Must meet medical necessity as determined by the Medical Director, LPHA’s, by contracted and licensed physicians, or by a nurse practitioner working within their scope of practice
- Must meet DSM and ASAM diagnostic and level of care criteria requirements

Medically Managed Intensive Inpatient Services, ASAM 4
- These are inpatient programs which provide 24-hour medically directed evaluation, care, and treatment of substance-related and co-occurring conditions in an acute care inpatient setting. Often
staffed by designated addiction-credentialed physicians and other mental and general health and addiction-credentialed clinicians.

- Must meet DSM and ASAM diagnostic and level of care criteria requirements
- Must meet medical necessity as determined by the Medical Director, LPHA’s, by contracted and licensed physicians, or by a nurse practitioner working within their scope of practice

**Medication Assisted Treatment**
- Must meet medical necessity as determined by a Medical Director and/or LPHA working within their scope of practice

**Recovery Services**
- Client has completed their course of treatment
- Client has met medical necessity criteria for recovery services level of care per determination by a Medical Director and/or LPHA working within their scope of practice
- Client is not eligible for recovery services if receiving SUD treatment services

**Case Management Services**
- Is a county resident
- Meets established medical necessity criteria. The initial medical necessity determination must be performed by a medical director, licensed physician, or Licensed Practitioner of the Healing Arts (LPHA)
- Case management services must be indicated on the treatment plan

**Self-Help and Program Structure**
Support groups should always be voluntary. An individualized treatment plan related to support groups should be driven by clients’ preferences. Any event or support group meeting at a program should maintain the strict confidentiality requirements aligned with 42 CFR Part 2. Programs will be held to minimum standards outlined on the Quick Guide-Residential Services (5 clinical (3.1)/ 10 Clinical (3.5) and minimum of 1 service per day). The 20 hours of program structure should be shaped to fit the clients’ individual needs and can be determined by programs. Programs can link clients to existing support group programs (e.g., 12-step) in the community and/or if confidentiality is a concern and since some clients may opt for not participating in support group programs, the program can choose to coordinate a support group program in a different location for clients that choose to participate.

**Continuing Services Justification**
All SUD providers within the County of San Diego system of care shall have written policy and procedure regarding continuing services justification per Federal, State, County, and program contractual laws, regulations, and agreement.

**Re-Assessment for Continuing Services**
Re-assessment of diagnosis, treatment modalities, intensity, and client goals, are needed if progress toward agreed upon goals is not being made within a reasonable time. During re-assessment, a Medical Director or LPHA shall reevaluate the client’s medical necessity qualification through the reauthorization process and document their determination that SUD services are still clinically appropriate for that individual. If during the course of the assessment, the provider determines adequate progress toward treatment goals has been made, plans to build upon these achievements need to be made, which may include transitions to other services and recovery-focused strategies. The Medical Director or LPHA shall determine medical necessity for continued services for the client. The determination of medical necessity to be documented by the
Medical Director or LPHA in the client individual client record (per the County of San Diego Intergovernmental Agreement with DHCS) and will include documentation that all have been considered:

- Client personal, medical, and substance use history
- Clients most recent physical examination is documented
- Client progress notes and treatment plan goals
- LPHA’s or counselors’ recommendations pursuant to the paragraph above
- Client prognosis

If the Medical Director or LPHA determines continuing treatment services for the client is not medically necessary, the provider will discharge the client from treatment and arrange the appropriate level of care for the client. Per 42 CFR, should a client have previously authorized services reduced, suspended, or terminated, the client must be given a “Notice of Adverse Benefit Determination” (see Grievance, Appeal, and State Fair Hearing section of the SUDPOH and 42 CFR for more details).

**Timeline**

Continuing services shall be justified for case management, intensive outpatient treatment, Naltrexone treatment, and outpatient services for each client, *no earlier than (5) months and no later than (6) months after* the clients admission to treatment date or the date of completion of the most recent justification for continuing services, the LPHA or counselor shall review the beneficiary’s progress and eligibility to continue to receive treatment services, and recommend whether the client should or should not continue to receive treatment services at the same level of care. Assessments need to be appropriately documented, reviewed, and updated on a regular basis at least annually, including at every care transition, so as to promote engagement and meet the client’s needs and preferences. Timeline requirements for ongoing medical necessity review are regulation and program specific as outlined under the Program Services section within the SUDPOH, Medical Necessity Criteria section within the SUDPOH, and program contracts.

**Treatment Continuation**

DMC beneficiaries who lose DMC status as a result of finding employment while in treatment will be allowed to continue receiving services. The clinical imperative is continuous care. Providers are expected to leverage other health coverage and/or funding sources if client has access to those sources. Services not covered by client’s available resources may be reimbursed as County billable.

**Documentation**

Assessments need to be appropriately documented, reviewed, and updated on a regular basis, including at every care transition, so as to promote engagement and meet the client’s needs and preferences. Medical Director or LPHA will type, legibly print name, signature with date the continuing services information when completed. For returning clients whom were discharged or closed but return to the provider for additional services within twelve (12) months of a completed assessment, the assessment may be updated with new clinical information as an addendum and re-used for the new treatment episode opening. If during the course of the assessment, the provider determines adequate progress toward treatment goals has been made, plans to build upon these achievements need to be made, which may include transitions to other services and recovery-focused strategies.

**Discharge**

The need to discharge a client from a treatment program can occur due to multiple circumstances. Discharge can either be voluntary or involuntary to include discharge due to loss of contact, loss of benefits, client refusal to continue treatment, client successful completion of treatment, lack of treatment progress, program
level of care not appropriate to meet client treatment needs, and lack of medical necessity for continued treatment. Regardless if discharge is voluntary or involuntary, a Discharge Summary is to be completed by the provider unless the client is transferred to another level of care within the same SUD program. SUD programs within the County of San Diego system of care shall have written policy and procedure regarding client discharge. Written criteria for discharge defining:

- Successful completion of program
- Unsuccessful discharge
- Involuntary discharge
- Transfers and referrals

**Discharge Plan**
Discharge planning is the process of preparing an enrolled client for referral to another level of care, post-treatment return, reentry into the community, and/or linkage of the client to essential community treatment, housing and human services. The discharge planning process should be initiated at the onset of treatment services to ensure sufficient time to plan for the client’s transition to subsequent treatment or recovery support services.

An LPHA or counselor must complete a discharge plan with each client, except for the client whom the provider has lost contact with, or if the client is transferred to a higher or lower level of care within the same SUD program.

**Timeline**
Clients are not required to be discharged from the program unless there has been more than a thirty (30) calendar day lapse in treatment services. All discharge plans to be prepared within thirty (30) calendar days prior to the scheduled date of the last face-to-face treatment with the client.

**Documentation**
During the LPHA’s or counselors last face-to-face treatment with the beneficiary, the LPHA or counselor and the beneficiary shall type or legibly print their names, sign and date the discharge plan. The Discharge Plan to include the following:

- Description of each of the clients relapse triggers
- The plan to assist the client to avoid relapse when faced with each trigger
- A support plan

**Discharge Summary**
Prior to completion of a Discharge Summary, the provider is required to provide documentation of his/her multiple outreach attempts to re-engage the client in treatment. For more information on the Discharge process, please see the SUDURM and AOD Certification Standards Sec. 7120 and the IA.

**Timeline**
Once the decision to discharge a client from treatment has been made, a LPHA or counselor shall complete a discharge summary within thirty (30) calendar days of the last face-to-face treatment contact with the client, unless a client is transferred to a higher or lower level of care based on ASAM criteria within the same SUD program, before thirty (30) calendar days from the last treatment service date.

**Documentation**
The Discharge Summary to include the following:
• Duration of the client treatment as determined by the dates of admission and discharge from treatment
• Narrative summary of treatment episode(s) to include presenting problem, all treatment provided:
  o Current alcohol and/or other drug usage
  o Legal status/criminal activity
  o Vocational/educational achievements
  o Living situation upon discharge
  o SUD services provided/completed
  o Treatment outcome
• Medications at discharge
• Primary Care Physician notification, additional providers working with client at discharge
• Client Prognosis with explanation
• Discharge recommendations to include transfers/referrals/linkages
• Reasons for discharge
• Clients continuing recovery or discharge plan signed by provider and client
• If discharge was involuntary; notification of Title 22 Fair Hearing Rights, Notice of Adverse Benefit Determination given (for DMC clients only)

Recovery Services
All clients shall have access to recovery supports and services upon completion of an SUD treatment program as supported by the assessment and treatment needs as identified in Dimension 6 of the ASAM Criteria, medical necessity, and within a Recovery Plan and/or Discharge Plan. Recovery services serve to support the client when he/she is triggered, has relapsed, or as a preventative measure to prevent relapse. Provider utilization of recovery services offer clients sustained engagement and long-term retention in SUD and behavioral health treatment within the SUD continuum of care. Recovery Services can be delivered to the client via face-to-face, telephone, by telehealth, and can be provided within the community and/or other appropriate settings as long as confidentiality can be maintained. Recovery Services can be delivered by an experienced registered or certified SUD counselor or an LPHA who assists in meeting the goals contained in their treatment plan for recovery service. Recovery Services to include:

• Outpatient Counseling:
  o Individual
  o Group (NOTE: Recovery Services Groups must be separate from the OS/IOS or Residential Groups)
  o Recovery Monitoring: coaching, monitoring via telephone and internet
  o Drug Screening (if medically appropriate)
• Case Management
  o Education and Job Skill Building: linkage to life skills, employment services, job training, and education services
  o Family Support: linkages to childcare, parent education, child development support services, family/marriage education
  o Support Groups: linkages to self-help and support, spiritual, and faith-based support
  o Other community Linkages/Ancillary Services: linkages to housing assistance, transportation, case management, individual service coordination

Prior to completing treatment, the current program should discuss the option of Recovery Services with the client and obtain permission to contact them after treatment ends. If the client has not been linked to
Recovery Services at treatment discharge, the Treatment program should make at least 3 attempts to engage client, on 3 separate days, to demonstrate efforts to engage client in recovery services. These contacts should be documented. If there is no contact from client after 30 days, no additional effort by the treatment program is required.

Upon completion of the Level of Care Recommendation Form and through the discharge planning process, clients who are determined to be interested in engaging in Recovery Services, the process for engaging the client in recovery services is as follows (prior to entering a SanWITS episode):

- An appointment will be scheduled with program providing Recovery Services.
- If the client no-shows, at least three (3) documented attempts to engage client, when client consents to this, on three (3) separate days are required to demonstrate efforts to engage client into the recovery service benefit. (NOTE: When engaging the client by phone for the purpose of connection to Recovery Services, discussions with the client may be billable as case management when a service takes place, such as discussing the client’s feelings about recovery services, their concerns about attending, educating about how Recovery Services may benefit the client, etc. Documentation would include a progress note and SanWITS encounter. Simply leaving a message for a client, or setting an appointment are not billable services. The attempt to engage the client would be documented in a progress note, but no encounter is SanWITS is required.)
- If the counselor has neither heard from nor made contact with the client for thirty (30) calendar days after the last attempted contact, additional efforts are not required. All follow-up contacts and/or attempts should be documented

In the event the client is transferred from a different program for recovery services, and the current program does not have a file for the client, the program must create a process for retention of documentation (i.e. electronically, 3-ring binder with documentation by date, etc.) The process must meet all regulations regarding storage of confidential client information. Since these clients would not be admitted to the program, there would not be a client file to maintain documentation for that treatment request.

Clients who reconnect more than three (3) months after treatment discharge requesting recovery services must be screened using the Initial Level of Care Assessment to determine if this level of care continues to be appropriate for the client’s needs at that time.

When the client is transitioning from current LOC to Recovery Services within the same organization, the program shall follow these steps:

- Current LOC program enrollment must be end dated in SanWITS
- Discharge in CalOMS – DO NOT CLOSE case
- Add new program enrollment for Recovery Service in SanWITS

The admission documentation for a client who will be remaining in the same program and receiving Recovery Services is as follows:

- An additional tab within the client’s current chart will hold all Recovery Services paperwork/documentation
- Review existing intake/assessment, current Level of Care Recommendation Form and current Treatment Plan
- New Diagnosis Determination Note (DDN) completed within 30 days of admit
- Treatment Effectiveness Assessment (TEA) completed within 30 days of admit
• Initial Recovery Plan completed within 30 days of admit.
• Updated Recovery Plan and TEA completed within 90 days from previous plan completion

When a client is transitioning from one level of care to Recovery Services in another program, care coordination will be based on warm handoff principles: carefully coordinated transfer or linkage of a client to another program, entity, agency, or organization who will continue, add, or enhance services. See Care Coordination guidelines section for detailed information about warm hand-off practices. Clients who will be participating in Recovery Services will most likely be “in remission” from their SUD, and the DDN from the previous provider may not reflect this. Therefore, a new DDN is required for Recovery Services, and this updated diagnosis must be entered in SanWITS.

When the client is being transferred/referred to another program for Recovery Services, the new program admission process will be to conduct care coordination between previous program and current program. Prior to discharge from the treatment program, a phone contact to schedule appointment for intake at new program and relay any relevant discharge information should take place. Transition to Recovery Services should occur within 10 calendar days from discharge from the treatment program. The treatment program shall fax required documentation to new program providing Recovery Services, and the new program shall review the following documentation:

• Discharge Summary and Discharge Plan (Recovery Services Recovery Plan builds on treatment discharge plan from previous program)
• DDN
• Initial Level of Care (LOC) Assessment
• Most recent treatment plan
• ASI/YAI
• Health questionnaire
• Risk Assessment

Case Management by the current provider is billable for the above linkage to Recovery Services.

If the new program is unable to obtain the treatment program’s intake documents within 30 days, the new program can choose to complete new intake documents. If the program chooses to use the previous program’s documents, they should be reviewed with the client and inaccurate or outdated information shall be updated following these documentation standards:

• Single line through inaccurate/outdated information
• Initials of staff making the change
• Date of the change
• Addition of new/accurate information

In a new program, the client will be opened in SanWITS with a Recovery Services enrollment. There is no CalOMS admission, annual update, or discharge in Recovery Services. The forms to be completed at admission for the new program are as follows:

• Financial Eligibility forms should be completed, and continued Recovery Services participation is based on eligibility criteria as specified in the Eligible Populations section of the SUDPOH (Section D).
• Administrative intake paperwork/documents
  o Consents
In addition to completing the administrative intake documents, the program will be required to complete, and have reviewed by an LPHA, the following admission documentation:

- Initial Recovery Plan completed within 30 days of admit
- DDN within 30 days of admit (completed by LPHA only)
- TEA within 30 days of admit
- Updated Recovery Plan and TEA completed within 90 days from previous plan completion.

Each client encounter will be entered into SanWITS. Outpatient standards for documentation/progress notes apply for Recovery Services. All services will require that a progress note be completed within 7 days from the date of service. The progress notes should capture relevant recovery details such as a summary of status and progress on the recovery plan, pertinent changes, relapse potential, etc. (NOTE: Programs are encouraged to implement Policies & Procedures regarding clients who are found to have relapsed/are using while in Recovery Services). In addition, clients shall receive a minimum of ninety (90) minutes of recovery services per month. Programs will follow missed appointment guidelines as outlined in the SUDPOH section: Service Delivery, D2.

**Discharge from Recovery Services**

Discharge planning should start during the beginning stages of Recovery Services. When the client has met their goals and no longer requires services, the program will discharge the client and complete the following:

- Discharge Plan to be completed with the client within 30 days prior to the last face-to-face visit (for a planned termination of Recovery Services). The Discharge Plan is not required when a client is transitioning back to a treatment level of service, or if the client has dropped out of Recovery Services.
- End date the Recovery Service program in SanWITS
- Close the episode in SanWITS
- Note: Discharge is to be completed within 30 days of last contact with client.

**Evidence Based Practices**

Research and innovations have yielded significant progress in the development, standardization, and empirical evaluation of psychosocial treatments for SUD. This has resulted in a wide range of effective programs for SUD that differ in both theoretical orientation and treatment technique. While a number of approaches and techniques are effective depending on the clinical situation, certain treatment approaches have a stronger evidence base and therefore must serve as the foundation of a high-quality system of SUD care.

Within the County of San Diego, although other psychosocial approaches may be used, SUD providers are at a minimum expected to implement the two evidence-based psychosocial interventions of Motivational Interviewing (MI) and Relapse Prevention. Below are brief descriptions of these evidence-based psychosocial interventions:
Motivational interviewing (MI): This is a client-centered, empathic but directive counseling strategy designed to explore and reduce a person’s ambivalence toward treatment and find the internal motivation they need to change their behavior. This approach frequently includes other problem solving or solution-focused strategies that build on beneficiaries past successes. According to the Motivational Interviewing Network of Trainers, MI “is designed to strengthen an individual's motivation for and movement toward a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion.”

Relapse Prevention: A behavioral self-control program that teaches individuals how to anticipate and cope with the potential for relapse. According to SAMHSA’s National Registry of Evidence-Based Programs and Practices, relapse prevention is “a behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment. Coping skills training strategies include both cognitive and behavioral techniques. Cognitive techniques provide clients with ways to reframe the habit change process as a learning experience with errors and setbacks expected as mastery develops. Behavioral techniques include the use of lifestyle modifications such as meditation, exercise, and spiritual practices to strengthen a client's overall coping capacity.”

Care Coordination
The goal of the DMC-ODS is to provide a full continuum of service to SUD clients, meeting their individualized needs at each phase of recovery as a person with a substance use disorder. This philosophy is succinctly expressed as providing:

- The right service
- At the right time
- For the right duration
- In the right setting

Care coordination and continuity of care processes are crucial to clients’ successful navigation of the SUD organized delivery system and an integral part of engaging a client in treatment to reach individualized treatment plan goals. Programs should educate clients about the continuum of care in the initial stage of services as part of orientation to the County of San Diego DMC-ODS. Likewise, programs should encourage the client to see any community provider engaged in the client’s mental or physical healthcare as critical members of their care team. Programs should facilitate information sharing with team members such as primary care physicians and mental health practitioners whenever proper consent allows for this best clinical practice. In this way, programs establish themselves as collaborators, with the client as well as with other providers within the greater SUD system and beyond. Expectations are made clear that as a client’s needs change, transitions occur either up or down within the continuum of care.

Policies and Procedures
In order to engage clients and ensure successful continuity of care, programs should create policies/procedures on care coordination focusing on seamless transitions without disruption to service for the client. Minimum considerations include the following:

- Each SUD client must be assigned a primary counselor at the initiation of services. The primary counselor will guarantee that the client is directed to appropriate resources within the program, including linkage to the program case manager. The primary counselor’s contact information must be provided to the client as their designated contact for assistance with in-program needs.
• The program case manager will coordinate with any external resources as indicated by the client’s needs, wishes and goals. The client must be provided with the program case manager’s contact information for assistance with resources outside the program.

• Program policies, procedures, and practices must allow for clients to have timely access to medically necessary and clinically indicated appointments, such as medical or mental health appointments, child visitation (including phone calls with children), and court/probation meetings. The program case manager will assist the client in scheduling and accessing appointments in the community. Routine program schedules or program rules, such as acclimation or “black-out” periods in residential programs, shall not be used as a rationale for arbitrarily delaying or restricting client access to medically necessary and clinically indicated appointments.

• In order to document coordination of care, programs shall obtain a signed authorization to release information for the client’s primary care physician, mental health provider and/or other health providers and document all care coordination efforts in the progress notes.

• Programmatic, interdisciplinary team meetings are expected as a means for all staff providing client services to maintain clear communication regarding assessed needs and any indications of change to level of care recommendations.

• Programs shall follow the Missed Scheduled Appointments protocol as defined previously in this section, as a means of continued client engagement and care coordination. These standards apply to new referrals (contacting within one business day by a clinical staff when a client does not show for a scheduled first appointment) and current clients (containing within one business day by clinical staff when missing a scheduled appointment without a call to reschedule). Clients with recent elevated risk factors will be contacted by clinical staff on the same day as the missed scheduled appointment.

• When a client is discharging from SUD services and transition to another program is not indicated, programs must offer recovery services when determined to be medically necessary for the client. Recovery services include substance abuse assistance, recovery monitoring (including relapse prevention), group counseling, individual counseling, and case management/care coordination delivered by an experienced registered or certified SUD counselor who assists in meeting the goals contained in their treatment plan for recovery service. Process for engaging client in recovery services is as follows:
  • The client should be contacted within two (2) business days of his/her last treatment service to ensure they are receiving necessary support, and recovery services offered.
  • At least three (3) documented attempts to engage client, when client consents to this, on three (3) separate days are required to demonstrate efforts to engage client into the recovery service benefit.
  • If the counselor has neither heard from nor made contact with the client for thirty (30) calendar days after the last attempted contact, additional efforts are not required. All follow-up contacts and/or attempts should be documented.
  • Clients who reconnect more than three (3) months after treatment discharge requesting recovery services must be screened to determine if this level of care continues to be appropriate for the client’s needs at that time.
• When a client is transitioning from one level of care to another (or to an ancillary service), care coordination will be based on warm handoff principles: carefully coordinated transfer or linkage of a client to another provider, entity, agency, or organization who will continue, add, or enhance services.

• This warm handoff process will:
  o Ensure communication between concurrent providers of service (for example, OTP and IOS providers treating a client at the same time)
  o Occur prior to the case closing at the current program
  o Ensure the client is clear on the reason for referral or transfer to another level of care
  o Include a direct conversation between providers to ensure passing of critical information in a timely fashion
  o Include all pertinent documents (including signed release of information when necessary and other relevant clinical information, including Level of Care Recommendation form) to ensure transfer in a timely manner
  o Occur anytime a referral is provided to another service provider

• The warm handoff will include:
  o Ideally, a joint session/meeting with the providers and the client via face-to-face, telephone, or telehealth
  o Information is shared between providers about client treatment and engagement history

Clients transitioning from non-OTP withdrawal management (WM) and residential services should begin services at the next indicated level of care within 10 business days of discharge from WM or residential services. For coordination up or down the continuum of care, the handoff is considered complete after there is confirmation that the client has engaged, and initial appointment has occurred.

In all cases of care transitions (both when the transition occurs along the SUD care continuum and when the transition occurs between other health systems), the last treating SUD provider is responsible for and must coordinate transitions in care. All coordination of care activities must be documented within the client record.

Provider Client Communications
Adequate communication serves a key component in ensuring proper care coordination for clients. Case managers have the responsibility of serving as an advocate for clients in the SUD system of care and shall assist with communication between clients and other service providers. Providers may have to exchange communication through emails, letters, telephone calls, progress notes, or reports to the County, State, or other service providers on behalf of the client. Case managers shall also assist clients in ensuring they are receiving adequate care from other service providers and inform clients of their right to appropriate treatment.

DMC-ODS Transition of Care Policy

According to DHCS Information Notice Number 18-051, the County of San Diego as a DMC-ODS county, is required to allow a beneficiary to continue receiving covered DMC-ODS service(s) with an out-of-network provider when their assessment determines that, in the absence of continued services, the beneficiary would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.
DMC-ODS treatment services with the existing provider shall continue for a period of no more than ninety (90) days unless medical necessity requires the services to continue for a longer period of time, not exceeding 12 months.

The County of San Diego DMC-ODS shall provide a beneficiary with transition of care with an out-of-network provider when all of the following criteria are met:

1. The County determines through assessment that moving a beneficiary to a new provider would result in a serious detriment to the health of the beneficiary, or would produce a risk of hospitalization or institutionalization;
2. The County is able to determine that the beneficiary has an existing relationship with an out-of-network provider (self-attestation is not sufficient to provide proof of a relationship with a provider);
   a. An existing relationship means the beneficiary was receiving treatment from the out-of-network provider prior to the date of his or her transition to the DMC-ODS County.
3. The out-of-network provider is willing to accept the higher of the County of San Diego’s DMC-ODS contract rates or DMC rates for the applicable DMC-ODS service(s);
4. The out-of-network provider meets the County of San Diego’s DMC-ODS applicable professional standards and has no disqualifying quality of care issues (a quality of care issue means the County of San Diego DMC-ODS can document its concerns with the provider’s quality of care to the extent that the provider would not be eligible to provide services to any other DMC-ODS beneficiaries);
5. The provider is verified as a current DMC certified provider; and
6. The out-of-network provider supplies the County of San Diego DMC-ODS with all relevant treatment information, for the purposes of determining medical necessity and developing a current treatment plan, as long as it is consistent with federal and state privacy laws and regulations. Additionally, the provider supplies the County of San Diego DMC-ODS with all relevant outcomes data.

Transition of Care Request Process
Beneficiaries, their authorized representatives, or their current provider, may submit a request to the County of San Diego DMC-ODS to retain their current provider for a period of time by calling the Access and Crisis Line (ACL) at (888-724-7240. TTY: 711). Upon receipt of the request, the County of San Diego DMC-ODS shall send the beneficiary written acknowledgement of receipt of the request and begin to process the request within three (3) working days.

Retroactive Transition of Care Request Process
The County of San Diego DMC-ODS shall retroactively approve a transition of care request and reimburse out-of-network providers for services that were provided if the request meets all transition of care requirements described above and the services that are the subject of the request meet the following requirements:

- Occurred after the member’s enrollment into the County of San Diego DMC-ODS; and
- Have dates of service that are within thirty (30) calendar days of the first service for which the provider requests retroactive continuity of care reimbursement.

Retroactive Transition of Care requests can be initiated by calling the Access and Crisis Line (ACL) at (888-724-7240. TTY: 711) for more information.
Transition of Care Request Denial Process
The County of San Diego DMC-ODS may deny a beneficiary’s request to retain their current provider under the following circumstance:

- The DMC-ODS county has documented quality of care issues with the DMC provider

If the County of San Diego DMC-ODS denies a beneficiary’s request to retain their current provider based on the above, then the County shall notify the beneficiary of the denial in writing, offer the beneficiary at least one in-network alternative provider that offers the same level of services as the out-of-network provider, and inform the beneficiary of their right to file a grievance if they disagree with the denial. If a DMC-ODS county offered the beneficiary multiple in-network provider alternatives and the beneficiary does not make a choice, then the DMC-ODS County shall refer or assign the beneficiary to an in-network provider and notify the beneficiary of that referral or assignment in writing.

Transition of Care Request Approval Process
On behalf of the County of San Diego DMC-ODS, Optum will manage Transition of Care request approvals. If the County of San Diego DMC-ODS and out-of-network provider are able to enter into a suitable arrangement for transitioning care for a given beneficiary, then the County shall allow a beneficiary to have access to that provider for the length of the continuity of care period, as deemed medically necessary, unless the out-of-network provider is only willing to provide services to the beneficiary for a shorter timeframe. In this case, the DMC-ODS County shall allow the beneficiary to have access to that provider for the shorter period of time, as established by the out-of-network provider.

Within seven (7) calendar days of approving a transition of care request, the County shall notify the beneficiary of the following in writing:

- The request approval;
- The duration of the continuity of care arrangement;
- The process that will occur to transition the beneficiary’s care at the end of the continuity of care period; and
- The beneficiary’s right to choose a different provider from the DMC-ODS County’s provider network.

At any time, beneficiaries may change their provider to an in-network provider regardless of whether or not a continuity of care relationship has been established. When the continuity of care agreement has been established, the County shall work with the provider to establish a care plan for the beneficiary.

Transition of Care Request Completion Timeline
Each transition of care request shall be completed within thirty (30) calendar days from the date that Optum, on behalf of the County of San Diego DMC-ODS, received the request. Retroactive claims for services from the date of request shall be processed as described above. A transition of care request is considered completed when:

- The County of San Diego DMC-ODS notifies the beneficiary, in the manner outlined above, that the request has been approved; or
- The beneficiary has either selected or been assigned to an in-network provider after the DMC-ODS county notified the beneficiary, in the manner outlined above, that the request was denied.
Termination of Transition of Care Process
The County of San Diego DMC-ODS shall notify the beneficiary in writing thirty (30) calendar days before the end of the transition of care period about the process that will occur to transition the beneficiary’s care to an in-network provider at the end of the transition of care period. This process includes engaging with the beneficiary and affected provider(s) before the end of the transition of care period to ensure continuity of services through the transition to an in-network provider.

Documentation
To promote consistency and standardization of County of San Diego required record documentation, a Uniform Record Manual (SUDURM) was implemented July 1, 2014. The SUDURM contains all required forms to ensure documentation compliance to Federal, State, and County laws and regulations under Title 9, Chapter 11, and 42 CFR. SUD providers are required to complete County-required protocols (including documentation standards and timelines) for assessment, treatment plans, level of care determination, progress notes, and other documentation requirements as specified within the SUDURM and SUDPOH. Within the SUDURM, documentation forms are filed in specific order starting with Section 1: Intake/Financial and ending with Section 8: Drug Test Results/Reports. Individual programs are responsible to ensure their providers utilize the required forms within the SUDURM as appropriate. SUDURM forms are located on the Optum San Diego website. Directions regarding access to this website can be found in the Appendix D.2 - Optum Website Tip Sheet.

State law, 45 CFR 164.524, regarding a client’s access to health records requires the following:

- Client records may be requested by any adult client, client personal representative, minor client authorized by law to medical treatment, or attorney.
- Health care providers cannot require a client’s request for health records to be submitted in writing.
- Requires health care providers to provide a copy of the records in a paper or electronic copy, in the form or format requested if the records are readily producible in that form or format.
- Requires health care providers to permit inspection of client records during business hours within five (5) working days after the receipt of the request.
- Requires health care providers to provide copies within fifteen (15) days after receiving the request.
- Requires health care provider fees to be based on specified costs for labor, supplies, postage, and preparing an explanation or summary of the client record instead of clerical costs. These costs are capped.
- Prohibits health care providers from withholding client records because of unpaid bills for health care services.
- Health care providers no longer can provide a summary in lieu of the actual record unless agreed upon by the client.
- Allows disclosure to a business associate for health care operations purposes.

Adult and minor child clients who consent or could have consented to their own treatment have a right to access their own records. Providers cannot refuse access based on the provider’s judgement that access would interfere with the therapeutic relationship or cause emotional harm. A summary of the record is not an acceptable alternative to providing access to the record. Parent access, however, can be limited if the minor child client consented or could have consented to the care.

OTP Documentation Standards
OTPs shall follow all applicable federal and state laws and regulations regarding confidentiality of,
procedures for, and content of patient records.

**Client Record Documentation**
County of San Diego SUD providers are required to establish, maintain, and update as needed, the individual client record for each client admitted to treatment and receiving services per Title 9, Chapter 11, and 42 CFR laws, regulations, guidelines, and professional standards. Upon the initial screen/intake and/or admission to treatment, the individual record shall contain client personal information to include the following:

- Information specifying client’s name and/or identifier number
- Client date of birth
- Client gender
- Client race and/or ethnic background
- Client address
- Client contact number
- Client next of kin or emergency contact name and number

**Clinical Documentation**
Clinical documentation refers to information within the client’s health record that describes the treatment and its rationale, as provided to the client. Clinical documentation is often written in narrative form to capture treatment process and analysis of each client encounter. Clinical documentation is a critical component of quality treatment service delivery and serves multiple purposes to:

- Ensure comprehensive quality care
- Ensure an efficient way to organize and communicate with other providers
- Protect against risk and minimize liability
- Comply with legal, regulatory and institutional requirements
- Facilitate quality improvement and application of utilization management

All clinical documentation must be credible and complete, and is protected by HIPAA and 42 CFR Part 2. It encompasses every aspect of clinical care to include initial assessments, progress notes, and all additional relevant encounters that occur outside of established appointments. All clinical documentation must include the following characteristics:

- Client name and/or unique identifier
- Must be legible
- Must be completed within timelines per regulation guidelines
- Contain a “complete” signature which includes the providers
  - Legible signature
  - Appropriate credentials
  - Date

**Treatment Episode Documentation**
Documentation of the treatment episode within the client record to include all activities, services, sessions, and assessment information not limited to:

- Intake and admission data/release and consent forms, and if applicable, physical examination
- Medical Necessity/Diagnosis determination
- Treatment Plans (Initial and Updated)
• Minimum Client Contact (e.g. one (1) contact per month for outpatient treatment)
• Progress Notes
• Referrals
• Continuing services justifications
• Lab test orders and results, physician consultation (medical documentation that verifies client pregnancy and the last day of pregnancy)
• Discharge Plan
• Discharge Summary
• Correspondence with or regarding the client
• Authorizations for Residential Services
• Drug screening results
• Additional information relating to the treatment services rendered to the client

Treatment Plan
Treatment Plans serve as a treatment guide for both provider and client. SUD providers within the County of San Diego system of care must develop an individualized treatment plan for each client admitted into treatment services. The LPHA or counselor will prepare an individualized written initial treatment plan based upon information obtained from screening, intake and comprehensive assessment process, and collateral sources to include other system providers. The LPHA or counselor will attempt to engage the client for the purpose of formulation of an initial treatment plan and all continuing, updated plans as well. As clients progress through treatment, treatment plans should be reviewed and updated to reflect client stability and/or notable events which are/may impact current client goals and/or treatment progress. For more information on Treatment Plans, see AOD Certification Standards (Sec. 7090) and the IA.

Initial and Updated Treatment Plans shall include all the following:
• A statement of problems identified through the ASAM, other assessment tool(s) or intake documentation (should be client driven)
• Goals/Objectives which are achievable and address each problem (should be client driven)
• Measurable action steps to be taken by the program and/or client to accomplish the identified objectives
• Target dates for the accomplishment of action steps and goals
• A description of the services, including the type of counseling, to be provided and the frequency of the counseling type
• The assignment of a primary LPHA or SUD counselor
• All SUD DSM-5 diagnoses labels, as documented on the Diagnosis Determination Note (DDN) by the Medical Director or LPHA. (See Appendix D.3 for the DSM-5 Substance Use Diagnosis Guide)
• If the client states they did not receive a physical exam within the 12-month period prior to the client admission to treatment date, a goal that the client has a physical examination must be on the treatment plan
• If the client’s physical exam (must have the actual physical exam) indicates the client has a significant medical illness, a goal that the client obtain appropriate treatment for the illness must be on the treatment plan
• The LPHA or counselor will type or legibly print their name, and sign and date the Treatment Plan
• The client will type or legibly print their name, sign and date the treatment plan after review and discussion. Should the client refuse to sign the treatment plan, the provider will document the reason for the client’s refusal and the providers strategy to engage the client in treatment participation
• The signed and dated treatment plan to be placed into the client record
Outpatient Timeline (Initial Treatment Plan)
- The LPHA or counselor will complete, type, print, sign and date the initial treatment plan within 30 days of admission to treatment.
- The client will review, approve, type, or legibly print their name, sign and date the initial treatment plan, indicating client participation in preparation of the treatment plan, within 30 calendar days of the admission to treatment date (if client refuses to sign, see above process).
- If a counselor completes the initial treatment plan, the Medical Director or LPHA shall review the initial treatment plan (as their scope of practice guidelines allows) to determine if services are medically necessary and appropriate for the client.
- If the Medical Director or LPHA determines services are medically necessary the Medical Director or LPHA will type, legibly print, and sign their name and date the treatment plan within 15 calendar days of signature by the counselor.

Outpatient Timeline (Updated Treatment Plan)
- The LPHA or counselor shall complete, type, legibly print their name, sign and date the updated treatment plan no later than 90 calendar days after signing the initial treatment plan, and no later than every 90 calendar days thereafter, or when there is a change in treatment modality or significant event, whichever comes first.
- The client shall review, approve, type or legibly print their name and sign and date the updated treatment plan, indication whether the client participated in preparation of the plan, by the LPHA or counselor (if client refuses to sign, see above).
- If a SUD counselor completes the updated treatment plan, the Medical Director or LPHA shall review each updated treatment plan to determine whether continuing services are a medically necessary and appropriate for the client.
- If the Medical Director or LPHA determines the services in the updated treatment plan are medically necessary, they shall type, legibly print, sign and date the updated treatment plan within 15 calendar days of signature by the counselor.

Residential Timeline (Initial Treatment Plan)
- The LPHA or counselor will complete, type, print, sign and date the initial treatment plan within 10 days from the date of client admission.
- The client will review, approve, type, or legibly print their name, sign and date the initial treatment plan, indicating client participation in preparation of the treatment plan, within 10 days of the admission to treatment date (if client refuses to sign, see above process).
- If a counselor completes the initial treatment plan, the Medical Director or LPHA shall review the initial treatment plan (as their scope of practice guidelines allows) to determine if services are medically necessary and appropriate for the client.
- If the Medical Director or LPHA determines services are medically necessary, the Medical Director or LPHA will type, legibly print, and sign their name and date the treatment plan within 10 days of admission.

Residential Timeline (Updated Treatment Plan)
- The LPHA or counselor shall complete, type, legibly print their name, sign and date the updated treatment plan within 30 calendar days from the date of client/counselor signature on the initial treatment plan, and no later than every 30 calendar days thereafter, or when there is a change in treatment modality or significant event, whichever comes first.
- The client shall review, approve, type or legibly print their name and sign and date the updated
treatment plan, to indicate client participation in preparation of the plan
  o If the client refuses to sign the updated treatment plan, the provider shall document the reason for refusal and the provider’s strategy to engage the client to participate in treatment
• If a SUD counselor completes the updated treatment plan, the Medical Director or LPHA shall review each updated treatment plan to determine whether continuing services are a medically necessary and appropriate for the client
• If the Medical Director or LPHA determines the services in the updated treatment plan are medically necessary, they shall type, legibly print, sign and date the updated treatment plan within 30 calendar days from the previous treatment plan.

Progress Notes

**Outpatient (OS, IOS, OTP, Recovery Services) Progress Notes**

For each service, either the LPHA or counselor who facilitated the service is required to complete a legible progress note for each client who participated in the counseling or treatment session to include treatment planning sessions and discharge planning sessions. All progress notes and individual narrative summaries will contain the following:

• Client’s name and client unique identifying number
• Information regarding client attendance, including the date, start and end of service time, documentation time, and travel time
• The purpose of the service or group topic (reflect treatment goals)
• A description of the client’s progress as it relates to the treatment plan problems, goals, action steps, objectives, and/or referrals to include new issues or problems which impact the client’s treatment or recovery plan
• Type of support and/or interventions offered by the program and/or other system providers
• Plan for the next session
• Identify if service(s) were provided in-person, by telephone, or by telehealth
• If services were provided in the community, identify the location and how the provider ensured confidentiality
• Note: Clients receiving Naltrexone Treatment Services at an OTP, shall include start and end times for individual and group services.

**Outpatient Timeline (Progress Notes)**
The LPHA or counselor will enter their typed or legibly printed name, and signature with date on the progress note, within (7) calendar days of the counseling session. The signature must be adjacent to the typed or legibly printed name.

**Residential (Progress Notes)**
All progress notes and individual narrative summaries to contain the following:

• A description of the client’s progress on the treatment plan, problems, goals, action steps, objectives, and/or referrals
• A record of the client’s attendance at each counseling session including the date, start and end times and topic of the counseling session
• Identify if services were provided in-person, by telephone, or by telehealth
• If services were provided in the community, identify the location and how the provider ensured confidentiality
• The therapist or counselor must type or legibly print their name, sign and date within the following
Residential Timeline (Progress Notes)
Residential programs may document progress notes in one of three ways. Please note, however, that programs should select the one option that will best suit their workflow and remain consistent with that option to maintain integrity of chart documentation:

- **Option 1:** Weekly Progress Note - This must be used in conjunction with the “Residential Weekly Progress Note – Services” form. This Weekly Progress Note summarizes the client’s participation in weekly activities/services, including client’s participation in structured activities such as counseling sessions, treatment planning sessions, discharge planning sessions, and/or other treatment services. (Case management services, however, are not included on the Weekly Progress note. Since Case Management is not part of the residential bed day, these are a separate service and must always be documented as a separate Individual Progress Note). Weekly progress notes shall be completed within the following week from when the service was provided, and programs shall have a process in place to identify staff writing the Weekly Progress Note, as multiple staff may have provided services during the week. Note: Per DHCS, a week is defined as Sunday to Saturday.

- **Option 2:** Individual Progress Note – With this option, a residential program would document each individual service provided to a client each day. The progress note would be completed by the LPHA or counselor providing the service within 7 days of the date of service.

- **Option 3:** Daily Progress Note – With this option, the client’s participation in services on a daily basis are summarized. The Daily Progress note is completed by the LPHA or SUD counselor who provided the majority of services for that day. (Case management services, however, are not included on the Daily Progress note. Since Case Management is not part of the residential bed day, these are a separate service and must always be documented as a separate Individual Progress Note). This note shall be completed every day a service is provided; if needed, multiple daily notes may be written each day. Daily Progress Notes are to be completed within seven days of the date of service.

The LPHA or counselor shall type, legibly print and sign their name, and date the progress note seven (7) days of the service. The signature must be adjacent to the typed or legibly printed name. Note: Per DHCS, a week is defined as Sunday to Saturday.

Case Management (Progress Notes)
For each client provided Case Management Services (at all levels of care), the LPHA or counselor who provided the treatment service to include treatment and discharge planning, shall record a progress note. All progress notes and individual narrative summaries to contain the following:

- Client’s name and client unique identifying number
- The purpose of the service
- A description of how the service relates to the client’s treatment plan problems, goals, action steps, objectives, and/or referrals
- Date, start and end of service time, documentation time, and travel time
- Identify if services were provided in-person, by telephone, or by telehealth
- Identify where services were provided, if in the community, identify the location and how the provider ensure confidentiality
Case Management Timeline (Progress Notes)
The LPHA or counselor shall type, legibly print and sign their name, and date the progress note within seven (7) calendar days of the case management service. The signature must be adjacent to the typed or legibly printed name.

Physician Consultation (Progress Notes)
For physician consultation services, additional medication assisted treatment, and withdrawal management, the Medical Director or LPHA working within their scope of practice that provided the treatment service, shall record a progress note and keep in the client’s file. All progress notes to include the following:

- Client name and client unique identifying number
- Purpose of the service
- Date, start, and end times of each service
- Identify if services were provided face-to-face, by telephone or by telehealth

Physician Consultation Timeline (Progress Notes)
The Medical Director or LPHA shall type, legibly print, sign and date the progress note within (7) calendar days of the service. The signature must be adjacent to the typed or legibly printed name.

Documentation Correction Guidelines
The following Documentation Correction guidelines have been developed to help programs and the County of San Diego reduce fraud, waste, and abuse, provide clear guidelines on when and how changes can be made to documentation in client records, including paper records and electronic health records (EHR), and encourage improved client participation and collaboration in Treatment Plan development.

General guidelines:

- For paper records, corrections can only be made with a single line through the error, initials of the person making the correction and the date the correction was made. The original documentation must remain legible.
- The original author of a document should be the only person making corrections to the document. The person who signs a clinical document is attesting to the accuracy of the documentation. For documentation that is written by or countersigned by an LPHA (such as LOC assessments and treatment plans), only the LPHA can make changes to the document once the LPHA has signed.
- If that person is no longer available (i.e. medical leave, no longer with the program), a supervisory LPHA (i.e. program manager or designee, clinical supervisor, other supervisory staff member) or Medical Director may make the correction. This does not apply for instances such as the staff out sick or on vacation. The reason for the correction should be documented. This may be done in a separate informational note.
- Corrections should not change the clinical content of the documentation.
- Administrative corrections (i.e. spelling errors that do not affect the clinical content of the document) or non-clinical factual corrections can be made by the SUD Counselor or LPHA with a line through the error, initials, and date.
- Once any document is signed, it should be considered final and a should not be removed from the client’s chart.
- Corrections made to documentation outside of the required timelines to bring an item in to compliance (i.e. correcting dates on a Progress Note after 7 calendar days or adding a Physical Exam Goal to a Treatment Plan) may be at risk of disallowance.
Treatment/Recovery Plans:

Treatment/Recovery plan correction standards incorporate the collaborative nature of developing them with clients. These documents guide the services a client in SUD Treatment will receive, and the client’s signature attests to their participation in the planning process.

- Corrections to plans are for minor non-clinical administrative errors (for example, spelling errors or typos), client signature is not required.
- Changes to treatment or recovery plans made to address a change in the client’s service or clinical needs must be made on an Updated Treatment or Recovery plan, with new documented and dated signatures by client, SUD counselor (if applicable), and LPHA. Updates required within timelines or based on clinical reasons cannot be done through the corrections process described above.

As SanWITS rolls out more Electronic Health Record functions, these standards will be updated to include guidance on corrections within that system.

Group Sign-in Sheets

All groups must establish and maintain client sign-in sheets per group counseling session, either initiated upon start of each group, or during each group. For more information regarding group sign-in sheets, please see the IA (Exhibit A, Attachment I, III, PP, 13) Sign in sheets to contain the following:

- Typed or legibly printed name, signature, and date of the LPHA(s) and/or counselor(s) conducting the counseling session. LPHA(s) and/or counselor(s) shall sign and date the sign-in sheet the same day of the group session. The signature(s) must be adjacent to the typed or legibly printed name(s). Signing the sign-in sheet establishes attestation by the LPHA and/or counselor that the sheet is accurate and complete
- Date of the group session
- Topic of the group session
- Start and end times of the group counseling session
- Typed or legibly printed list of the participants names and signature of each participant that attended the group counseling session

Note: A sample template for group sign-in sheets that programs may use can be found in Appendix D.4. Please note it is not a requirement for programs to utilize this sample template; however, all group counseling sign-in sheets must contain the above-mentioned elements.
E. SUD PROGRAM REQUIREMENTS

Target Population
Programs shall ensure that Substance Use Disorder (SUD) treatment and recovery services are provided to adults and adolescents with a SUD, including those with co-occurring disorders. Programs shall provide these services to a specific subset of this population (e.g., women, probationers) based on the nature of their program. Programs are advised to refer to their contract for detailed information regarding their program’s target population. In order to serve the target population to the standards expected by the County of San Diego Behavioral Health Services (COSDBHS), the following admission protocols shall be developed by the Programs:

Admission Policies, Procedures and Protocols
Programs shall develop and maintain written program admission policies, procedures and protocols. The policies, procedures and protocols shall be developed to ensure services to the target population and shall comply with the non-discrimination and related clauses in Article 8, Compliance with Laws and Regulations, of the Service Template. Programs shall implement non-discriminatory admission policies, ensuring that clients are admitted to treatment and recovery services regardless of anticipated treatment outcome. Policies shall also comply with the entry criteria and priority as defined by the contracts. Admission policies and procedures shall be submitted for review and approval by the COR within 60 days of Agreement execution (For a list of other required program policies and procedures, please refer to Appendix E.1). In the very rare occasions that providers should exclude clients from their program (example: clients become violent), providers are to use case managers to do a warm hand-off to appropriate services. Medi-Cal beneficiaries are entitled to receive DMC services. Providers should consult with their legal entity when excluding DMC beneficiaries from receiving services as this does not align with the SOW and SUDPOH requirements. Legal entities may discuss with CORs.

Acclimation Periods
Programs are required to follow their policies and procedures as developed with the program’s Medical Director in determining length of, and rules around, any type of acclimation (i.e. “blackout”) period after clients’ admission to a residential program. (Please note programs are not required to have such a period). These policies and procedures shall ensure that clients at residential facilities may correspond, have reasonable access to telephones, and have regularly scheduled opportunities to meet with visitors consistent with treatment needs. Program rules and restrictions must always be germane to treatment and consistent with trauma informed and DMC-ODS principles, and the policies and procedures for the acclimation period must allow for access to medically necessary and clinically indicated appointments, such as mental health appointments, medical appointments, child visitation (including phone calls with children), court and probation meetings, etc. Additionally, client correspondence addressed to, or from, the County of San Diego, public officials, attorneys, and clergy shall be unrestricted and shall be forwarded promptly without being opened or read by provider staff. Best practice guidelines indicate that arbitrary, blanket rules tend to be disempowering and may negatively impact the treatment milieu, therefore any restrictions to access during the acclimation period should be based on individualized risk assessment factors that are clearly documented in the client’s chart.

Geographical Service Area
Programs shall establish and operate substance use disorder treatment and recovery services for individuals in San Diego County. Service area may be specified to one of six HHSA-identified regions (North Coastal, North Inland, North Central, South, East, and Central). Specific service areas are listed in the contracts, but
services shall not be limited to geographic/residential criteria and shall be available to individuals seeking treatment in San Diego County.

Facilities
Programs shall provide all facilities, facility management, supplies and other resources necessary to establish and operate the program. The facility shall meet the County of San Diego Behavioral Health Services (COSDBHHS) Health, Safety and Appearance Standards as described in the HHSA-BHS-ADS 1077 (See Appendix E.2).

Space
The facility shall have sufficient space for services and activities, specified in the statement of work, as well as staff and administrative offices. The facility shall also include:

- Child Care Space: Programs providing perinatal services shall establish and maintain appropriate space for childcare if serving pregnant and parenting women and their children. The childcare may be state licensed or parent/childcare cooperative but must be supervised by an individual with at least one year of experience in a state licensed facility.

- Service Address and Hours of Operation: Program’s business shall be accessible by public transportation in compliance with Americans with Disability Act (ADA) and California State Administrative Code Title 24. Non-residential programs shall be open no less than 40 hours per week and 5 days per week, except County of San Diego Holidays. When closed, programs shall provide information to clients (i.e. outgoing voice mail message, signage on program door, reminders provided during services prior to the closure, etc.) concerning the availability of short-term emergency counseling or referral services, including, but not limited to, emergency telephone services. For residential programs, services shall be available to residents 7 days a week, 24 hours a day. Programs shall not change the hours of operation or location from those listed in their County contract without prior written approval from the Contracting Office Representative (COR). Prior to any change in location, the COR reserves the right to conduct a site visit(s), inspect the facility plans, and approve the location and any budget and/or service delivery impact which may result from the proposed move to a new location/facility.

NOTE: Programs licensed and/or certified by DHCS shall also notify DHCS of facility relocation, change of ownership, or change in scope of services, and copy their program COR on such correspondence. See Section H: Administrative Oversight, for further details about changes to DMC Certified programs.

Licensing
The California Department of Health Care Services (DHCS) offers facility certification to both residential and nonresidential SUD programs (AOD Certification), and licensing of residential programs. Additionally, DHCS certifies all programs to bill Drug Medi-Cal (i.e. DMC Certification).

Outpatient SUD programs shall obtain and retain facility certification and DMC certification. Residential programs shall obtain and retain facility certification and licensing as well as DMC Certification. All programs shall comply with provisions obtained in the current State of California, DHCS standards, and the County of San Diego shall utilize these standards in monitoring program’s delivery.
AOD Certification and Re-Certification
All outpatient, intensive outpatient, and residential providers are required to obtain and maintain an AOD Certification from DHCS. School site TRC’s are exempt from this requirement. Refer to the DHCS AOD Certification Standards for more information.

Initial Certification
A complete application package for a program applying for initial AOD certification consist of the following completed Department of Healthcare Services (DHCS) forms along with all supporting documents required as specified in the form’s instructions and application fees:

- DHCS From 5999 – Request for License and/or Certification Extension

Re-certification
Providers are eligible to renew certifications every two years provided the program remains in compliance with these Standards, corrects deficiencies in accordance with section 5000 and does not have its certification suspended, terminated, or revoked.

In accordance with the Alcohol and/or other Drug Program Certification Standards, Section 3000(b), the program shall submit the Request for License and/or Certification Extension DHCS Form 5999 (12/18) with all supporting documentation and renewal fees to the department 120 days prior to the expiration date reflected on the certificate. Failure to provide all necessary documentation shall result in the termination of the certification in accordance with Section 3000(d).

Drug Medi-Cal Certification and Re-Certification

Initial Certification
Providers applying for initial Drug Medi-Cal (DMC) certification are required to submit a complete application and supporting documents electronically via Provider Application and Validation for Enrollment (PAVE).

Additionally, new enrolling entities must complete a Live Scan for any person with a 5% or greater ownership or control and/or the Executive Director and Officers of the Corporation. Note: satellites (e.g. high school sites) are no longer permitted by DHCS and need their own DMC certification, CalOMS number, and NPI number. When applying for DMC certification for school sites, best practice is to use only the school address and avoid using classroom numbers as this limits the DMC certification to a specific classroom; if a room changes are necessary, and services are provided in a non-DMC certified classroom, DMC billing will not be accepted.

Re-certification
All DMC certified Providers shall be subject to continuing certification requirements at least once every five (5) years. DHCS may allow the Providers to continue delivering covered services to clients at a site subject to on-site review by DHCS as part of the recertification process prior to the date of the on-site review, provided the site is operational, the certification remains valid, and has all required fire clearances.

Re-certification is required for program relocation, remodeling, or change of ownership of greater than 50%. Refer to the PAVE link above for information on the recertification process. Providers are required to contact the program COR regarding any event that would trigger the need for DMC re-certification. It is the responsibility of the contracted provider to provide updated certifications to the provider’s assigned COR and at no time should certifications lapse. Providers shall notify the COR immediately upon
notification from DHCS that its license, registration, certification or approval to operate a SUD program or a covered service is revoked, suspended, modified, or not renewed by DHCS.

Other Changes
For other changes (e.g., a change in ownership less than 50% and a change with the Medical Director, staff, and/or service modality), providers must complete and submit to DHCS form DHCS 6209: Medi-Cal Supplemental Changes.

Resources
- Drug Medi-Cal Continued Certification questions: DHCSDMCRecert@dhcs.ca.gov
- Webinars, regulations, etc
- Provider Enrollment Regulations (CCR Title 22, Division 3) in effect on August 17, 2015

The above Provider Enrollment Regulations link includes the amendment to section 51341.1, which addresses abusive and fraudulent practices identified during targeted field reviews and Post Service Post Payment (PSPP) reviews conducted by DHCS. The regulation contains definitions, describes in more detail how counseling sessions are to be conducted, imposes physical examination requirements, distinguishes an initial treatment plan from an updated treatment plan, and requires treatment services to be recorded in more detail.

Incidental Medical Services
Residential programs that have received approval by DHCS may provide Incidental Medical Services (IMS). IMS are services provided at a licensed residential facility by a health care practitioner that address medical issues associated with either detoxification or the provision of alcoholism or drug abuse recovery or treatment services to assist in the enhancement of treatment services.

In order to provide IMS at an approved residential program, the licensed residential provider must adhere to the conditions outlined in sections 11834.03, 118346.36, 11834.025 and 11834.026 of the Health and Safety Code, as well as to DHCS MHSUDS Information Notice Number 18-031.

Programs providing ASAM 3.2 – WM are strongly encouraged to obtain an IMS license through DHCS.

Medications
Clients on medications will seek services. Clients shall not be denied services based solely on the fact that they are taking prescribed medication, regardless of the type of medication. Senate Bill No. 992 prohibits a licensee from denying admission to any individual based solely on the individual having a valid prescription from a licensed health care professional for a medication approved by the federal Food and Drug Administration for the purpose of narcotic replacement treatment or medication-assisted treatment of substance use disorders. Accordingly:

- Programs shall not deny services to a client with current, physician-prescribed medications. However, a program shall consider whether the nature and extent of the prescribed medications requires a higher level of care than offered at that program.
- With client consent, providers shall coordinate with the client’s physician or health practitioner when she/he enters treatment with prescribed medications that have psychoactive characteristics. Services and support plans shall be reviewed with the prescribing physician or health practitioner.
- If while in treatment, a client exhibits behavior that is a cause for concern, the treatment provider may address this as a program issue with the client and the client’s physician or health practitioner.
- Programs shall have a safety policy regarding the use of prescribed medications by a program client,
Safeguarding Medications

When applicable, and to ensure appropriate access, program may store clients’ medication in the program facility. All medications must be in bottles with prescription labels and shall not be in envelopes. Program staff may assist with client’s self-administration of medication in accordance with all relevant regulations and the DHCS Alcohol and/or Other Drug Program Certification Standards. Medication may include over-the-counter (OTC) medicines or prescription medications for specific health conditions, inclusive of medications for substance use disorder, mental health, and physical health conditions. Programs shall maintain a central destruction log for medications, which includes two staff signatures verification medications has been destroyed.

It is the responsibility of the Substance Use Disorder Program Medical Director to develop and implement medical policies and standards for the provider. At a minimum, Contractors shall ensure adherence to its own entity's policies and procedures, as developed by the Medical Director, to safeguard clients’ medication, and follow documentation standards for medication storage and destruction as specified in the Substance Use Disorder Uniform Record Manual (SUDURM). Policies and procedures may include, but are not limited to: process of observing clients’ self-administration of medication; security or storage/inventory system; procedure to address clients’ adverse reaction to medication (e.g., loss of consciousness, physical difficulties requiring hospitalization, etc.); clients’ and program staff’s responsibility in reporting loss or theft.

Naloxone in Licensed Alcohol and Other Drug (AOD) Residential Treatment Programs and Certified AOD Outpatient Programs

Naloxone is a life-saving medication that works to reverse an opioid overdose while having little to no effects on an individual if opioids are not present in their system. Naloxone blocks opioid receptor sites, reversing the toxic effects of the overdose. Naloxone is administered when a patient is showing signs of opioid overdose. The medication can be given by intranasal spray, intramuscular (into the muscle), subcutaneous (under the skin), or intravenous injection.

As stated in DHCS Information Notice 19-009 effective March 5, 2019, licensed residential treatment programs and certified outpatient AOD treatment programs are permitted to utilize Naloxone at their program site. All forms of Naloxone are allowed at the program. If a program chooses to provide Naloxone, all forms of the medication shall be recorded, stored, and destroyed in the same manner as prescription medications. It is the responsibility of the program to develop policies, procedures, and protocols for how the program will store the medication, and accurately document the administration and disposal of Naloxone. The staff person who administers Naloxone must have successfully completed Naloxone administration training and the training must be documented in their individual personnel file.

Facility Licensing

Chapter 7.5, Part 2, Division 10.5 of the California Health and Safety Code states that “no person, firm, partnership, association, corporation, or local government entity shall operate, establish, manage, conduct, or maintain an alcoholism or drug abuse recovery or treatment facility in this state without obtaining a current, valid license pursuant to this chapter”.

The code defines an alcoholism or drug abuse recovery, treatment, or detoxification facility as any facility, place or building which provides 24-hour residential non-medical services in a group setting to adults. For the purpose of further defining whether licensure is required, alcoholism or drug abuse recovery or treatment services mean services which are defined to promote treatment and maintain recovery from
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alcohol or drug problems which include one or more of the following: detoxification, group sessions, individual sessions, educational sessions, and recovery or treatment planning.

DHCS has the sole authority to license any facility providing 24-hour residential non-medical services to adults who are recovering from problems related to substance use disorders and who need SUD treatment. Licensure is required when at least one of the following services is provided: detoxification, group sessions, individual sessions, educational sessions, or alcoholism or drug abuse treatment or recovery planning. Additionally, facilities may be subject to other types of permits, clearances, business taxes or local fees that may be required by the cities or counties in which the facilities are located.

There are some residential facilities that do not provide SUD services and do not require licensure by the State. These include cooperative living arrangements with a commitment or requirement to be free from substance use, sometimes referred to as a sober living environment, a sober living home, transitional housing, recovery residences, or alcohol and drug free housing. It is important to note that while sober living environments or alcohol and drug free housing are not required to be licensed by DHCS, they may be subject to other types of permits, clearances, business taxes or local fees which may be required by the cities or counties in which they are located.

Residential facilities licensed by other State departments such as adolescent group homes (licensed by the Department of Social Services) or Chemical Dependency Recovery Hospitals (licensed by the Department of Public Health) do not require a residential AOD license by DHCS.

Residential Facility Licensing Requirements

- Code of Federal Regulations (CFR): Title 45 CFR, Part 96 Subpart L: Substance Abuse Prevention and Treatment Block Grant
- United States Code (USC): Title 42 USC, Section 300x-21-300x66: Substance Abuse and Treatment Block Grant

Fire Safety Inspection

A valid and appropriate fire clearance issued from the fire authority having jurisdiction over the area in which the facility is located is required. The fire clearance shall include a determination of the number of beds for ambulatory residents and for non-ambulatory residents in the facility and any restrictions regarding non-ambulatory clearances [Regulations Section 10517 (a) (1)]. The fire clearance shall also include the number of dependent children allowed in the total capacity and the age range of the dependent children. If no number of dependent children is indicated, then no dependent children are allowed.

Plan of Operation

Plan of Operation shall include but not be limited to the following:

- **Statement of program goals and objectives** - written statement to include program goals (intent or purpose of its existence) and objectives of the facility [Regulations Section 10517 (a) (2) (A)].
- **Outline of activities and services** – written statement listing the activities and services being provided by the facility [Regulations Section 10517 (a) (2) (B)].
- **Admission policies and procedures** – written statement of admission policies and procedures regarding acceptance of residents [Regulations Section 10517 (a) (2) (C)].
- **Assurance of nondiscrimination in employment practices and provision of benefits and services** – written assurance of nondiscrimination in employment practices, provision of benefits and
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services [Regulations Section 10517 (a) (2) (D)].

- Facilities residential admission agreement – [Regulations Section 10517 (a) (2) (E)]. Pursuant to Title 9, California Code of Regulations, Section 10566, current admission agreement used by the facility that specifies all the following:
  - Services to be provided,
  - Payment provisions including (amount assessed and payment schedule),
  - Refund policy,
  - Those actions, circumstances or conditions which may result in resident eviction from the facility,
  - The consequences when a resident relapse and consumes alcohol and/or non-health sustaining drugs, and
  - Conditions under which the agreement may be terminated.

- Table of administrative organization of the facility – a chart that shows the governing board, advisory groups, including resident councils when applicable, and both lines of authority (straight lines) and communications lines (broken lines) to all staff positions [Regulations Section 10517 (a) (2) (F)].

- Staffing plan, job descriptions, and minimum staff qualifications for each position [Regulations Section 10517 (a) (2) (G)].

- Sample menus and schedule for one calendar week – menu(s) shall include times of food service, food provided for breakfast, lunch, and dinner for one week, and type and availability of snacks [Regulations Section 10517 (a) (2) (J)].

- Consultant and community resources to be utilized by the facility as part of its program. An inventory that shall be used as a resource for assisting participants in securing additional services to meet and maintain their personal well-being while continuing to enhance personal development [Regulations Section 10517 (a) (2) (K)].

Provisions for Safeguarding Residents’ Property – the process of safeguarding a resident’s personal property if accepted by the licensee for safekeeping and this is in the licensee’s policy to accept such valuables.

Operational Procedures
Providers shall develop and maintain written Operational Procedures in accordance with current State of California Standards and the most current and appropriate HHSA requirements. The written procedures shall be submitted to the COR upon request. The written procedures and all updates shall be provided to all employees charging staff hours to a County contract. Changes to a program’s functions require a written change to the Operational Procedures. Providers may prepare additional written procedures not in conflict with the contract.

Program Advisory Group (PAG)
Contractor shall conduct a PAG a minimum of two (2) times per year to advise Contractor on program design, practice, and policies. The PAG membership shall consist of at least six (6) members, at least fifty percent (50%) of whom shall be clients or families served by the program and shall reflect the ages and cultures of the client population.

- Meeting minutes and action items based on PAG input shall be reported to the Contracting Officer’s Representative (COR) or designee in the program status report.

Alcohol and Drug Free Environment
Programs shall provide an alcohol and drug-free environment, and all participants shall be alcohol and drug free while participating in program activities.
Recognizing that substance use disorders for many is a chronic, relapsing disease, the program shall make every effort to retain clients in treatment and shall have written policies regarding appropriate supports to the client during a relapse episode. Addressing relapse is a necessary part of the treatment/recovery process and presents an opportunity to re-engage and re-assess levels of care and motivation to change. Policies relating to relapse shall be consistent with the alcohol and drug-free environment of the program.

Clients may be discharged if they engage in illegal activities or activities listed under Title 9 that compromise their safety or the safety of others, such as possessing, selling, or sharing alcohol or other drugs on-site at a program facility.

**Trauma Informed Facilities**

Environments that are trauma and developmentally appropriate have been shown to be beneficial to individuals seeking services. Welcoming all clients upon arrival by their first name is a best practice as it can empower the individual and honor who they are as people not just as clients. Contractor shall provide facilities that are in accordance with best practices described by resources such as:

- Creating Trauma- Informed Services: Tip Sheet Series- Tips for Creating a Welcoming Environment
- Enhancing Substance Abuse Recovery Through Integrated Trauma Treatment

**Trauma Informed Services**

Contractor’s systems and services shall be “trauma-informed” and accommodate the vulnerabilities of trauma survivors. Services shall be delivered in a way that will avoid inadvertently re-traumatizing clients and facilitate client participation in treatment. Contractor’s trauma-informed systems and services shall include: screening of trauma; consumer driven care and services; trauma-informed, educated and responsive workforce; provision of trauma-informed, evidence-based and emerging best practices; safe and secure environments; and, ongoing performance improvement and evaluation regarding program’s provision of trauma-informed services.

**Information from the National Center for Trauma Informed Care & Alternatives to Seclusions and Restraint**

**Trauma-Informed Approach**

According to SAMHSA’s concept of a trauma-informed approach, “A program, organization, or system that is trauma-informed:

1. **Realizes** the widespread impact of trauma and understands potential paths for recovery;
2. **Recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
3. **Responds** by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. Seeks to actively resist re-traumatization."

A trauma-informed approach can be implemented in any type of service setting or organization and is distinct from trauma-specific interventions or treatments that are designed specifically to address the consequences of trauma and to facilitate healing.
SAMHSA’s Six Key Principles of a Trauma-Informed Approach
A trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting- or sector-specific:

1. Safety
2. Trustworthiness and Transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice and choice
6. Cultural, Historical, and Gender Issues

From SAMHSA’s perspective, it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma. Consistent with SAMHSA’s definition of recovery, services and supports that are trauma-informed build on the best evidence available and consumer and family engagement, empowerment, and collaboration. Additional information and resources: [https://www.samhsa.gov/nctic/trauma-interventions](https://www.samhsa.gov/nctic/trauma-interventions).

Trauma Informed Care for those that have experienced Human Trafficking
Survivors of human trafficking have experienced high levels of trauma. These experiences can impact many aspects of their life, including their self-concept, behavior, and mood. Programs that work with survivors of human trafficking should be aware of the additional needs of these individuals. Below are several resources with tips and tools to assist programs in developing appropriate interventions.

- Department of Health and Human Services- Resources Specific to Victims of Human Trafficking
- National Human Trafficking Hotline Resource Library
  - [https://humantraffickinghotline.org/resources](https://humantraffickinghotline.org/resources)
- The National Child Traumatic Stress Network- Understanding and Addressing Trauma and Child Sex Trafficking

Drug Testing
Providers shall develop, implement, and maintain a testing protocol to ensure against the falsification and/or contamination of any urine and/or oral fluid samples. Providers shall conduct observed, random drug testing of clients when mandated by the referral source(s) and/or in adherence to the individual treatment plan. (For justice referrals expected to follow NADCP guidelines for drug testing, see Appendix E.3 for additional information). Any observed urinalysis shall be conducted by a staff member of the same gender during collection. All drug testing results shall be documented in the client record. Providers shall use the BHS designated urinalysis/oral fluid drug testing vendor unless prior written approval for another vendor is received from the COR.

Drug Testing Results Reporting
All positive drug tests shall be reported to the referring entity within two business days of testing date, if the client has provided appropriate prior consent.

Drug Testing Technologies
Drug testing may include any of the following technologies:
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- Urinalysis
- Oral Fluid Testing
- Breathalyzer

Co-Occurring Disorders
In accordance with the Health and Human Services Agency Co-occurring Psychiatric and Substance Abuse Disorders Consensus Document, all SUD programs shall be welcoming to individuals with co-occurring disorders by posting a SUD-approved Welcoming Statement and by providing materials, brochures, posters and other appropriate information regarding co-occurring disorders. Individuals shall receive a helpful and appropriate response whether the help they seek is voluntary or court mandated. Providers shall have capacity at a minimum to screen and refer clients/residents with co-occurring disorders to identified co-occurring treatment. It is the County of San Diego’s expectation that all programs are, at a minimum, Co-Occurring Capable, with the goal of becoming Co-Occurring Enhanced.

CYF Program Requirements

Smoking Prohibition Requirement
Providers shall comply, and require that subcontractors comply, with Public Law 103-227, also known as the Pro-Children Act of 1994, which requires that smoking is not permitted in any portion of any indoor facility owned, leased, or contracted for or by an entity and used to provide services to children under the age of 18.

Transportation of Minors
Minors shall always be escorted when being transported by any non-public, private, or commercial transportation service including but not limited to taxi and rideshare services.

Public Contact
Providers shall have sufficient staff with adequate knowledge, skills and ability available during operating hours specified in their contracts to ensure that all persons who contact the program in person or by phone during operating hours are quickly and appropriately served with information or a referral to appropriate services.

Linkages with Support Services Organizations
SUD programs shall initiate linkage agreements, which may include a Memoranda of Understanding (MOU), and establish procedures that will ensure strong, reliable linkages with other community service providers, and service organizations for client support. These MOUs and linkages shall be designed to integrate, coordinate, and access necessary support services within the community in order to ensure successful client treatment and recovery. These efforts shall help achieve Federal, State and County goals to integrate services, prevent relapse by using community support services, reduce fragmentation of care, and establish better communication and collaboration at all levels, but particularly among local providers and agencies who work with this target population.

Promotional Materials
All promotional materials for County funded programs shall include the HHSA and the Live Well San Diego logos, shall be provided to COR for review before distribution, and are subject to COR approval. Promotional materials shall include but not be limited to electronic and printed materials such as brochures, flyers, and other materials.
Outreach Services

Documentation of Outreach Services
Documentation of providers’ outreach services shall be made available in the event of a County audit.

General and Injection Drug User (IDU) Alcohol and Drug Outreach Services
Providers shall conduct outreach to individuals experiencing substance use disorders problems, with special attention to reaching injection drug users and helping them to access treatment and recovery services.

Information and Education
Providers shall provide information and education to prevent and minimize the health risks of substance use disorders. Providers shall promote awareness about the relationship between substance use and the personal health risks of communicable disease such as Sexually Transmitted Infections (STIs) and Human Immunodeficiency Virus (HIV) and, for pregnant women, the relationship between substance use and the risks to their children.

Homeless Shelter Outreach Services
Providers shall make available staff or volunteer participation in regional homeless shelter outreach services during the cold/wet winter months, which are typically defined as December through March.

Homeless Outreach Worker Services
The target population for the provision of Homeless Outreach Services are individuals who are homeless and may have a serious mental illness and/or substance use disorder. Homeless Outreach consists of the following services:

- Outreach and engagement
- Screening for mental health, physical health, and substance use disorders
- Linkage to services which may include:
  - Mental Health
  - Substance Use Disorder
  - Physical Health
  - Social Services
  - Housing
  - Employment Services
  - Advocacy
  - Other services as indicated
- Referral and placement in emergency homeless shelters
- Short-term care coordination and case management
- Coordination and collaboration with other providers to include psychiatric hospitals and other fee-for-service (FFS) providers.

Homeless Outreach Workers (HOWs) respond to community requests, as directed by their COR. HOWs will be notified of any known environmental safety hazards at the time of the initial referral and program shall notify COR of any safety concerns identified during outreach. Program shall develop policies and procedures for Outreach Safety in the community. Programs are required to complete a follow up report for COR requested HOW outreach services. For an overview of the HOW services model and documentation requirements, see Appendix E.4 – HOW Service Model & Data Collection Flow Chart (also available on County Technical Resource Library).
Homeless Funds
Homeless incidental funds are used for client-related needs including food, clothing, transportation, and other incidentals necessary for accessing ongoing benefits.

Communicable Disease Information, Education, and Prevention
Providers shall provide information, education and prevention services on the following communicable diseases for each individual admitted to the program: Human Immunodeficiency Virus (HIV), Hepatitis C (HCV), Tuberculosis (TB) and Sexually Transmitted Diseases (STD).

Cooperation with Other Agencies
Providers shall cooperate with other agencies and allow presentations to program clients, especially those who are at high risk or who are positive for any of the disease referenced above. Providers shall cooperate with on-site and off-site interventions, medical evaluation, laboratory testing, case management, and pharmaceutical therapy programs that assist participants in preserving their immune system function.

Staff Training on Communicable Diseases
Providers shall ensure that all employees and volunteers receive training in the diseases referenced above, methods of preventing transmission, confidentiality requirements, and available communicable disease-related resources that are appropriate referrals to supportive services. All training shall be documented in each personnel file.

Liaison
Providers shall designate a minimum of one staff person to serve as a liaison between the program site, the program’s community and BHS on issues related to communicable disease services. The designated staff person shall attend regularly scheduled BHS and providers facilitated meetings and shall provide staff communicable disease training and update sessions at least once every six months. Providers with multiple programs shall designate additional staff to serve in the liaison role.

HIV/HCV Services
Providers shall provide Human Immunodeficiency Virus (HIV) and Hepatitis C Virus (HCV) information and referral services for each individual admitted into the program. Providers can refer a client to Public Health Services for testing, if needed.

TB Control
As specified by the County of San Diego’s TB Control, providers shall screen each client admitted into the program for possible signs of tuberculosis and take action based on the results of each individual client’s screening within the specified timelines. Refer to the TB Questionnaire Instructions in the SUDURM for additional information.

Emergency Critical Services
The County of San Diego, Behavioral Health Services, has identified, at a minimum, residential contracts as Emergency Critical. If designated and informed by the COR, providers must identify the primary program contact for emergency/disaster communication and any succession of authority should the primary contact be unavailable. Emergency/disaster contacts must be made known to the COR within 15 days of start or annual renewal of the contract, or whenever there is a change in contact person.

If the need to evacuate the primary service site arises, residential program providers must have arrangements for either an alternate site to house program participants, or a plan to discharge clients back to their own
homes. The alternate site or plan to discharge to home must be made known to the COR within 15 days of start or annual renewal of contract.

DHCS requires all DMC certified providers to report emergencies to DHCSDMCRecert@dhcs.ca.gov that result in displacement of a DMC certified facility to avoid interruption of or inability to continue billing for DMC services. DHCS will request the following: nature of the emergency including when and where it happened; location of temporary location; what services were provided prior to the emergency and if services will differ at the temporary location; and projected timelines of the temporary site.

Disaster Preparedness
Providers shall contact their COR if there is an evacuation or relocation of services during the provision of services. COR must grant approval for any discontinuation of services. Funding sources specify that funding can only be claimed for services in support of contracted activities. Redirection of staff to other non-evacuation/emergency activities during an emergency/disaster may cause their time to be non-reimbursable, depending on funding availability and regulations. Note that discontinuation of outpatient services shall, in cost reimbursement programs, result in staffing and other service costs being ineligible for reimbursement during the period of program closure. Fixed price and pay for performance contracts may also be reduced if pay points are not achieved or deliverables are interrupted.

Local Emergencies
In the event that a local health emergency or local emergency is declared, or when the State or federal government has declared an emergency that includes areas within the County of San Diego, the prompt and effective utilization of contractor resources essential to the safety, care and welfare of the public shall occur at the direction of the County, to the extent possible. Contractors shall provide assistance in the prevention of, response to, and recovery from, any public health emergency, as applicable. Contractors’ staff shall be available upon request of BHS to assist in any necessary tasks during a public health disaster or County emergency state of alert. Providers shall work with the County to initiate processes and develop and implement plans, guidelines and procedures as required. As relevant, contractors shall also refer to the disaster preparedness and disaster response language outlined in this section.

Disaster Response
In the event that a local, state or federal emergency is proclaimed within San Diego County, programs shall cooperate with the County in the implementation of a Behavioral Health Services response plan. Response may include staff being deployed to provide services in the community, out of county under mutual aid Contracts, in shelters, and/or other designated areas.

Programs shall provide BHS with a roster of key administrative personnel’s after-hours phone numbers, pagers, and/or cell phone numbers to be used in the event of a regional emergency or local disaster. These numbers will be held confidential and never given out to other than authorized personnel.

Programs shall identify 25% of direct service staff to prepare for and deploy (if needed and available) to a critical incident. These staff shall participate in County provided Disaster Training (or other approved training) and provide personal contact information to be included in the Disaster Personnel Roster maintained by the County. COSDBHS Disaster Training is available through https://theacademy.sdsu.edu/programs/rihs/. Programs shall advise COR of subsequent year training needs to maintain 25% trained direct service staff in the event of staff turnover. Programs shall maintain 25% staff deployment capability at all times. (See Appendix E.5 – How to Access RIHS Trainings.)
Charitable Choice Regulations
Charitable Choice regulations require that religious organizations provide notice to all clients regarding their right to referral to another provider to which they have no religious objection. Charitable Choice referrals shall be reported to the County. This is applicable to religious organizations only. Please refer to: 68 FR 56429 9/30/2003 (model notice on page 56438) [www.federalregister.gov/documents/2003/09/30/03-24289/charitable-choice-regulations-applicable-to-states-receiving-substance-abuse-prevention-and](www.federalregister.gov/documents/2003/09/30/03-24289/charitable-choice-regulations-applicable-to-states-receiving-substance-abuse-prevention-and)

Nondiscrimination against religious organizations

- A religious organization is a nonprofit organization which is eligible on the same basis as any other organization to participate in applicable programs consistent with the First Amendment to the U.S. Constitution. These applicable programs include those under the Substance Abuse Prevention and Treatment (SAPT) Block Grant, 42 U.S.C. 300x to 300x-66 and the Projects for Assistance in Transition from Homelessness (PATH) Formula Grants, 42 U.S.C. 290cc-21 to 290cc-35 as these programs fund substance abuse and/or treatment services.
- Nothing in these regulations except the provisions provided herein and the SAMHSA Charitable Choices provisions which are the provisions of 42 U.S.C. 300x-65 and 42 U.S.C. 290kk, et seq. shall limit the ability of a governmental entity to have the same eligibility conditions apply to religious organizations and any other nonprofit private organization.
- No governmental entity receiving funds under these programs shall discriminate against an organization on the basis of religion or religious affiliation.

Religious activities, character, and independence

- Programs which receive funds from SAMHSA, or a governmental entity will not use these funds for religious activities. The organization’s religious activities must be offered in a separate time or location and participation is voluntary for an individual who receives substance use disorders services.
- A religious organization maintains its independence from governmental entities to practice and express its religious beliefs.
- Faith-based organizations which provide services need not remove religious materials from their facilities. A SAMHSA-funded religious organization may keep its structure of governance and include religious terms in its printed material and governing documents.

Non-discrimination requirement

- A religious organization which provides substance abuse services will not discriminate against a program beneficiary or a participant who receives substance abuse services based on religious beliefs or a refusal to participate in a religious practice.

Rights to services from an alternative provider

- An individual who receives or is interested in services and disagrees with the religious nature of the program has a right to obtain a notice, a referral, and alternative services within a reasonable time period.
- A program that provides a referral to an individual or interested individual will provide the participant with a notice of a right to receive services from an alternative provider who will meet the requirements of needed services such as accessibility and timeliness of treatment.
- Programs will maintain a system that ensures that appropriate referrals are made which meets the needs of the individual such as in the geographic area. A SAMHSA treatment locator may be used.
- Referrals will maintain the laws of confidentiality and specifically confidentiality regarding alcohol and drug abuse records (42 CFR Part 2). The program will contact the State regarding the referral and make sure the individual contacts the alternative provider.
Persons with Disabilities (PWD) Access to Services
Any enterprise licensed or certified by the DHCS or any entity (counties and providers) receiving state or federal funding that has been allocated by DHCS must comply with statutory and regulatory requirements such as:

- Americans with Disability Act (ADA) Exhibit 1
- Section 504 and 508 of the Rehabilitation Act of 1973;
- 45 Code of Federal Regulations (CFR), Part 84, Non-discrimination on the Basis of Handicap in Programs or Activities Receiving Federal Financial Assistance;
- Title 24, California Code of Regulations (CCR), Part 2, Activities Receiving Federal Financial Assistance and;
- Unruh Civil Rights Act California Civil Code (CCC) Sections 51 through 51.3 and all applicable laws related to services and access to services for persons with disabilities (PWD).

These statutory and regulatory requirements assist in ensuring Persons with Disabilities (PWD) are provided access to Substance Use Disorder (SUD) prevention, treatment and recovery services. The legislation and implementing regulations require all providers make reasonable accommodations and provide accessible services for PWD, and this also includes providers making electronic and information technology accessible to people with disabilities. These are per program standards within the Legal Entity, so each program site needs to comply with the above statutory and regulatory requirements.

Providers applying for initial licensure or certification must plan to be fully accessible at the time of application. Applicants for renewal of a licensure or certification must have conducted an assessment to identify barriers to service and develop an Access to Service Plan (i.e., corrective action plan) for removing or mitigating any identified barriers. Applicants failing to address these requirements can anticipate denial of their initial application or the withholding of renewals for existing licensed or certified programs until these requirements are adequately addressed.

The county is responsible for ensuring that SUD services and the SUD contracted providers are accessible and do not discriminate against or deny equal opportunity to a PWD to participate in and benefit by the provided service. Therefore, county-contracted SUD service programs must complete an accessibility assessment (see Appendix E.6 – Program Accessibility Assessment) and based on the results of the assessment, a corrective action plan and submit this to the County Quality Management SUD Unit. The SUD providers must take action to identify all physical and programmatic barriers to services and develop plans for removing or mitigating the identified barriers. If a new SUD county contracted program opens or if an existing SUD program relocates, an updated accessibility assessment must be completed and submitted to the Quality Management SUD unit through the QIMatters.HHSA@sdcounty.ca.gov email within 30 days of opening to ensure continued accessibility for PWD at the SUD program. Failure to do so can result in civil penalties and possible suspension, or revocation of licensure, certification or contract cancellation. The County Quality Management SUD Unit will review these assessments and corrective action plans for compliance and maintain them for reference to provide to DHCS upon request.

PWD SUD Service Report
The County QI department also completes a bi-annual PWD SUD Service Report to determine the extent of the need for PWD SUD services within the county in the six defined geographic locations based on the percentage of clients served with various disabilities (e.g., mobility, hearing, etc.) by extracting client disability information from SanWITS. This PWD SUD Service Report and the individual program accessibility assessments are reviewed by the Quality Management unit. This information is utilized to
determine the percentage of PWD in each geographic region and the number of county contracted SUD service providers that accept PWD to ensure that there is a sufficient number of outpatient and residential SUD services providers accessible by PWD strategically placed throughout the county.

If a SUD county contracted program is not able to accept a PWD client for any reason (e.g., facility was built prior to ADA regulations and the program cannot financially make the necessary renovations to be ADA compliant), then the program must provide a direct referral to another SUD provider who can accept this PWD client and provide equivalent services (e.g., residential) in the same geographic region (e.g., Central). The program is to determine the appropriate PWD program referral by utilizing the county’s PWD SUD Provider list (see Appendix E.7 – PWD SUD Provider list), which will be updated on a bi-annual basis by the county SUD QM unit. The program is to provide the client with the contact information for the other SUD providers in the same geographic region or another region, if requested by the client. The current program may need to assist the client with contacting the referred PWD SUD program to ensure the PWD client will be accepted and that equivalent services will be provided.

Country Access Coordinator (CAC)
The County is also required to designate a County Access Coordinator (CAC) for serving PWD. The role of the CAC is that of a liaison between the SUD provider community, County BHS Administrator’s office, and DHCS. The CAC is responsible for ensuring the integrity of the county’s compliance with all issues related to PWD SUD services and that all the different types of SUD services are available to all individuals, regardless of mobility, communication and/or cognitive impairments as required by state and federal laws and regulations. If a SUD program requires assistance with completion of an accessibility assessment and/or corrective action plan or a PWD referral, they may contact the CAC: Erin Shapira at 619-584-3093 or Erin.Shapira@sdcounty.ca.gov for assistance.

Ethical and Legal Standards
Programs shall develop and implement policies, procedures and training protocol that ensure that its employees, subcontractors, subcontractor employees and volunteers adhere to the highest ethical and legal conduct standards when performing work under the terms and conditions of the contract.

Code of Conduct
A Code of Conduct is a statement signed by all employees, contractors, and agents of an organization that promotes a commitment to compliance and is reasonably capable of reducing the prospect of wrongful conduct. Codes of Conduct should be created at the agency level. Programs shall have a written code of conduct that pertains to and is known about by staff, paid employees, volunteers, and the governing body and community advisory board members. Each staff, paid employee, and volunteer shall sign a copy of the code of conduct and a copy shall be placed in their personnel file. The program shall post the written code of conduct in a public area that is available to clients. The code of conduct shall include the program policies regarding at a minimum the following:

- Use of alcohol and/or other drugs on the premises and when off the premises
- Personal relationships with participants
- Prohibition of sexual contact with participants
- Sexual harassment
- Unlawful discrimination
- Conflict of interest
- Confidentiality
In addition to the minimum requirements listed above, all CYF providers are encouraged to utilize the 2019 Trauma-Informed Care Code of Conduct in the creation of their agency code of conduct. This document, created by young adults with lived experience, is intended to guide programs in developing policies and procedures related to trauma informed care, to inform trainings for staff, and to be offered to clients to outline the commitment of the program to follow trauma informed principles. See Appendix E.8 – Trauma Informed Care Code of Conduct.

**Counselor/Client Relationships**
Relationships between clients and program staff beyond the realm of treatment are prohibited. Staff must maintain healthy boundaries between themselves and their clients at all times. Staff members’ failure to adhere to this standard shall be disciplined at the discretion of the program director.

**Sexual Contact**
Sexual contact shall be prohibited between program staff, including volunteers, and members the Board of directors, and the participants. A written statement explaining the sexual contact policy shall be included in every participant’s rights statement given at admission to a program. Programs shall include a statement in every personnel file noting that the employees and volunteers have read and understood the sexual contact prohibition. The policy shall remain in effect for six months after a participant is discharged from services, or a staff member of volunteer terminates employment.

**Client Confidentiality**
Providers shall comply with federal client confidentiality regulations (Confidentiality of Substance Use Disorder Patient Records- 42U.S.C.290dd-2; 42CFR part 2), and all applicable Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations.

**Client Answering Program Business Phones**
Providers shall have trained provider staff available to answer business phone calls during hours of operation. Program shall ensure participants in DMC-ODS programs shall not answer phones on behalf of program staff. Providers shall ensure client confidentiality is maintained at all times.

**Client File Storage and Transportation**
Sites must keep a record of the clients/patients being treated at that location. If it is required to transport records offsite, to maintain the confidentiality of all client files and medical records, the standard protocol for storing confidential material shall be maintained until transport is possible. Client files are to be stored under double lock and key (i.e., locked cabinet in a locked room) at the program location. No client files are to be taken to staff’s private residences. The program supervisor shall designate staff members who will be responsible for the transportation of client files. A staff member shall inform the program director if file transport is necessary. Client files shall be transported in a portable locked file box. When transporting identifying client data or medical record such as progress notes or forms requiring signatures, no identifying information shall be put on the documents until which time said documents are secured in the client’s medical record at the primary clinic where the record is being stored. Progress notes or other individual documents transported while in the field shall not contain the full name of the client. Under no circumstances are any records to be left unattended.

**Off Site Record Storage**
DHCS requires notification if client records are moved off site permanently (i.e. records moved to storage). Program is required to notify their program COR when this occurs so that the County may complete the required notification.
SUD Quality Management (QM) Responsibilities & Confidentiality

In order to ensure compliance with confidentiality procedures and protocols, the SUD QM enforces the following procedures:

- Every member of the workforce is informed about confidentiality policies as well as applicable state and federal laws regarding anonymity and the confidentiality of clinical information.
- As a condition of employment, each member of the workforce signs a confidentiality agreement promising to comply with all confidentiality protocols. This statement must include a minimum General Use, Security and Privacy safeguards, Unacceptable Use, and Enforcement Policies.
  - The statement must be signed by the workforce member prior to access to protected health information (PHI).
  - The statement must be renewed annually.

Any client treatment records gathered during the course of provision of services, provider site and record reviews, or as necessary are protected through strictly limited access. Program staff has access to case data or files only as necessary to do their jobs.

Providers within the County of San Diego SUD system of care demonstrate ongoing commitment and compliance to the protection of client personal and health information as defined in 42 CFR Part 2, Health Insurance Portability and Accountability Act of 1996 (HIPAA), the State/County agreement, and other Federal, State regulations/laws through:

1. Established written policy and procedure to address workforce members’ code of conduct to include protection of client confidentiality while providing services within the SUD system of care. (“Workforce members” includes, but is not limited to, all employee types, including per diem/contracted/temporary volunteers, students/interns, subcontractors, and others with access to clients and/or client data).

2. Verifiable program orientation and/or trainings/staff meetings, with focus on current/updated client confidentiality/disclosure information and applicable Federal and State laws governing such.

3. All workforce members, working within the SUD system of care, are required to sign an agreement to comply with all confidentiality protocol as defined by law, regulation, and program code of conduct policy and procedure.

4. The Confidentiality Agreement must include language in which the workforce member agrees to not divulge personal information (PI), personal identifiable information (PII), and protected health information (PHI) to any unauthorized person or organization unless authorized or required by law. PI, PII and PHI definitions are found in Article 14 of the program’s contract with the County.

5. Workforce members will be given access to client PHI after #1 and #2 are completed.

6. Workforce members will renew their Confidentiality Agreement annually as verified by signature and date on the statement and placement within their personnel record.

7. Programs will have written policy and procedure which identify potential sanctions should violations of unauthorized release of confidential client health information occur.

8. Providers will respect a client’s right to revoke a consent/authorization to disclose information in
part or whole. Should this occur, the SUD treatment providers must notify the involved entities of this update immediately.

All substance use disorder treatment services shall be provided in a confidential setting in compliance with 42 CFR, Part 2 requirements. If services were provided in the community, documentation must identify the location and how the provider ensured confidentiality.

**Final Rule, 42 CFR Part 2**
The SUD system of care is moving into a new era that encourages information sharing with the physical and mental health systems for improvement of care coordination and client health outcomes. (See Examples of Permissible Payment and Healthcare Operations Activities below.)

It is well recognized that SUD clients often have additional health conditions that complicate care and can prevent long-term achievement of recovery goals if left un/under treated.

Final Rule, 42 CFR Part 2, published January 2018, effective February 2, 2018, implements new changes to the federal rules governing confidentiality and disclosures of substance use disorder patient records, known as 42 CFR Part 2 or “Part 2” to afford persons with substance use disorder, receipt of integrated and coordinated care while still protecting client confidentiality. While the new Final Rule maintains Part 2’s core protections, including consent requirements, it expands the ways in which patients’ protected substance use disorder information may be shared. For more information, please reference the Final Rule 42 CFR Part 2.

Examples of Permissible Payment and Health Care Operations Activities under 42 CFR Part 2 Section 2.33(b) SAMHSA:

- Billing, claims management, collections activities, obtaining payment under a contract for reinsurance, claims filing and related health care data processing
- Clinical professional support services (e.g., quality assessment and improvement initiatives; utilization review and management services)
- Patient safety activities
- Activities pertaining to the training of student trainees and health care professionals
- Activities pertaining to the assessment of practitioner competencies
- Activities pertaining to the assessment of provider and/or health plan performance, and
- Activities pertaining to the training of non-health care professionals
- Accreditation, certification, licensing, or credentialing activities
- Underwriting, enrollment, premium rating, and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care
- Third-party liability coverage
- Activities related to addressing fraud, waste and abuse
- Conducting or arranging for medical review, legal services, and auditing functions
- Business planning and development, such as conducting cost-management and planning related analyses related to managing and operating, including formulary development and administration, development or improvement of methods of payment or coverage policies
- Business management and general administrative activities, including management activities relating to implementation of and compliance with the requirements of this or other statutes or regulations
Customer services, including the provision of data analyses for policy holders, plan sponsors, or other customers
Resolution of internal grievances
The sale, transfer, merger, consolidation, or dissolution of an organization
Determinations of eligibility or coverage (e.g., coordination of benefit services or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims
Risk adjusting amounts due based on enrollee health status and demographic characteristics
Review of health care services with respect to medical necessity, insurance coverage under a health plan, appropriateness of care, or justification of charges.

SUD providers are advised to contact the legal representative within their organizations for legal interpretation and direction in regard to application of Confidentiality Law/Regulations to program specific policy and procedure. Should legal entities or programs have further questions regarding interpretation of 42 CFR Part 2 Final Rule, please see more information through the County of San Diego Health & Human Services Compliance Office.

Mandated Reporting
All treatment providers shall adhere to mandated reporter requirements regarding child abuse and neglect, elder abuse and neglect, and homicide or homicidal ideations. Mandated reporting as required by law is not to be considered unauthorized release of confidential information. Permissive exceptions to confidentiality may include:

- Danger to self
- Danger to others
- Another’s property
- When such disclosure is necessary to prevent the threatened danger (Tarasoff Notification)

Credentialing Requirements
County of San Diego DMC-ODS Plan for credentialing and re-credentialing providers is designed to comply with national accrediting organization standards as well as local, state and federal laws. The program described below applies to all Legal Entities which opted to complete credentialing using Optum’s centralized process. Legal Entities are responsible to ensure successful completion of credentialing activities for all new staff upon hire. Per Info Notice 18-19 PROVIDER CREDENTIALING AND RE-CREDENTIALING FOR MENTAL HEALTH PLANS (MHPs) AND DRUG MEDICAL ORGANIZED DELIVERY SYSTEM (DMC-ODS) PILOT COUNTIES, credentialing requirements outlined below are applicable to all Licensed, Registered, or Certified Providers that provide direct billable services.

All Direct Services Staff who participate in County of San Diego DMC-ODS Plan must be credentialed/re-credentialed according to COSD requirements. Among these requirements is primary source verification of the following information:

- Current and valid license to practice as an independent practitioner at the highest level certified or approved by the state for the provider’s specialty or facility/program status;
- Professional License current and valid and not encumbered by restrictions, including but not limited to probation, suspension and/or supervision and monitoring requirements;
- Clinical privileges in good standing at the institution designated as the primary admitting facility if applicable, with no limitations placed on the practitioner’s ability to independently practice in his/her specialty;
- Graduation from an accredited professional school and/or highest training program applicable to the academic degree, discipline or licensure;
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- Board Certification, if indicated on the application;
- A copy of a current Drug Enforcement Administration (DEA) or Controlled Dangerous Substance (CDS) Certificate, as applicable;
- No adverse professional liability claims which result in settlements or judgments paid by or on behalf of the practitioner, which disclose an instance of, or pattern of, behavior which may endanger patients;
- No exclusion or sanctions/debarment from government programs;
- Current specialized training as required for practitioners;
- No Medicare and/or Medicaid sanctions.

COSD also requires:
- Current, adequate malpractice insurance coverage;
- Work history (past 5 years) for the provider’s specialty;
- No adverse record of failure to follow SDCBHP policies, procedures or Quality Management activities. No adverse record of provider actions which violate the terms of the provider agreement;
- No adverse record of indictment, arrest or conviction of any felony or any crime indicating patient endangerment;
- No criminal charges filed relating to the provider’s ability to render services to patients;
- No action or inaction taken by provider that, COSD’s sole discretion, results in a threat to the health or well-being of a patient or is not in the patient’s best interest;
- Residential Programs (facilities) must be evaluated at credentialing and re-credentialing. Those who are accredited by an accrediting body accepted by Optum (currently JCAHO, CARF, COA and AOA) must have their accreditation status verified. On-accredited Residential Facilities/Sites providers must provide documentation from most recent audit performed by DHCS, DHS or CMS as applicable.

Credentialing
Initial credentialing processes begin with submission of completed and signed applications, along with all required supporting documentation using the following method:

- Completion of Optum’s on-line application by calling the Behavioral Services Credentialing Department at (800) 482-7114 or by sending a notification email to BHSCredentialing@optum.com

This includes without limitation attestation as to: (a) any limits on the provider’s ability to perform essential functions of their position or operational status; (b) with respect to individual practitioner providers, the absence of any current illegal substance or drug use; (c) any loss of required state licensure and/or certification; (d) with respect to individual practitioner providers, any loss or limitation of privileges or disciplinary action; and (f) the correctness and completeness of the application.

Re-credentialing
COSD requires that individual practitioners and Residential Programs Sites undergo re-credentialing every three (3) years. Re-credentialing will begin approximately six (6) months prior to the expiration of the credentialing cycle.

Required documentation includes without limitation attestation as to: (a) any limits on the participating provider’s ability to perform essential functions of their position or operational status; (b) with respect to individual practitioner participating providers, the absence of any current illegal substance or drug use; and
(c) the correctness and completeness of the application (including without limitation identification of any changes in or updates to information submitted during initial credentialing).

Failure of a participating provider to submit a complete and signed re-credentialing application, and all required supporting documentation timely and as provided for in the re-credentialing application and/or requests from Optum, may result in termination of participation status with COSD and such providers may be required to go through the initial credentialing process.

Credentialing information that is subject to change must be re-verified from primary sources during the re-credentialing process. The practitioner must attest to any limits on his/her ability to perform essential functions of the position and attest to absence of current illegal drug use.

**Delegates and Delegation**
Entities that have opted to be delegates for credentialing their own providers will have to adhere and continue adherence to state and local regulations, COSD Criteria and National Committee of Quality Assurance Standards (NCQA) while performing their duties as Credentialing Delegates.

Delegated Entities will be audited by Optum on behalf of COSD and must receive a score of 85% or higher as a result of each audit. The Delegation Oversight Audits will be on an annual basis and Legal Entities will receive at a minimum thirty (30) days prior notice to allow for proper preparation. Any scores below 85% will be given Corrective Action Plans to address any deficiencies and to ensure continuance of the programs’ integrity and compliance.

**Staffing Requirements**
The Department of Health Care Services (DHCS) ensures the provision of quality treatment through the enforcement of standards for professional and safe treatment. DHCS does not certify counselors; however, DHCS does ensure counselors provide quality treatment to clients by enforcing the Counselor Certification Regulations found in the California Code of Regulations (CCR), Title 9, Division 4, Chapter 8.

Providers shall:
- Administer, staff, and provide management systems and procedures for programs.
- Recruit, hire, train and maintain staff qualified to provide required services.
- Ensure all staff has appropriate experience and necessary training upon hire.
- Ensure clients currently in treatment are not to be used in staff positions*.
- Verify identify and determine the exclusion status of all staff prior to hire (see Federal and State Database Checks below).
- Ensure all personnel are competent, trained and qualified to provide any services necessary.
- Ensure non-professional receive appropriate onsite orientation and training prior to performing assigned duties.
- Ensure professional and non-professional staff are required to have appropriate experience and any necessary training at the time of hiring.
- Ensure documentation of trainings, certifications and licensure shall be contained in personnel files.
- Ensure professional and/or administrative staff supervise non-professional staff.
- Maintain records of current certification and NPI registration. Registered and certified SUD counselors shall adhere to all requirements in Title 9, Chapter 8.

* Providers shall have trained provider staff available to answer phone calls during hours of operation. Program shall ensure participants in DMC-ODS programs shall not answer phones on behalf of program...
staff. Providers shall ensure client confidentiality is maintained at all times.

**Discrimination**
Providers shall not unlawfully discriminate against any person as defined under the laws of the United States and the State of California. Programs may not discriminate between employees with spouses and employees with domestic partners or discriminates between employees with spouses or domestic partners of a different sex and employees with spouses or domestic partners of the same sex or discriminates between same-sex and different-sex domestic partners of employees or between same-sex and different-sex spouses of employees. ([Public Contract Code section 10295.3](#))

Programs may not discriminate between employees on the basis of an employee’s or dependent’s actual or perceived gender identity, including, but not limited to, the employee’s or dependent’s identification as transgender. ([Public Contract Code section 10295.35](#))

**Criminal Background Check Requirement**
Providers shall ensure that criminal background checks are required and completed prior to employment or placement of program staff and volunteers in compliance with any licensing, certification, or funding requirements, which may be higher than the minimum standard described herein. At a minimum, background checks shall be in compliance with [Board of Supervisors policy C-28](#) and are required for any program staff or volunteer assigned to sensitive positions funded by this contract. Sensitive positions are those that: (1) physically supervise minors or vulnerable adults; (2) have unsupervised physical contact with minors or vulnerable adults; and/or (3) have a fiduciary responsibility to any County client, or direct access to, or control over, bank accounts or accounts with financial institutions of any client.

Providers shall have a documented process to review criminal history of candidates for employment or volunteers that will be in sensitive positions. At a minimum, providers shall check the California criminal history records, or state of residence for out of state candidates. Programs shall review the information and determine if criminal history demonstrates behavior that could create an increased risk of harm to clients. Programs shall document review of criminal background findings and consideration of criminal history in the selection of a candidate. For example, document consideration of such factors as: if there is a conviction in the criminal history, how long ago did it occur, what were the changes, what was the level of conviction, and if selected, where would the individual work and is the conviction relevant to the position. Programs shall either utilize a subsequent arrest notification service during the staff or volunteer’s employment or check California criminal history annually. Programs shall keep the documentation of their review and consideration of the individual’s criminal history on file. All staff must be free of probation or parole supervision for a minimum of one (1) year prior to employment. (This is a County of San Diego BHS standard.)

Providers will ensure that all staff members working with clients are fingerprinted (LiveScan) and pass Department of Justice and Federal Bureau of Investigations background checks.

**Volunteer Staff**
If a program utilizes the services of volunteers, it shall develop and implement written policies and procedures, which shall be available for, and reviewed with all volunteers. The policies and procedures shall address all the following:

1. Recruitment
2. Screening
3. Selection
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4. Training and orientation
5. Duties and assignments
6. Supervision
7. Protection of client confidentiality; and
8. Code of conduct.

Professional Staff
Professional staff shall be licensed, registered, certified or recognized under California scope of practice. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Licensed Practitioners of the Healing Arts (LPHA) include: Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologists, Licensed Clinical Social Workers, Licensed Professional Clinical Counselor, Licensed Marriage and Family Therapists, and License Eligible Practitioners working under the supervision of Licensed Clinicians. **NOTE:** DHCS has recently clarified that although RNs are considered LPHAs, they are not permitted to determine a SUD diagnosis because it is not within their scope of practice; therefore, programs shall not use a RN as a LPHA to complete the diagnosis on the DDN (Diagnosis Determination Note) or on the Initial LOC Assessment (note: provisional diagnosis is required on this form for all programs). Any counselor or registrant providing intake, assessment of need for services, treatment or recovery planning, case management, individual or group counseling to participants, patients, or residents in a DHCS licensed or certified program is required to be certified as defined in Title 9, Division 4, Chapter 8.

Counselor Certification
Regulations require licensed and certified Substance Use Disorder (SUD) programs to ensure that their counseling staff are appropriately registered and/or certified at all times by an approved certifying organization, or appropriately professionally licensed. In addition, SUD programs must continue to meet the regulatory requirement that 30% of the staff providing SUD counseling are certified or professionally licensed. SUD programs must also demonstrate that their registered SUD counselors do not exceed the five (5) year registration limit (from the date of initial registration). SUD programs failing to ensure compliance with these requirements will be cited appropriately.

Counselor certification is based upon the Addiction Counseling Competencies: The Knowledge, Skills and Attitudes of Professional Practice (TAP 21) published by the Center for Substance Abuse Treatment. Staff who provide counseling services such as intake, assessment of need for services, treatment planning, recovery planning, individual or group counseling to participants, patients, or residents in any substance use disorder (SUD) program licensed or certified by DHCS are required by the State of California to be certified. To obtain certification, counselors must register with one (1) of the approved certifying organizations. From the date of registry, counselors have five (5) years to become certified with any certifying organization (CCR, Section 13035(f)(1)). If a counselor fails to become certified after being registered for five (5) years, the counselor will not be permitted to provide counseling services to clients. The provision which allowed an individual six months from the date of hire to become registered has been repealed. **Per DHCS MHSUDS Information Notice 18-035:**

*Health and Safety Code 11833 repeals California Code of Regulations (CCR) Title 9, Section 13035(f), which allowed an individual to provide counseling services, within six months of the date of hire, prior to registering with a certifying organization. In accordance with HSC Section 11833(b)(1), any individual who provides counseling services in a licensed or certified AOD program, except for licensed professionals, must be registered or certified with a DHCS approved certifying organization.*
Certified counselors are required to provide documentation of completion of a minimum of 40 hours of continuing education and payment of a renewal fee to their certifying organization in order to renew their AOD certification during each two-year period.

Per DHCS, as of March 11, 2019, there are three (3) Certifying Organizations (CO) approved by the California Department of Health Care Services (DHCS) to register and certify individuals to provide substance use disorder (SUD) counseling. Any SUD counselor registered or certified with a CO no longer approved by DHCS will need to re-register with one of approved CO’s to continue providing counseling services.

- California Association of DUI treatment Programs (CADTP)
- California Consortium of Addiction Programs and Professions (CCAPP)
- California Association for Drug/Alcohol Educators (CAADE)

See Appendix E.9 – SUD Credentials for a list of current SUD credentials for each credentialing body and how to verify the counselor credentials.

**Staffing Ratios**

The following guidelines for staffing ratios reflect County standards for best practice. Prior discussion with COR is needed if higher caseload ratios are proposed for LPHA, Case Manager, or SUD Counselor based on program design.

<table>
<thead>
<tr>
<th>Staff Position</th>
<th>Residential Caseload Ratio (Staff to Client)</th>
<th>Outpatient Caseload Ratio (Staff to Client)</th>
<th>Residential Withdrawal Management Caseload Ratio (Staff to Client)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Title</td>
<td>CYF</td>
<td>AOA</td>
</tr>
<tr>
<td>LPHA</td>
<td>1:25</td>
<td>1:25</td>
<td>1:25</td>
</tr>
<tr>
<td>Case Manager</td>
<td>1:25</td>
<td>1:25</td>
<td>1:25</td>
</tr>
<tr>
<td>HOW (OP)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Overnight Staff (Residential)</td>
<td>2 staff per shift</td>
<td>2 staff per shift</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*In addition to above position titles, it is required for all programs to have a Medical Director. Contact your program COR with questions regarding withdrawal management nursing requirements and overnight staff questions.

**Mental Health Licensed or Licensed Eligible**

A California-licensed or license-eligible (post master’s degree interns registered with the appropriate State Board of licensing who are receiving clinical supervision) Mental Health Specialist shall be available to provide clinical consultation as necessary, and to conduct mental health assessments for those clients who have a co-occurring mental health diagnosis. The Mental Health Specialist shall also conduct clinical supervision for staff delivering program services. A plan for provision of services to clients with a co-occurring disorder must be approved by the COR within 60 days of Agreement execution. If providers do not have such consultation available, a documented plan shall be approved by the COR to ensure adequate assessment and referral of co-occurring diagnosed individuals and clinical supervision for program staff.
Mental health licensed or licensed eligible staff shall meet all California Board of Behavioral Sciences or Board of Psychology licensure requirements, as well as having documented experience working with substance abuse services for a minimum of one year. For license verification, click here. The license shall be in good standing and clear of licensing authority disciplinary actions for a minimum of three years at the date of hire and continuously while employed by Providers as an employee or consultant.

- Post Master's degree interns registered with the appropriate State Board of licensing who are receiving clinical supervision may be used to provide direct services in the program.

Medical Director
The typical pre-DMC-ODS role of the medical director was a focus on signing treatment plans. Under the DMC-ODS, the focus is broader, and physicians should be engaged and integrated as a significant role into the SUD system.

Medical Directors at SUD provider agencies should ideally perform functions that others within the agency are unable to optimally perform. Some possible ways to maximize the benefit and role of the Medical Director within the program include:

- Provision of Medication Assisted Treatment (MAT) when clinically necessary
- Provision of Withdrawal Management (WM), if within program scope, when clinically necessary
- Provision of clinical supervision for staff
- Assist other professional staff with challenging cases
- Refer/treat co-occurring physical and mental health conditions
- Conduct clinical trainings on issues relevant to staff (e.g., ASAM Criteria, DSM-5, MAT, co-occurring conditions)

[Note: Provision of MAT, WM or treatment of physical health conditions in a residential setting requires an Incidental Medical Services (IMS) license through DHCS.]

The substance use disorder medical director's responsibilities shall at a minimum include all of the following:

- Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care.
- Ensure that physicians do not delegate their duties to non-physician personnel.
- Develop and implement medical policies and standards for the provider.
- Ensure that physicians, registered nurse practitioners, and physician assistants follow the provider's medical policies and standards.
- Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.
- Ensure that provider's physicians and LPHA's are adequately trained to perform diagnosis of substance use disorders for beneficiaries, determine the medical necessity of treatment for beneficiaries and perform other physician duties, as outlined in this section.
- Review clients’ health/medical information and drug history and document their review along with any orders and/or recommendations.

The substance use disorder medical director may delegate his/her responsibilities to a physician consistent with the provider's medical policies and standards; however, the substance use disorder medical director shall remain responsible for ensuring all delegated duties are properly performed.
Consistent with these responsibilities, programs must have written roles and responsibilities and a code of conduct for the medical director that is clearly documented, signed and dated by a provider representative and the physician.

A substance use disorder medical director shall receive a minimum of five (5) hours of continuing medical education in addiction medicine each year.

Each program’s assigned COR will be responsible for evaluating a medical director’s credentials to determine the salary cap.

Federal and State Database Checks
Prior to employment, programs are required to check the following databases to verify the identity and determine the exclusion status of all providers:

- Social Security Administration's Death Master File
- National Plan and Provider Enumeration System (NPPES)
- List of Excluded Individuals/Entities (LEIE)
- System for Award Management (SAM)
- CMS’ Medicare Exclusion Database (MED)
- DHCS’ Suspended and Ineligible Provider List

Certification on Disbarment or Exclusion
All claims for reimbursement submitted must contain a certification about staff freedom from federal disbarment of exclusion from services. In order to be in compliance with these federal regulations, all organizational providers must verify monthly the status of employees with the federal System for Award Management (SAM), the Office of the Inspector General (OIG), Government Services Agency (GSA) and the Suspended and Ineligible Provider (S&I) List.

Provider shall be responsible for checking, on a quarterly basis, the office of the Inspector General (OIG) website that none of the Providers officers, board members, employees, and agents providing services are on the OIG or Medi-Cal list of excluded individuals to provide direct services to County clients. Providers shall notify, in writing within thirty (30) days if any personnel are found listed on this site and the actions taken to remedy the situation.

Verification
- Federal System for Award Management (SAM) list
- OIG Exclusion list and the GSA debarment list
  - Reasons for placement on OIG list
- Medi-Cal Provider Suspension
  - Reasons include:
    - Convicted of felony
    - Convicted of misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service.
    - Suspended from the federal Medicare or Medicaid programs for any reasons
    - Lost or surrendered a license, certificate, or approval to provide health care
    - Breached a contractual agreement with the Department of Health Care Services that explicitly specifies inclusion on this list as a consequence of the breach.
Best Practice

- Providers must retain the records verifying that these required monthly checks have been performed and the names of the employees checked.
- Any employees who appear on the OIG, GSA or Suspended and Ineligible Medi-Cal lists are prohibited from working in any County funded program.
- Providers are encouraged to consult with their compliance office or legal counsel should any of their employees appear on either of the exclusion lists.

License Verifications

All SUD providers are required to verify the license status of all employees who are required by the contract Statement of Work to have and maintain professional licenses. The verification must be submitted at the time of contract execution, renewal or extension. This is in accordance with the Service Template requirements. In order to ensure the license is valid and current, the appropriate website(s) shall be checked. All providers are responsible for ensuring that all staff licenses are active and valid. Providers shall keep documentation that evidences active licensure for staff.

Personnel Files

Personnel files shall be maintained on all employees, volunteers, and interns. These records will contain: application for employment and/or resume, signed employment confirmation statement, signed annual confidentiality statements, job description (which shall include position title and classification; duties and responsibilities; lines of supervision; and education, training, work experience and other qualifications for the position), performance evaluations, health records/status as required by program or Title 9 (i.e. health screening report or health questionnaire, including annual TB results), other personnel actions (e.g. commendations, discipline, status change, employment incidents and/or injuries), training documentation relative to substance use disorders and treatment, current registration, certification, intern status or licensure; proof of continuing education required by licensing or certifying agency and program, and program code of conduct. (Note: While DHCS will not look for the certifying organization copy of their Code of Conduct during personnel file reviews, registered/certified SUD counselors are still required to have a Code of Conduct with their specific certifying organization as per those organization requirements).

The program’s written code of conduct for employees and volunteers/interns shall be established which addresses at least the following: use of drugs and/or alcohol; prohibition of social/business relationship with clients or their family members for personal gain; prohibition of sexual contact with the clients; conflict of interest; providing services beyond scope of practice; discrimination against clients or staff; verbally, physically, or sexually harassing, threatening, or abusing clients, family or other staff; protecting client confidentiality; the elements found in the code(s) of conduct for the certifying organization(s) the program’s counselors are certified under; and, cooperation with grievance investigations.

MD’s and LPHA’s will receive a minimum of five (5) hours of continuing education related to addiction medicine each year. Such documentation shall be maintained in the file and the last day of the first full month of employment and shall be available for County monitoring purposes. For more information about required training for medical directors, see Appendix E.10 – DMC-ODS Medical Director Training Requirements.

Provider Directory

Per DHCS Information Notice 18-020, a provider directory captures site-specific content for a contracted program, to include all licensed, waivered, or registered mental health providers and licensed substance use disorder service providers employed within the program*. On a monthly basis, programs shall respond to a polling request for updates to their provider directory, using the following process:
1. Designated program lead shall provide COR with a complete and up-to-date provider directory no later than the 3rd Monday of each month.
2. Directory shall be sent to Program COR via email, utilizing the requested electronic format, and cc'ing program analyst, if applicable.
3. Program shall ensure all the following data elements are accurately captured:

<table>
<thead>
<tr>
<th>Provider Directory Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provider’s name and group affiliation, if any</td>
</tr>
<tr>
<td>• Provider’s business address(es) (e.g., physical location of the clinic or office)</td>
</tr>
<tr>
<td>• Hours of Operation</td>
</tr>
<tr>
<td>• HHSA Region</td>
</tr>
<tr>
<td>• Telephone number(s)</td>
</tr>
<tr>
<td>• Email address(es), as appropriate</td>
</tr>
<tr>
<td>• Website URL, as appropriate</td>
</tr>
<tr>
<td>• Specialty, in terms of training, experience and specialization, including board certification (if any)</td>
</tr>
<tr>
<td>• Services / modalities provided, including information about populations served (i.e., perinatal, children/youth, adults)</td>
</tr>
<tr>
<td>• Whether the provider accepts new beneficiaries</td>
</tr>
<tr>
<td>• The provider’s cultural capabilities (e.g., veterans, older adults, Transition Age Youth, Lesbian, Gay, Bisexual, Transgender)</td>
</tr>
<tr>
<td>• The provider’s linguistic capabilities including languages offered (e.g., Spanish, Tagalog, American Sign Language) by the provider or a skilled medical interpreter at the provider’s office</td>
</tr>
<tr>
<td>• Whether the provider’s office / facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment</td>
</tr>
</tbody>
</table>

In addition to the information listed above, the provider directory must also include the following information for each rendering provider:

| • Type of practitioner, as appropriate                                                      |
| • National Provider Identifier number                                                       |
| • California license number and type of license                                             |
| • An indication of whether the provider has completed cultural competence training           |

*Registered and Certified SUD counselors are not considered licensed SUD providers and do not need to be reported as part of the Provider Directory. The requirement is referring to licensed providers in SUD programs such as LMFTs, LCSWs, LPHAs, Physicians, etc.

Notification in Writing of Status Changes
Providers are required to notify BHS Contract Support, (BHSCS) COR and QM in writing if any of the following changes occurs:

- Any change with DMC Certification, such as surrendering certification or closing program, any event triggering a DMC recertification, such as change in ownership, change in scope of services, or change in location.
- Change in office address, phone number or fax;
- Addition or deletion of a program site;
- Change of tax ID number or check payable name (only to BHSCS);
 Notification of Key Personnel Changes
Programs shall notify the COR within seventy-two (72) hours when there is a change in key personnel funded by the resulting contract.

On-Site Manager/Director
Programs shall provide a full-time on-site Program Manager or Director for each program, unless prior approval received by COR. If the program manager is also serving as the program coordinator, time may be divided between administration and direct services.

Review and Comment on the Qualifications of On-Site Managers, Directors, and Higher-Level Staff
The COR shall review and comment on the final candidates under consideration for hire at the Program Manager, Director, or higher level prior to selection. Should the COR choose to provide written comments, the comments shall be provided within five (5) days of receipt of candidates’ resumes and supporting documentation.

Residential Programs and Overnight Staffing
Residential programs shall ensure that a minimum of two (2) staff are onsite and on-duty 24 hours a day, 7 days a week, including but not limited to:

- Of the 2 on-duty overnight staff, at least 1 staff shall be a SUD Counselor (Certified or Registered) or LPHA
- At all times, at least 1 staff on site is CPR-certified, and First Aid trained
- Neither of the 2 on-duty overnight staff is a volunteer nor an active client of the program
- A security staff or LVN staff may count towards 1 of the 2 on-duty overnight staff
- Awake overnight staff are required to conduct regular walk-throughs of the facility
- Overnight coverage staffing schedule shall be posted.

Minimum Qualifications
- CPR/First Aid/Safety training and certification obtained within 90 days of hire and maintained;
- Eighteen (18) years or older;
- Trained on SUD confidentiality, ethics, and cultural competence/sensitivity; and,
- Trained and able to respond to emergency situations.

Note: 24/7 residential service hours are to include intake and admissions.

It is recommended that residential programs designated as ASAM Level 3.2 obtain the Incidental Medical Services (IMS) license through DHCS. A minimum of LVN level staff is recommended 24/7 in these programs and must follow the policies and procedures as established by the program’s medical director. Providers are expected to implement policies and procedures that have been developed with the Medical Director, that includes at a minimum, working collaboratively with emergency departments and primary care physicians that the client is safe to return to the WM program when in-house 24/7 nursing staff is not used.
Residential Staff Living Onsite
Residential facilities licensed or certified by DHCS are for beneficiary treatment purposes. Any part of certified or licensed facilities and beds designated for treatment may not be used for staff’s personal use (i.e. as staff residence). Common areas within the facility, such as kitchen and storage, may be used by staff during their work shifts as needed. Providers are to refer to the license and/or certification blueprint approved by DHCS for verification. If staff resides outside of the certified or licensed portion of the treatment facility, personal living expenses may not be charged to the BHS contract, and must be aligned with the program’s Cost Allocation Plan.

Staff Development and Training Plans
Programs shall develop and maintain a management and staff training (including volunteers and interns) and development plan. The staff training plan shall be updated annually and written reports on management and staff progress in achieving their development goals shall be maintained in the employee’s personnel file. Staff training and development plans shall include at minimum: ASAM training for staff completing screening/intake, assessment and treatment planning – and those supervising them (i.e. LPHA, Medical Director) - must be completed prior to providing these services; specific treatment standards for services provided, client confidentiality, client screening and assessment, client referral, CPR, communicable diseases, cultural diversity, data collection and reporting requirements, drug testing protocols, program admissions procedures, and Evidence Based Practices of at a minimum of Relapse Prevention and Motivational Interviewing. Relapse Prevention and Motivational Interviewing trainings are available through RIHS but staff may receive these trainings through other means, as long as the trainings meet the same content and length as those provided by RIHS. For updated training information, please refer to the most recent DMC-ODS Training Guide at https://sandiegocounty.gov/dmc. Contractors shall utilize County-approved training sources as indicated on the DMC-ODS Training Guide. Contractors may utilize training providers other than those indicated on the DMC-ODS Training Guide if approved by the COR to ensure minimum required standards are met.

Some of the following trainings may be tracked on the MSR/QSR:

- ASAM Training: Completion of ASAM A, B & C (via CIBHS) or completion of ASAM e-training Modules 1 and 2 (“Multidimensional Assessment” and “From Assessment to Service Planning and Level of Care” (via the Change Companies) is required prior to provision of screening/intake, assessment and treatment planning services are provided (and by those supervising staff providing these services, i.e. LPHA, Medical Director)
- Cultural Competency Trainings - Minimum of four hours annual requirement for all staff. When an in-service is conducted, program shall keep on file a training agenda and a sign-in sheet for all those in attendance with sign-in/out times. For outside trainings, certificate of completion shall be kept on file at the program. Cultural Competency Trainings are also available through RIHS e-learning
- Evidence Based Practices - Professional staff shall be trained in Motivational Interviewing and Relapse Prevention
- BHS Disaster Training is available through RIHS e-learning. A minimum of 25% of contracted staff need to be disaster trained
- System of Care training is available through RIHS e-learning. All direct service staff shall complete e-learning about BHS System
- CalOMS Web-based Training – For more information regarding this section, please refer to Section 7.
- Continuing Education Units (CEUs) - Contractor shall require clinical staff to meet their licensing requirement. Professional staff (LPHAs) are required to receive a minimum of five (5) hours of
continuing education related to addiction medicine each year. Other paraprofessional staff shall have a minimum of sixteen (16) hours of clinical training per year.

**Comprehensive, Continuous, Integrated System of Care (CCISC) CADRE**
Each organization shall have a minimum of one (1) current staff person complete the CCISC CADRE, within the life of the contract.

**Completion of CCISC CADRE**
When an Agency has completed the CCSC CADRE change agent training, it shall be expected to meet the following minimum requirements:

- Programs shall use an approved SUD tool to measure progress toward co-occurring capability or enhancement and shall identify specific objectives that are measurable and achievable in that time frame. Each program shall document what actions they are taking toward co-occurring capability or enhancement, at a minimum annually and submit to the COR by May 15th of every option year.
- Annual development of Quality Improvement Action Plan for achievement of progress, in consultation with COR and/or designee will identify Agency or Program specific objectives that are measurable and achievable to be reviewed at the time of site visit.
- Ongoing Agency participation in CADRE committees and activities, following CADRE change agent training completion.

**Cultural Competence**
Cultural Competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family member providers, and professionals that enables that system, agency or those professionals, consumer, and family member providers to work effectively in cross-cultural situations.

**Training**
Cultural Competence Trainings are available through some of County of San Diego’s Behavioral Health Services’ (COSDBHS) larger agencies. These agencies offer their own such trainings to their own program staff, but other providers may send staff on a fee basis. COSDBHS Contracted Trainings are available through the Responsive Integrated Health Solutions (RIHS). Limited classroom training and on-line trainings are available at no cost to staff of County-contracted programs. RIHS also offers a one-hour eLearning on the implementation of CLAS Standards.

**Requirements**
To meet State and County requirements, providers are required to maintain and reflect linguistic and cultural competence through all levels of their organization and in their policies, procedures, and practices. Providers must ensure that program staff is representative of, and knowledgeable about the client’s cultural diverse backgrounds and that programs are reflective of the specific cultural patterns of the service region.

**Cultural Competence Plans**
The QI Unit and the CORs are responsible for monitoring and evaluating compliance with cultural competence standards as outlined in the County’s Cultural Competence Plan and with State and Federal requirements. Provision of/ usages of the tools listed below are cultural competence requirements:

**Program-Level Requirements:**
1. **Cultural Competence Plan (CC Plan):** CC Plans are required for all legal entities. If your organization does not have a CC Plan, the CC Plan Component Guidelines outlined below may
be used to assist in developing a CC Plan. They are available in the Cultural Competence Handbook (pages 12-13) on the County of San Diego Behavioral Health Services Technical Resource Library website.

The CC Plan Component Guidelines are as follows:

- **Current Status of Program**
  - Document how the mission statements, guiding principles, and policies and procedures support trauma-informed cultural competence.
  - Identify how program administration prioritizes cultural competence in the delivery of services.
  - Agency training, supervision, and coaching incorporate trauma-informed systems and service components.
  - Goals accomplished regarding reducing health care disparities.
  - Identify barriers to quality improvement.

- **Service Assessment Update and Data Analysis**
  - Assessment of ethnic, racial, linguistic, and cultural strengths and needs of the community.
  - Comparison of staff to diversity in community.
  - A universal awareness of trauma is held within Agency. Trauma is discussed and assessed when needed and relevant to client/target population needs.
  - Use of interpreter services.
  - Service utilization by ethnicity, race, language usage, and cultural groups.
  - Client outcomes are meaningful to client’s social ecological needs.

- **Objectives**
  - Goals for improvements.
  - Develop processes to assure cultural competence (language, culture, training, and surveys) is developed in systems and practiced in service delivery.
    - Trauma-informed principles and concepts integrated
    - Faith-based services

New contractors need to submit a CC Plan, as specified above, unless their legal entity has already provided one. As new programs are added, legal entities are expected to address their unique needs in the CC Plan. CC Plans can be sent via email to BHSQIPIT@sdcounty.ca.gov.

2. **Annual Program Evaluation**: every year, program managers are required to complete a cultural competence assessment of each program, using the tool which will be provided by SDCBHS electronically to each program manager. Every program manager is provided two weeks to complete the survey. The survey can be completed in approximately one hour or less. For your information, a copy of the assessment is included in the Cultural Competence Handbook.

3. In order to present a welcoming appearance to unique communities, providers are required to ensure that their facility is comfortable and inviting to the area’s special cultural and linguistic populations. Program hours of operation must be convenient to accommodate the special needs of the service’s diverse populations.

- **Staff-level Requirements:**
  1. **Biennial Staff Evaluation**: Every two years, staff members of the County-contracted and County-operated behavioral health programs are required to self-assess their cultural competence in providing behavioral health services. The staff are provided two weeks to
compete the survey. For your information, a copy of the assessment is included in the Cultural Competence Handbook.

2. Minimum of 4 hours of Cultural Competence Training Annually: Contractors shall require that, at a minimum, all provider staff, including consultants and support staff interacting with clients or anyone who provides interpreter services must participate in at least four (4) hours of cultural competence training per year. Training may include attending lectures, written coursework, a review of published articles, web training, viewed videos, or attending a conference can count the amount of time devoted to cultural competence enhancement. A record of the annual minimum four hours of training shall be maintained on the Monthly/Quarterly Status Report. The following conditions also apply:
   a. Staff hired after May 15 are exempt from the requirement for that fiscal year.
   b. Volunteers who have served or are expected to serve 100 or more hours at the program must meet the requirement.

National Culturally and Linguistically Appropriate Services (CLAS Standards)
To ensure equal access to quality care by diverse populations, each service provider receiving funds from the County of San Diego shall adopt the federal Office of Minority Health (OMH) National Culturally and Linguistically Appropriate Services (CLAS) Standards. The CLAS Standards are intended to inform and facilitate the efforts towards becoming culturally and linguistically competent across all levels of a health care continuum. The CLAS Standards are comprised of 15 Standards as follows:

• **Principal Standard**
  1) Provide effective, equitable, understandable and respectful quality care and services that are response to diverse cultural health beliefs and practices, preferred languages, health literacy and other communications needs.

• **Governance, Leadership and Workforce**
  2) Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources.
  3) Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.
  4) Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

• **Communication and Language Assistance**
  5) Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
  6) Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
  7) Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individual and/or minors as interpreters should be avoided.
  8) Provide easy to understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

• **Engagement, Continuous Improvement and Accountability**
  9) Establish culturally and linguistically appropriate goals, polices and management accountability, and infuse them throughout the organizations’ planning and operations.
10) Conduct ongoing assessments of the organization’s CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities.

11) Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

12) Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

13) Partner with community to design, implement and evaluate polices, practices and services to ensure cultural and linguistic appropriateness.

14) Create conflict and grievance-resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or grievances.

15) Communicate the organizations progress in implementing and sustaining CLAS to all stakeholders, constituents and the public.

Language Requirement
Services should be provided in the client’s preferred language. Providers are required to inform individuals with limited English proficiency in a language they understand that they have a right to free interpreter services. There shall not be the expectation that family members provide interpreter services, including the use of minor children. A consumer may still choose to use a family member or friend as an interpreter, only after first being informed of the availability of free interpreter services. Programs shall access professional certified interpreter services as needed for deaf, hard of hearing and late deafened participants to facilitate complete communication and to ensure provision of appropriate confidential treatment and recovery services. The offer of interpreter services and the client’s response must be documented, as should the use of an interpreter, and include documentation when services are provided in a language other than English.

Trafficking Victims Protection Act of 2000
The purpose of this Protection Act is to combat trafficking in persons, a contemporary manifestation of slavery whose victims are predominately women and children, to ensure just and effective punishment of traffickers, and to protect their victims. Trafficking in persons is a modern form of slavery, and it is the largest manifestation of slavery today. Trafficking in persons is not limited to the sex industry, but also includes forced labor and involves significant violations of labor, public health, and human rights standards worldwide.

Providers shall comply with Section 106(g) of the Trafficking Victims Protection Act of 2000 as amended (22 U.S.C. 7104). This amendment states that SUD providers and their employees may not engage in severe forms of trafficking in persons, procure a commercial sex act, or use forced labor in the performance of the contract. If any of these violations occur, then the contract and/or funding may be terminated. SUD providers are to have policies and procedures in place to ensure that all SUD provider staff are aware of these requirements and to ensure full compliance with the terms of the statutory requirement. For full text of the award term, see 42 CFR Part 175.
F. PROVIDER CONTRACTING

All contracted providers, including subcontractors, shall adhere to and support the Substance Use Disorder (SUD) Intergovernmental Agreement executed between San Diego County and the California State Department of Health Care Services (DHCS).

All SUD providers must contract with the County of San Diego in order to receive reimbursement for Substance Use Disorder Services. Please read your contract carefully. It contains:

- General terms applicable to all contracts;
- Special terms specific to a particular contract;
- A description of work or services to be performed;
- Payment Schedule and/or budget; and
- Statutes and/or regulations particular to the DMC-ODS SUD programs as well as programs supported by other funds.

Selection and monitoring of organizational agencies is governed by contracting procedures, which require a review of the organization’s fiscal soundness, resumes of principal administrators and supervisors, the agency’s experience with similar services, and a proposed staffing plan. All contracted providers will be expected to adhere to these requirements. Please contact your Behavioral Health Services Contracting Officer’s Representative (COR) if you have any questions regarding your contract.

Disclosure Requirements

The SUD Intergovernmental Agreement (IA) providers and contractors shall disclose to the state any persons or corporations with an ownership or control interest in an organization that:

- Has direct, indirect, or combined direct/indirect ownership interest of 5% or more of the Legal Entity’s equity;
- Owns 5% or more of any mortgage, deed of trust, note, or other obligation secured by the Legal Entity if that interest equals at least 5% of the value of the Legal Entity’s assets;
- Is an officer or director of a Legal Entity organized as a corporation; or
- Is a partner in a Legal Entity organized as a partnership.

Disclosure to the State shall be done during the following:

- When the Legal Entity submits a proposal in accordance with the County’s procurement process or when the Legal Entity submits a provider application.
- When the Legal Entity executes a contract with the County or when the provider executes a provider agreement with the state.
- When the state renews or extends the County contract.
- Within 35 days after any change in ownership of the contractor/disclosing entity.
- Upon request of the state during the revalidation of the provider enrollment.
- Within 35 days after any change in ownership of the disclosing entity.
- See Section 1124(a)(2)(A) of the Act; section 1903(m)(2)(A)(viii) of the Act; 42 CFR 438.608(c)(2); 42 CFR 455.100 - 104]
Social Security Death Master File Verification
Prior to executing a contract with a provider, the SUD Plan is required to verify that the provider (individual) is not listed within the Social Security Death Master File (DMF) upon enrollment. Should a contract provider appear on the list, the SUD Plan will notify the County to take the appropriate action regarding enrollment or disenrollment from the SUD Plan and notify the appropriate regulatory authority.

National Provider Identification Verification
All HHSA contractors are required to verify that all clinical staff, licensed or not, have an active National Provider Identification (NPI) number. For new employees, contracted programs are to provide employee with necessary paperwork needed to apply for an NPI number, should they not already have one. If the new employee has an NPI number, the contractor shall verify in the National Plan and Provider Enumeration System (NPPES) for accuracy. Contractors must update the NPPES system as needed when the employee’s information changes. The SUD Plan is required to complete the same verification process for the contracted providers. When contractor submits their Access Request Form (ARF) for staff account set up in the electronic health record, the MIS unit performs validation through the NPPES database. Staff shall not have access to the electronic health record without a valid NPI number.

Contractor Orientation
All new contracts require a contractor orientation meeting within 45 days of contract execution. The COR, in conjunction with the BHS Contract Support Services Unit and Agency Contract Support, shall be responsible for contractor orientation. Contractor will designate a contact person to coordinate attendance of necessary contractor staff at the orientation. This orientation provides important information regarding contractual obligations and monitoring activities conducted by the County.

As a contractor in the SUD Plan, it’s important for providers to be aware of the objectives of the DMC-ODS, which are:

- To increase the County SUD provider network capacity and offer new services to an expanded number of Medi-Cal beneficiaries.
- To increase local oversight of the SUD provider network with the goals of improved service quality and cost efficiencies.
- To ensure efficient care coordination and linkages among physical health, mental health and SUD services.
- To increase public safety through the implementation of evidence-based treatment services.

Goals
Programs shall provide clients with comprehensive, preventive, rehabilitative, and therapeutic behavioral health care delivered in the least restrictive environment and in the most effective mode based on ASAM criteria. Overall goals of this program include client access to timely care, retention in treatment, reduction of substance use relapse, reduction in justice involvement, and improvement in quality of life.

Measures
Providers shall refer to their contract Statement of Work for quality of care measures, outcome measures, and process objectives specific to their program. Measures may be adjusted during the contract term to meet changes in Federal, State, and County requirements.

Quality of Care Measures include areas such as the following:
- Assessment
Outcome Measures include areas such as the following:
- Reduction in Justice Involvement
- Housing Support Services
- Self-Sufficiency
- Newborn Health
- Continuum of Care
- Client Satisfaction

Process Objectives include areas such as the following:
- Minimum number of client admissions
- Minimum number of bed days

**Service Eligibility**
Services shall not be refused to clients based on race/ethnicity, disability, culture, religion, gender, sexual orientation, or the inability to pay, if the client meets the County’s eligibility population requirements.
Clients who are CalWORKs eligible shall not be charged fees. Clients who are DMC eligible shall not be charged fees unless there is Share of Cost (SOC).

**County of Responsibility and Residency**
All clients receiving services through a County BHS contract shall have San Diego County residency. Regarding residency, for non Medi-Cal beneficiaries, a specific period of residence in the county or state is not required to qualify for services. Intent to reside in San Diego County is a necessary condition and is established by the client’s verbal declaration. This applies to foreign nationals, including individuals with immigrant or nonimmigrant status. Without intent to reside in San Diego County, any client must be billed at full cost. County of Responsibility claims adjudication information is provided in the County of San Diego Behavioral Health Services Drug Medi-Cal Organizational Providers Billing Manual.

**Financial Status Evaluation**
During the treatment intake process, programs shall conduct a financial assessment of all clients and collect information about participants’ personal health insurance coverage, if any. If potential third-party payers are identified, programs shall develop procedures to bill the third-party payer. Programs that provide Drug Medi-Cal (DMC) services shall be responsible for verifying the Medi-Cal eligibility of each client for each month of services prior to billing for DMC services for that client. Medi-Cal eligibility verification should be performed prior to rendering service, in accordance with and as described in the Department of Health Care Services DMC Provider Billing Manual. Options for verifying the eligibility of Medi-Cal beneficiary are described in the DHCS DMC Provider Billing Manual.

**Sliding Fee Scale**
Programs shall utilize the standardized sliding fee scale for determining client’s ability to pay for services or low-income clients (between 138% to 200% of the Federal Poverty Level - FPL) without Medi-Cal. The sliding fee scale will indicate the maximum client fee allowed, based on economic indicators. The indicated amount may be adjusted based on a client’s ability to pay, and no service will be refused due to a client’s inability to pay. Refer Appendix F.1 for the BHS sliding fee scale.
Note: Fees may not be charged to CalWORKs, Medi-Cal beneficiaries, or Medi-Cal eligible clients (other than Share of Cost/SOC. Please refer to the County of San Diego Behavioral Health Services Drug Medi-Cal Organizational Providers Billing Manual for more information on SOC).

Monitoring Activities
The County performs various monitoring activities including desk reviews, client record reviews, and site visits conducted by the Program Monitor/COR as well as the Quality Improvement Unit. Contractor’s Program Managers shall be available during regular business hours and respond to the Program Monitor/COR or designee within 2 business days. Contractor shall have the technological capability to communicate, interface and comply with all County requirements electronically using compatible systems, hardware and software. Providers are required to submit status reports for review, and it is important to become familiar with the status reports to document pertinent information as required. The Status Report templates offers drop-down boxes including codes to make data entry collection easier.

Corrective Action Notice
Corrective Action Notice (CAN) is a tool identifying deficiencies in compliance with contractual obligations and requires corrective actions within a specified time frame. A CAN may result from findings during site visits or information derived from reports. Contractors are required to respond to the CAN specifying course of actions initiated/implemented to comply within the specified time frame.

Contract Issue Resolution
Issues, problems or questions about your contract shall be addressed to your COR.

Claims and Billing for Contract Providers

Contractor Payments
Contractors will be paid in arrears after the month for which a service has been provided. BHS Administrative Services Unit (ASU) will process claims (invoice) in accordance with the contract terms.

Budgets, Cost Reports and Supplemental Data Sheets and Claims (Invoices)
- Budgets, cost reports, supplemental data sheets, and claims (invoices) must comply with the established procedures.
- Year-end Cost report is due by August 31.
- Drug Medi-Cal (DMC) annual cost report is generally due November 1 following the end of the previous fiscal year.
- The State reconciles after receiving the year end cost report. This is an on-going process.

Submitting Claims (Invoice) for Services
Please submit all claims (invoice) for payment to:
Behavioral Health Services Contract Support, (BHSCS) (P531K)
P O Box 85524
San Diego, CA 92186-5524
Fax to: (619) 563-2730, Attn: Lead Fiscal Analyst
Email scanned copy to: ADS_Claims.HHSA@sdcounty.ca.gov

Overpayment
In the event of overpayments, excess funds must be returned or offset against future claim payments.
Certification on Disbarment or Exclusion
All claims for reimbursement submitted must contain a certification about staff freedom from federal disbarment, exclusion, suspension or ineligibility from services. For additional information on these requirements, refer to Section E: SUD Program Requirements.

Publicity, Announcements, and Materials
All public announcements and materials distributed to the community shall identify the County of San Diego as the funding source for contracted programs. Copies of publicity materials related to contracted programs shall be filed with the HHSA BHS SUD (Substance Use Disorder) unit.

Funding Restrictions
Programs shall not solicit or accept payments, contributions or donations from any business or organization primarily engaged in the manufacture, distribution or wholesale or retail sale of alcoholic beverages.

Hatch Act
Provider agrees to comply with the provisions of the Hatch Act (Title 5 USC, Sections 1501-1508), which limit the political activities of employees whose principal employment activities are funded in whole or in part with federal funds.

No Unlawful Use or Unlawful Use Messages Regarding Drugs
Provider agrees that information produced through these funds, and which pertains to drug and alcohol related programs, shall contain a clearly written statement that there shall be no unlawful use of drugs or alcohol associated with the program. Additionally, no aspect of a drug or alcohol related program shall include any message on the responsible use, if the use is unlawful, of drugs or alcohol (HSC Section 11999-11999.3). Provider agrees to enforce these requirements.

Limitation on Use of Funds for Promotion of Legalization of Controlled Substances
None of the funds made available through a County may be used by any activity that promotes the legalization of any drug or other substance included in Schedule I of Section 202 of the Controlled Substances Act (21 USC 812).

Restriction on Distribution of Sterile Needles
No Substance Abuse Block Grant (SABG) funds made available through a contract with the County shall be used to carry out any program that includes the distribution of sterile needles or syringes for the hypodermic injection of any illegal drug unless the State choose to implement a demonstration syringe services program for injecting drug users.

Restrictions on Salaries
No part of any federal funds provided under San Diego County contracts shall be used by providers or their subcontractors to pay the salary of an individual at a rate in excess of Level II of the Executive Schedule. Salary schedules may be found at https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/.

Restrictions on the Use of Federal Block Grant Funds
Pursuant to 42 U.S.C. 300x-31, Programs shall not use SABG Block Grant funds on the following activities:

- Provide inpatient services;
- Make cash payment to intended recipients of health services;
PROVIDER CONTRACTING

- Purchase or improve land, purchase, construct or permanently improve (other than minor remodeling) any building or other facility or purchase major medical equipment;
- Satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds;
- Provide financial assistance to any entity other than a public or nonprofit private entity;
- Pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of level I of the Executive Salary Schedule for the award year:
- Purchase treatment services and penal or correctional institutions in the State of California; and
- Supplant state funding of programs to prevent and treat substance abuse and related activities.

Payment of Last Resort
Contracted programs shall use SABG Block Grant funds as the “payment of last resort” and shall make every reasonable effort, including the establishment of systems for eligibility determination, billing, and collection, to:

- Collect reimbursement for the costs of providing such services to persons who are entitled to insurance benefits under the Social Security Act, including programs under title XVIII and title XIX, any State compensation program, any other public assistance program for medical expenses, any grant program, any private health insurance, or any other benefit program; and
- Secure from patients or clients payments for services in accordance with their ability to pay. [Note: Clients who are DMC eligible shall not be charged fees unless there is Share of Cost (SOC)].

Gift Card Usage
Gift cards may be used to directly benefit clients and program objectives (i.e. grocery store vouchers). Gift cards may not be used as an incentive for Drug Medi-Cal billed services (i.e. as prizes for opportunity drawings for group attendance).

Programs must comply with the following:

- Have adequate internal controls and procedures in place to mitigate misappropriation of Gift Cards
- Gift Cards maintained in a secured and locked environment accessible only to the designated Contractor employees
- Gift Cards are accounted for by receipts, tracking system, and follow the Contractor’s internal purchase policies
- Disbursement of Gift Cards are accounted for by a tracking system that indicates at a minimum:
  - Full name of the recipient
  - Amount of the Gift Card
  - Date disbursed
  - Two full signatures (one of which must be a Contractor employee). If both signatures are those of contract employees, one must be a supervisor.
- In the event Contractor discovers misappropriation of Gift Cards, Contractor must contact assigned BHS COR within one workday of the occurrence.
- Gift card purchase receipts, tracking log and internal polices shall be available to COR or Designee for review and inspection at any time
- Records to support the use of gift cards shall be available for in-depth review visits. Gift Cards that are not used or disbursed at the end of their original approved contract year must be justified and pre-approved (again) prior to being used in the next or any future contract years.
See Appendix F.2 for the Health and Human Services Agency – Behavioral Health Services Gift Cards Approval Form.

Cost Limitations
For each term period stated on the Signature page of the Contract:

- The parties estimate that performance of the Agreement will not cost the County more than the maximum Agreement amount specified in the Compensation clause of the Agreement Signature page.
- The Provider agrees to use their best efforts to perform the work specified and all obligations under the agreement within the maximum Agreement amount.

The Provider shall adhere to the requirements in their contract’s Exhibit C, C1 and C2. Provider shall notify the Contracting Officer Representative (COR) in writing whenever there is reason to believe:

- The costs the Providers expects to incur under the agreement in the next 60 days, when added to all costs previously incurred, will exceed 75% of the maximum Agreement term amount as specified in the Compensation clause of the Agreement Signature page, or
- The total cost for the performance of the Agreement will be either greater or substantially less than had been previously agreed to for that term.

As part of the notification, the Contractor shall provide the COR a revised estimate of the total cost of performing the Agreement for that term.

Unless otherwise stated in the agreement, the County is not obligated to reimburse the Provider for costs incurred in excess of the maximum Agreement amount specified in the Compensation clause of the Agreement Signature page.

The Provider is not obligated to continue performance under the Agreement (including actions under the Termination clause of the Agreement) or otherwise incur costs in excess of the maximum Agreement amount specified in the Compensation clause of the Agreement Signature page, until the COR notifies the Providers in writing that the maximum Agreement amount has been increased and provides a revised maximum Agreement amount of performing this Agreement.

No notice, communication, or representation in any form other than that specified in the contract, or from any person other than the COR, shall affect the contract's maximum Agreement amount to the County. In the absence of the specified notice, the County is not obligated to reimburse the Providers for any costs in excess of the maximum Agreement amount.

If the maximum Agreement amount is increased, any costs the Contractor incurs before the increase that are in excess of the previously maximum Agreement amount shall be allowable to the same extent as if they incurred afterward, unless the COR issues a termination or other notice directing that the increase is solely to cover termination or other specified expenses.

False Claims Act
All HHSA employees, contractors, and subcontractors, are required to report any suspected inappropriate activity. Suspected inappropriate activities include but are not limited to, acts, omissions or procedures that may be in violation of health care laws, regulations, or HHSA procedures. The following are examples of health care fraud:
• Billing for services not rendered or goods not provided
• Falsifying certificates of medical necessity and billing for services not medically necessary
• Billing separately for services that should be a single service
• Falsifying treatment plans or medical records to maximize payment
• Failing to report overpayments or credit balances
• Duplicate billing
• Unlawfully giving health care providers such as physicians’ inducements in exchange for referral services.

Any indication that any one of these activities is occurring should be reported immediately to the County of San Diego HHSA compliance hotline at 1-866-549-0004 to request information or report suspected inappropriate activities. This line directs the caller of the option to remain anonymous.

Drug Medi-Cal
Per Cost Reporting/Data Collection Manual the “policy of the State Agency is that reimbursement for Drug Medi-Cal services shall be limited to the lowest of published charges and actual costs”.

Definitions
• Provider means the program providing the SUD services. It is part of a legal entity on file with the State’s Department Health Care Services (DHCS).
• Published Charge or Published Rate is a “term used in CFR Title 42 to define provider cost reimbursement mechanisms from third party sources. This generally means that customary charges throughout the year should be as close to actual (cost) as possible to avoid a lesser of costs or charges audit exception circumstance.” Published rates for services provided by organizational providers must be updated at the beginning of each fiscal year to ensure the County’s MIS has the accurate information as well as ensuring no potential loss of Medi-Cal revenue. The published rate for a specific service should, at a minimum, reflect the total cost for providing that service to ensure no loss of Medi-Cal revenue. Published rates are to be submitted to BHS Contract Support Unit (CSU) NLT than August 1 of each year.
• Actual Cost is reasonable and allowable cost based on year-end cost reports and Medicare principles of reimbursement per 42 CFR Part 413 and HCFA Publication 15-1.
• Federal Financial Participation per Title 9 CCR Chapter 11 means the federal matching funds available for services provided to Medi-Cal beneficiaries under the Medi-Cal program.

Medi-Cal Billing to the State
For the most current information on Medi-Cal billing, refer to the County of San Diego Behavioral Health Services Drug Medi-Cal Organizational Providers Billing Manual. For Same Day Billing information, see Appendix F.3 – DMC ODS Same Day Billing Matrix.

Medi-Cal Revenue
For the most current information on Medi-Cal billing, refer to the County of San Diego Behavioral Health Services Drug Medi-Cal Organizational Providers Billing Manual.

Medi-Cal Disallowance/Recoupment
BHS is obligated to disallow SUD services for Medi-Cal reimbursement per the terms of the Intergovernmental Agreement between DHCS and the County. When standards are not met in
documentation of Medical Necessity, Treatment Plans, Progress Notes, Group Sign-In Sheets and other standards as described in the current version of the SUDURM, disallowance/recoupment occurs.

Organizational providers shall be responsible for ensuring that all medical records comply with federal, state and county documentation standards when billing for reimbursement of services. The Medi-Cal claims for the above circumstances will be deducted from contractors’ invoice and contract payment. In accordance with State guidelines, these disallowances may be subject to future change. Contractor shall reimburse BHS for any disallowance of DMC payments, and reimbursement shall be based on the disallowed units of service at the Contractor’s actual unit rate.

Billing Disallowances – Provider Self Report
The policy of San Diego County Behavioral Health Services Administration (SDCBHS) is to recoup costs by disallowing billing which has been identified and reported to the SDCBHS by the Contracted Organizational Providers in accordance with documentation standards as set forth in the current Substance Use Disorder Uniform Record Manual (SUDURM).

Procedures
The following are the procedures to be followed for Self-Reporting of Billing Disallowances to ensure consistent procedures are used when the information is reported to Behavioral Health Services Administration by providers.

Provider Requirements
1. Outpatient providers are required to conduct internal review of medical records on a regular basis (i.e. monthly) in order to ensure that the documentation meets all County, State and Federal standards and that billing is substantiated. Additionally, outpatient providers must participate in Quality Assurance Reviews (QAR) as described in Section G: Quality Management.
2. Residential providers are required to conduct internal review of medical records on a regular basis (i.e. monthly) in order to ensure that the documentation meets all County, State and Federal standards and that the billing is substantiated. Additionally, residential providers must participate in compliance reviews by QM staff as described in Section G: Quality Management.
3. If the review of a Drug Medi-Cal client’s chart results in a finding that the clinical documentation does not meet the documentation standards as set forth in the current SUDURM, the provider shall be responsible for addressing the issue by completing the payment recovery form with the adjustment reason. If there is any billing error found such as wrong time or procedure code, contact BHS Billing Unit via email or phone call 619-338-2385 for further instructions.
4. To file a self-report of billing disallowances request with the County of San Diego for voiding a claim item, providers shall fill out the Provider Drug Medi-Cal Payment Recovery Form (See Appendix F.4) Refer to the County of San Diego Behavioral Health Services Drug Medi-Cal Organizational Providers Billing Manual for form instructions.
5. Outpatient, residential, and OTP providers filing a self-report of billing disallowance from their own internal review, follow this process:
   - Submit the encrypted recovery form to both BHS QM staff and the BHS Billing Unit:
   - SUD QM: send report via secure email to QIMatters.HHSA@sdcounty.ca.gov or fax to 619-236-1953
• BHS Billing Unit: send report via secure email to
  [ADSBillingUnit.HHSA@sdcounty.ca.gov](mailto:ADSBillingUnit.HHSA@sdcounty.ca.gov) or fax to 619-236-1418

6. Providers reporting billing disallowances from QM related compliance reviews, such as QAR, MRR, TA, shall follow the same process outlined above.

7. Providers shall ensure that the claim item listed on the form as disallowances are noted correctly and do not contain errors. Items that are listed on the form incorrectly are the responsibility of the provider to correct. All disallowed services must be listed on the form exactly as they were billed.

8. For details on how to process disallowed services in SanWITS, please refer to the [County of San Diego Behavioral Health Services Drug Medi-Cal Organizational Providers Billing Manual](#).

9. All providers are required to review the DHCS Remittance Advice (RA) list of denied claims (Excel Claim Denial Report), sent by the BHS Billing Unit, to determine if the claims or the denial reasons are valid and track internally for cost reporting or claims reconciliation purposes.

**BHS Contract Support Procedures**

1. At a minimum annually, SUD QM conducts a medical record review. This review includes a report of findings regarding disallowances/recoupments for not meeting standards as described above. Programs are required to follow the process for disallowance/recoupment as described in the medical record review (MRR) report.

2. Contractors are expected to reflect the disallowed units (including self-report) in the next invoice if findings are made within the same fiscal year.

3. If findings are made after the fiscal year ends, Contractors that have been overpaid may elect to repay the recoupment via check or an offset from future payments.
   - If the contractor pays by check, the check is received by ASU staff and forwarded to Financial Management staff for deposit. The payment is logged in the contract file along with a copy of the payment.
   - If no check is received by ASU within 15 business days from the date of the letter to the Contractor; the recoupment amount is deducted from the next scheduled provider payment.

**Billing Inquiries**

Questions regarding claims (invoice) for payment should be directed in writing to:

BHS Contract Support (P531K)
PO Box 85524
San Diego, CA 92186-5524
Attn: Lead Fiscal Analyst

Note: Questions can also be addressed by calling the Contract Support Unit Fiscal Analyst

**Inventory Guidelines for County Contracts**

All Capital Assets/Equipment, Minor Equipment, and Consumable Supplies purchases shall be included in Cost Reimbursement contract budgets and shall be approved by the Contracting Officer’s Representative (COR) upon budget submission. The equipment and supplies shall directly benefit clients and program’s objectives.
County retains title to all non-expendable property provided to Contractor by County, or which Contractor may acquire with contract Agreement funds if payment is on a cost reimbursement basis, including property acquired by lease purchase Agreement. Internal Controls and Procedures below provide guidelines on handling Capital Assets and Minor Equipment.

Definitions

- **Capital Assets/Equipment:** Tangible non-expendable property that has been purchased with County funds and has a normal life expectancy of more than one year and a unit cost of $5,000 or more. Prior written approval from the COR is required for the acquisition of Capital Assets/Equipment. Examples of Capital Assets/Equipment include, but are not limited to building improvements, vehicles, machinery, furnaces, air conditioners, multifunction copy machines, furnishings, etc.

- **Minor Equipment:** Any non-consumable implement, tool, or device that has a useful life of more than one year and an acquisition amount of $100 to $4,999. Examples of Minor Equipment include, but are not limited to televisions, video recorders and players, computer monitors, therapy equipment, refrigerators, hand-held electronic devices, electronic games, modular furniture, desks, chairs, conference tables, etc.

- **Consumable Supplies:** Goods that have a useful life of one year or less and an acquisition value under $500. Examples of consumable supplies include, but are not limited to pens, pencils, paper, notepads, file folders, post-it notes, toner or ink cartridges, waiting room supplies, etc.

Internal Controls and Procedures

Contractors shall have the following internal controls and procedures in place for managing Capital Assets/Equipment and Minor Equipment, whether acquired in whole or in part with County funds, until disposition takes place:

1. Prior written approval from the COR is required for the acquisition of Capital Assets/Equipment through budget development requests or Administrative Adjustment Requests.
2. Contractors shall place County of San Diego Property tags on Capital Assets/Equipment and Minor Equipment to identify items purchased with County funds. These tags can be requested through the COR.
3. Contractors shall include the expenditure of Capital Assets/Equipment and Minor Equipment on the monthly invoice/cost report that immediately follows the acquisition.
4. Contractors shall maintain inventory records that include a description of the item, a serial number or other identification number (if applicable), the acquisition date, the acquisition cost, location of the item, condition of the item, program funding for the item, and any ultimate disposition data including the date of disposal.
5. Contractors shall submit an Inventory Report of Capital Assets/Equipment and Minor Equipment purchased using County funds at the end of each fiscal year. The inventory report is due to the COR no later than thirty (30) days after the end of the fiscal year. The COR will review the Inventory Report to determine if the information is reasonable and complete based on their knowledge of the contract and approval of invoices containing charges for equipment.
6. The Inventory Report is to include all Capital Assets/Equipment and Minor Equipment items purchased since inception of the cost reimbursement contract.
7. Inventory records on non-expendable equipment shall be retained and shall be made available to the County upon request, for at least three years following date of disposition.
8. Contractors may choose to utilize their own Inventory Report as long as the required information above is included. Otherwise, contractors can utilize the BHS Inventory Form.

9. Contractors shall include in the Inventory Report any items that were transferred from one County program to another and note the transfer date and program. A DPC 203 form shall be completed.

10. Contractors shall make all purchased items available to the COR (or their designee) for inspection at any time.

11. Contractors shall be responsible for accounting of all items purchased with County funds.

12. Contractors that are required to work with computers, laptops, portable devices or media that contain personal information relating to clients, patients and residents shall have a duty to protect this data from loss, theft or misuse (refer to Article 14 Information Privacy and Security Provisions in the contract). For all Electronic Property and Information Technology (IT) related items capable of storing information, regardless of acquisition price and useful life. Examples of Electronic Property and IT related items capable of storing information include, but are not limited to cellphones, laptops, tablets, USB memory devices, cameras, etc.

13. Contractors do not need to include in the Inventory Report consumable supplies valued under $500.

Disposition
- Contractors should not remove the items previously listed on their Inventory Report submitted to the County, unless the COR approved the salvage or transfer of those items, or a County Behavioral Health Services policy provided such instructions.
- Minor Equipment not meeting the requirement to be listed on the Inventory Report and Consumable Supplies does not need to be disposed through the County process.
- Non-expendable property that has value at the end of a contract (e.g. has not been depreciated so that its value is zero), and which the County may retain title, shall be disposed of at the end of the contract Agreement as follows:

At County's option, it may:
- Have Contractor deliver to another County contractor or have another County contractor pick up the non-expendable property;
- Allow the Contractor to retain the non-expendable property provided that the Contractor submits to the County a written statement in the format directed by the County of how the non-expendable property will be used for the public good; or
- Direct the Contractor to return to the County the non-expendable property.

Stolen, Damaged or Missing Equipment
- Contractor shall inform the COR in writing within 48 hours of any stolen, damaged or missing equipment purchased with County funds. Exception: Any lost or missing item that contains personal information shall be reported in writing to the COR within 24 hours. Article 14 Information Privacy and Security Provisions requirements shall be followed when appropriate.
- Contractor may be responsible for reimbursing the County for any stolen, damaged or missing equipment at the current book value of the asset.
Vehicles

- The preferred method for Contractor(s) to acquire vehicles is through a lease arrangement. If purchase is necessary, COR and County Management preapproval must be obtained. Vehicles shall be registered with the Contractor as the lien holder and registered owner. Whether vehicles are leased or purchased, Contractor shall maintain appropriate insurance on vehicles, follow maintenance schedule, as required by the automobile manufacturer. Vehicle(s) usage and insurance requirement language will be included/amended in the contract.

At contract termination, or when the original or replacement equipment/vehicle is no longer needed, or has become obsolete, or is inoperable and impractical to repair, a formal disposition process will be required (refer to BHS Property Transfer/Disposal Process). Contractors shall work with the COR, who will determine the final disposition of the item(s).

Inventory Disposition

1. Contact the COR before disposing of property purchased with County funds, and which the County may retain title under this paragraph, shall be disposed of at the end of the Contract Agreement as follows:

   At County’s option, it may:
   - Have contractor deliver to another County contractor or have another County contractor pick up the non-expendable property;
   - Allow the contractor to retain the non-expendable property provided that the contractor submits to the County a written statement in the format directed by the County of how the non-expendable property will be used for the public good;
   - Direct the Contractor to return to the County the non-expendable property.

2. BHS Property Inventory Form, (see Appendix F.5)

   - As the contractor disposes of equipment the following columns on the BHS Inventory form must be completed and a copy provided to the COR.
   - “Date of Disposition of Capital/Fixed Assets or Minor Equipment”: This is the actual date the item was delivered and accepted by County Salvage.
   - “Date form AUD253 completed”: This is the date the COR signs and returns AUD253 form to the contractor.

3. DPC 203 Transfer or Disposition of Minor Equipment Form(s) and Procedures

   NOTE: Procedure for Property Transfer to the County of San Diego – Property Disposal or Transfer to another contractor. For purposes of this section on disposal of minor equipment, “contractor” refers to the specific numbered County contract, and that contract’s County-owned property, not to the combined County-owned assets of multiple County contracts held by a parent organization/organizational provider. Both versions of form DPC 203 and the Mobile Devices SUPPLEMENTAL form can be:
   - Downloaded from links in the Technical Resource Library (TRL);
   - Provided to the contractor by BHS staff; or
BHS Contract Support administrators will keep an internal record of any County-owned property and conduct an inventory of all County-owned property during selected site visits.

There are three distinct transfer/disposition procedures in place for minor equipment. These are for disposal of Non-IT items that do not have memory, IT items containing memory, and Mobile Devices. All minor equipment salvage requests are to be completed by the contractor on the appropriate version of the DPC 203 form and forwarded to their Contracting Officer’s Representative (COR) who will review, approve, sign and forward the DPC 203 form to the appropriate County staff. Once processed and approved by BHS and/or the Department of Purchasing and Contracting (DPC), the COR will notify the contractor of further steps. All DPC 203 forms must include the program name, contract number, COR name, address (with Zip Code) identifying the physical location of the items, and full site contact information including name, phone number and email. Directions for transfers between contracts are included below for each procedure. A new fillable .pdf version of the basic DPC 203 (DPC 203 Fillable) is now available for use for Non-IT and IT disposal. There is not a fillable .pdf version or the DPC 203 Mobile Devices SUPPLEMENTAL; both Excel files are still in use for Mobile Devices. Contractors are not to make changes to the DPC 203 forms, including changing pre-filled wording or making any entries in the forms’ boxes #7 through #16. Non-IT equipment, IT equipment and Mobile Devices cannot be listed on the same DPC 203 form. Flowcharts for the three procedures are also located in the TRL and the Optum Website. (See Appendix F.6, Appendix F.7, and Appendix F.8 for the DPC 203 forms, and Appendix F.9 for the DPC 203 Flowcharts).

a. Non-IT Disposal Requests (furniture, office equipment without memory: printers, most copiers, non-memory-containing computer accessories [computer monitors, keyboards, and mice], routers, docking stations, wireless access points, DVD players, etc.)
   - Requests are to be completed on the DPC 203 Fillable .pdf form, checking the Non-IT box, and sent to the COR for review, approval, electronic signature and forwarding.
   - Non-IT requests require the condition of the items to be noted and must be accompanied by photos in .jpg format, preferably with items grouped but individually identifiable in the photos.
   - Once DPC’s approval is final, the COR will provide the program with the approved DPC 203 form (with a Control No.) and directions for delivery by the program, per pre-scheduled appointment, accompanied by the approved DPC 203 form, to the County’s disposal contractor. Contractors are to retain the disposal contractor’s proof of delivery and forward the documentation to the COR.
   - [Transfers of Non-IT items between contracts/programs require the sending program to complete the DPC 203 Fillable, entering both the sending and receiving programs’ names, contract numbers, COR names, current and future addresses of property, the site contact names, phone numbers and email addresses, and forward to the sending COR. The sending COR reviews, approves, electronically signs the form, and secures the receiving COR’s approval and electronic signature (if different). The COR then forwards the approved form to BHS staff for further processing. Transfers of Non-IT items do not require photos or condition.]
b. IT Disposal Requests (those items with memory: computers, laptops, notebooks, servers, zip drives, higher-end copiers with memory, etc.)

- Requests are to be completed on the DPC 203 Fillable form, checking the IT box, and then sent to the COR for review, approval, electronic signature and forwarding. The DPC 203 Fillable form includes a section for Wipe Certification for use with IT disposals. (HHSA only recognizes Department of Defense (DOD) level wiping done by its approved IT Wipe Vendor.)
- For IT items, the serial numbers must be provided, using the “Serial No./Listing No.” column. Contractors list type, make and model of items in the “DESCRIPTION” column. Pictures and condition are not required for IT items. IT items must be physically located at the address provided on the DPC 203 and retained at that site for pick up.
- Following receipt of the disposal form with COR approval, the contractor will be contacted by HHSA IT’s Wipe Vendor (currently Perspecta), to arrange for pick up for disposal. (Include the power cords for all types of computers at point of pick-up. Note the physical location of the serial number on each unit, as the Wipe Vendor must verify serial numbers as a condition for pick up).
- Once the equipment is picked up, the contractor will send a copy of the DPC 203 form with the completed wipe pick-up confirmation to the COR.
- [Transfers of IT items between contracts/programs following DOD wiping, require the sending program to complete the DPC 203 Fillable, entering both the sending and receiving programs’ names, contract numbers, COR names, current and future addresses of property, the site contact names, phone numbers and email addresses, and forward to the sending COR. The sending COR reviews, approves, electronically signs the form and secures the receiving COR’s approval and electronic signature (if different), and forwards the DPC 203 form to BHS staff. BHS staff then arrange for HHSA IT’s Wipe Vendor to pick up the items, do the DOD wipe, and return the wiped items to the contractor at the pick-up location. The contractor secures the DOD Wipe Vendor’s signature on the DPC 203 at point of pick up (first box of Wipe Certification) and again when wiped items are returned (second box of Wipe Certification). Following DOD wiping, the sending program sends the COR the DPC 203 with both sections of the Wipe Certification completed. The sending and receiving programs then coordinate transfer of wiped equipment. Contractors should discuss situations with their CORs when the wiping requirement may potentially be waived, for example certain same provider re-procured (rollover) contracts, or when a new provider will be serving the identical client base and providing identical services. In these situations, a wipe waiver, obtained by the COR from HHSA Compliance Office, is required.]

c. Mobile Devices Disposal Requests (cell phones, flip phones, smart phones, hotspots, Wi-Fi cards, tablets, etc.)

- Requests are to be completed using two Excel format DPC 203 forms, the DPC Mobile Devices and the Mobile Devices SUPPLEMENTAL, and sent to the COR for review, approval, signature and forwarding.
- The Mobile Devices DPC 203 looks similar to the DPC 203 Fillable form but has the notation “Please See Attached Supplemental Form for List of Mobile Devices” instead.
of a list of items. The “Initiating Department Remarks” section is to be completed with full contract and contact information, and the total number of devices entered in the “ITEM QUANTITY” column.

- The DPC 203 Mobile Devices SUPPLEMENTAL form is to be completed, listing individual items by brand, model and type, providing serial numbers (NOT model numbers) and passwords for unlocking items, and indicating “N” (for No) in the “GRANT FUNDED” column. (While the DPC 203 Mobile Devices form may be scanned and forwarded with the COR’s signature as a .pdf file, the DPC 203 SUPPLEMENTAL must be submitted in its Excel file format to meet a technical requirement of the Mobile Devices Salvaging Vendor.)

- This salvage process requires a group photo, in .jpg format, of the listed Mobile Devices, and results in a FedEx-generated email which must be forwarded by the COR to the contractor along with the approved DPC 203. The Fed-Ex-generated email includes a live link to print a shipping label that must be opened only by the contractor, who then opens the link, prints the shipping label, attaches it to the package of devices, encloses a copy of the approved DPC 203 Mobile Devices form with the Control No. in the package, writes the Control No. on the outside of the package, and takes the package to the FedEx outlet for shipping to the County’s Mobile Devices Salvaging Vendor.

- NOTE: DPC requires that all Mobile Devices be reset to their factory default setting prior to shipping.

- [Transfers of Mobile Devices are limited to situations where: either the provider, program and services remain the same and only the contract number changes; or where a new provider will be assuming identical services for an identical client population. For Mobile Device transfers where a provider has changed, a wipe waiver must be secured by the COR from the HHSA Compliance Office before the devices can be made available to the new provider.]

4. Electronic Property/IT

- Contractors Inventory Minimum Guidelines on A Cost Reimbursement and Fixed PRICE Contract

- Inventory responsibility includes these minimum guidelines for the security of client information and portable electronic and data storage devices. This responsibility exists whether the information is in paper or electronic form. Additionally, all Contractor employees have the duty to protect any County assets assigned to them or in their possession, including desktop computers, portable devices and portable media.

Definitions

- Client Data: Any identifying information relating to any individual receiving services from any program.

- Portable Devices: Tools such as laptops, external hard drive, PDAs, cell phones, Tablet PCs, other USB memory devices and cameras (digital, non-digital, and video).

- Portable Media: Any tool used to transport information any distance such as CDs, DVDs, USB memory sticks, flash drives or smart cards.
Minimum Guidelines

All Contractors’ executives shall be responsible for maintaining a current inventory of all portable devices and portable media in their program.

- All Contractors’ electronic devices shall be password protected.
- All electronic provider files containing DHCS PHI or PI and stored on removable media or portable devices shall be encrypted with a FIPS 140-2 certified algorithm.
- Portable devices or portable media shall not be used for routine storage of client data.
- For any privacy incident (e.g., lost or stolen laptop, client files/records accessed, etc.) refer to Serious Incident Reporting procedures in Section G of this manual.
G. QUALITY MANAGEMENT

Quality assurance and monitoring constitutes the processes by which the County will ensure improvement and high quality of care provided to clients. The County of San Diego’s quality assurance and monitoring will adhere to the larger framework established by the County of San Diego Behavioral Health Services with DHCS DMC-ODS and EQRO oversight. The processes by which the County will perform involve ensuring compliance of regulations set forth by governmental and/or administrative entities. Essentially, the goal of quality assurance is to assess and evaluate quality of services, recognize and address issues with service delivery, construct plans of action to overcome issues and maintain quality improvement, continuing to follow-up and monitor that plans of action meet their anticipated objectives.

The County of San Diego is committed to providing high quality substance use disorder services that are client-centered, clinically effective, accessible, integrated, outcome-driven, and culturally competent. In order to achieve the goal, each program in the system must have internal quality improvement controls and activities in addition to those provided by the County of San Diego. These activities may involve peer review, program manager monitoring of charts and billing activity, and/or a formal Quality Improvement department or position, which offers training and technical assistance to program staff. Internal monitoring and auditing are to include the provision of prompt responses to detected problems. Staff shall participate in activities that promote quality assurance and quality improvement and bring concerns regarding possible deficiencies or errors in the quality of care, treatment or services provided to clients to the attention of those who can properly assess and resolve the concern.

Each program shall develop written policies and procedures regarding internal quality assurance and improvement controls and activities, and maintain internal systems of controls and monitoring to ensure that all aspects of the program including, but not limited to, personnel files, client files, billing and fiscal, data, and programming are in compliance with the contract and maintain the highest possible standards.

Programs shall conduct an internal review and evaluation at least once every fiscal year as it relates to the statement of work. Results of the review and any plans for correction shall be available for review by the County of San Diego.

In addition, all provider programs are required to attend regular Program Manager Meetings, quarterly Leadership Plus meetings, QM In-Service, Documentation trainings and other behavioral health meetings as required. Attendance at these meetings is essential to keep abreast of system changes and requirements as part of our continuous improvement efforts. Since communication is vital to ongoing quality improvement, programs are also required to read and disseminate information that is provided by the County of San Diego, including (but not limited to) materials such as the BHS QM monthly newsletter, “Up to the Minute” (UTTM) as these communications are relied upon as mechanisms for sharing updated information from DHCS, form revisions, and other important announcements related to providing quality SUD services within the County.

The quality of the SUD system of care and service delivery system is ensured by continually evaluating important aspects of care and service, using reliable, consistent, and valid measurements, with the goal of maximizing each program’s effectiveness. The basis of this evaluation process rests in State and Federal legislation and regulations including:

- 42 CFR, (Code of Federal Regulations)
- Title 22 of the California Code of Regulations
- State Department of Health Care Services (DHCS) Letters and Notices,
The Intergovernmental Agreement between DHCS and the County of San Diego, and
The Special Terms and Conditions (STCs) of the DMC-ODS Waiver

**Quality Improvement Plan**

The purpose of the County of San Diego’s BHS Quality Improvement (QI) Program is to ensure that all clients and families receive the highest quality and most cost-effective mental health, substance use, and administrative services available.

The QI Program delineates the structures and processes that will be used to monitor and evaluate the quality of mental health and substance abuse services provided. The QI Program encomases the efforts of clients, family members, clinicians, behavioral health advocates, substance abuse treatment programs, quality improvement personnel, and other stakeholders.

The QI Program and QI Work Plan (QIWP) are based on the following values:

- Development of QI Program and QIWP objectives is completed in collaboration with clients and stakeholders.
- Client feedback is incorporated into the QI Program and QIWP objectives.
- QI Program and QIWP are mindful of those whom data represent and, therefore, integrate client feedback to improve systems and services.

The QI Unit monitors the services provided for safety, effectiveness, responsiveness to clients, timeliness, efficiency, and equity. Key variables related to practices and processes performed or delivered by service providers that affect the outcome of services to client and family members are measured and analyzed on a weekly, quarterly, or annual basis. QI staff perform client record reviews and work with contracted providers on continuous improvement activities. Access times, serious incidents, and grievances are tracked and trended. Surveys are conducted to monitor client and provider satisfaction.

**Monitoring**

SUD programs are monitored by DHCS for Substance Abuse Block Grant (SABG) and DMC compliance and by the County of San Diego for these and additional standards, such as the DMC-ODS STCs. For the audit, evaluation, or inspection purposes, all providers shall make available their premises, physical facilities, equipment, books, record, contracts, computer and other electronic systems related to their Medi-Cal clients. All programs shall comply with requirements established within the State of California and DHCS standards, and the County of San Diego shall utilize their requirements to monitor program compliance and provision of services.

DHCS, CMS, the Office of the Inspector General, the Comptroller General, the County, and their designees may, at any time, inspect and audit any records or documents, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related services (i.e. Drug Medi-Cal) are conducted. The right to audit exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. Therefore, contracted providers are to retain medical records for no less than ten (10) years after discharge date for adults. For minors, records are to be kept until they have reached the age of 18, plus seven (7) years. This includes beneficiary grievance and appeal records in 42 CFR §438.416, and the data, information, and documentation specified in 42 CFR §§438.604, 438.606, 438.608, and 438.610.

**Cultural Competence Requirement Monitoring**

Providers are expected to provide services that are suitable for and sensitive to clients’ cultural, developmental, and linguistic needs. Providers are required to adhere to the National Standards for
Culturally and Linguistically Appropriate Services (CLAS) and shall implement policies and procedures to ensure that all methods utilized, and services provided are in line with this expectation. In order to provide appropriate and adequate services, it is vital that Providers ensure that these values are ingrained in the structural and daily practices of their organization. The County of San Diego’s QI Unit and CORs are responsible for monitoring and evaluating compliance with cultural competence standards as outlined in the County’s Cultural Competence Plan and with State and Federal requirements. (Refer to Staff Development and Training in Section 4: SUD Program Requirements for the Cultural Competence Plan, Annual Program Evaluation, and Staffing requirements that are monitored).

Provider Selection
Selection and monitoring of organizational agencies is governed by contracting procedures, which require a review of the organization’s fiscal soundness, resumes of principal administrators and supervisors, the agency’s experience with similar services, proposed program design, outcomes, staffing plan and budget. All contracted providers are expected to adhere to contractual requirements which are routinely monitored by BHS.

Contractor Orientation
Once providers are contracted with BHS, they will receive a contractor orientation to review all contract requirements. Providers will also have assigned to their program a designated Program Monitor (also known as Contracting Officer’s Representative - COR) to assist with all questions related to contract compliance.

Program Monitoring
At the beginning of each Fiscal Year a risk assessment is conducted for each program and a monitoring plan is developed based on the risk level determined. The designated COR monitors compliance with outcome measures, productivity requirements and other performance indicators, analyzes reports from providers, and provides programmatic review for budgets and budget variances in accordance with contract terms and conditions. Program monitors/CORs hold regular providers meeting to keep providers informed on the System of Care. All provider contract questions should be directed to the assigned Program Monitor/COR.

An additional note: Contractor’s Program Manager shall be available during regular business hours and respond to the Program Monitor/COR or designee within 2 business days. Contractor shall have the technological capability to communicate, interface and comply with all County requirements electronically using compatible systems, hardware and software

Notification in Writing of Status Changes
Providers are required to notify BHS Contract Support, (BHSCS) COR and QM in writing if any of the following changes occurs:

- Change in office address, phone number or fax;
- Addition or deletion of a program site;
- Change of tax ID number or check payable name (only to BHSCS);
- Additions or deletions from your roster of Medi-Cal billing personnel (BHSCS & MIS); or
- Proposed change in Program Manager or Head of Service.

Site Visits
The County of San Diego will conduct, at a minimum, annual site visits to all organizational providers from various County HHSA departments. Site visits include BHS Program Monitor/COR/Designee, BHS Administrative Services Unit, BHS Quality Management (QM) Unit, and the Health and Human Services Agency (HHSA) Contract Support Unit. All site visits are part of the contract monitoring process.
The site visit may include, but is not limited to, a review of:

- Compliance with contractual statement of work;
- Review of client files for compliance with:
  - Documentation Standards
  - ASAM principles
  - Evidence Based Practice requirements
  - Substantiation of medical necessity
  - Care coordination and case management activities
- Building and safety issues;
- Staff turnover rates;
- Insurance, licensure, NPI, and certification validation;
- Fiscal and accounting policies and procedures (including Policies on preventing Fraud, Waste and Abuse and paid claims verification);
- Beneficiary informing materials requirement;
- Compliance with DHCS required processes for credentialing/re-credentialing
- Compliance with standard terms and conditions.

Also, to ensure program compliance with confidentiality procedures and protocols, SUD QM will monitor the following as part of site visits:

- Program written confidentiality policy and procedures
- Workforce member initial and renewed, signed Confidentiality Agreement
- Workforce member Confidentiality Training and/or communication of updated Confidentiality Laws and/or Regulations
- Client consent/authorizations/release of information forms (content and signatures)

Additionally, BHS Program Monitor/COR/Designee and BHS Quality Management Unit will monitor for compliance with the Minimum Quality Drug Treatment Standards for DMC and SABG. These standards are required in addition to CCR Title 9 and 22 regulations for all SUD treatment programs either partially or fully funded through DMC and/or SABG. If conflict between regulations and standards occurs, the most restrictive shall apply. These standards include the following:

**A. Personnel Policies**

1. Personnel files shall be maintained on all employees and volunteers/interns and shall contain the following:
   a) Application for employment and/or resume;
   b) Signed employment confirmation statement/duty statement;
   c) Job description;
   d) Performance evaluations;
   e) Health records/status as required by program or Title 9;
   f) Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries);
   g) Training documentation relative to substance use disorders and treatment;
   h) Current registration, certification, intern status, or licensure;
   i) Proof of continuing education required by licensing or certifying agency and program; and
   j) Program Code of Conduct and for registered/certified SUD counselors, a copy of the certifying/licensing body’s code of conduct as well.
2. Job descriptions shall be developed, revised as needed, and approved by the Program’s governing body. The job descriptions shall include:
   a) Position title and classification;
   b) Duties and responsibilities;
   c) Lines of supervision; and
   d) Education, training, work experience, and other qualifications for the position.

3. Written code of conduct for employees and volunteers/interns shall be established which addresses at least the following:
   a) Use of drugs and/or alcohol;
   b) Prohibition of social/business relationship with beneficiary’s or their family members for personal gain;
   c) Prohibition of sexual contact with beneficiary’s;
   d) Conflict of interest;
   e) Providing services beyond scope;
   f) Discrimination against beneficiary’s or staff;
   g) Verbally, physically, or sexually harassing, threatening, or abusing beneficiary’s, family members or other staff;
   h) Protection beneficiary confidentiality;
   i) The elements found in the code of conduct(s) for the certifying organization(s) the program’s counselors are certified under; and
   j) Cooperate with complaint investigations.

4. If a program utilizes the services of volunteers and or interns, procedures shall be implemented which address:
   a) Recruitment;
   b) Screening;
   c) Selection;
   d) Training and orientation;
   e) Duties and assignments;
   f) Scope of practice;
   g) Supervision;
   h) Evaluation; and
   i) Protection of beneficiary confidentiality.

Written roles and responsibilities and a code of conduct for the medical director shall be clearly documented, signed and dated by a program representative and physician.

B. Program Management

1. Admission or Readmission

   a) Each program shall include in its policies and procedures written admission and readmission criteria for determining beneficiary’s eligibility and suitability for treatment. These criteria shall include, at minimum:
      i. DSM diagnosis;
      ii. Use of alcohol/drugs of abuse;
      iii. Physical health status;
      iv. Documentation of social and psychological problems;
      v. Level of Care determination
b) If a potential beneficiary does not meet the admission criteria, the beneficiary shall be referred to an appropriate service provider.

c) If a beneficiary is admitted to treatment, a consent to treatment form shall be signed by the beneficiary.

d) The Medical Director or LPHA shall document separately from the treatment plan the basis for the diagnosis in the beneficiary's record within timelines specified for the respective treatment modality (i.e. Within 30 calendar days of admission to outpatient services or within 10 calendar days of admission to residential services, for example.) The basis for the diagnosis shall be a narrative summary based on DSM-5 criteria, demonstrating the Medical Director or LPHA evaluated each beneficiary’s assessment and intake information, including their personal, medical, and substance use history. The Medical Director or LPHA shall type or legibly print their name, and sign and date the diagnosis narrative documentation. The signature shall be adjacent to the typed or legibly printed name.

e) All referrals made by program staff shall be documented in the beneficiary record.

f) Copies of the following documents shall be provided to the beneficiary upon admission:
   i. Beneficiary rights share of cost if applicable, notification of DMC funding accepted as payment in full, and consent to treatment.

   g) Copies of the following shall be provided to the beneficiary or posted in a prominent place accessible to all beneficiaries:
      i. A statement of nondiscrimination by race, religion, sex, ethnicity, age, disability, sexual preference, and ability to pay, if the client meets the County’s eligibility population requirements;
      ii. Grievance process and procedures;
      iii. Appeal process for involuntary discharge; and
      iv. Program rules, expectations and regulations.
      v. Notice of Privacy Practices

   h) Where drug screening by urinalysis is deemed medically appropriate the program shall:
      i. Establish procedures which protect against the falsification and/or contamination of any urine sample; and
      ii. Document urinalysis results in the beneficiary’s file.

2. Treatment
   a) Assessment for all beneficiaries shall include:
      i. Drug/Alcohol use history;
      ii. Medical history;
      iii. Family history;
      iv. Psychiatric/psychological history;
      v. Social/recreational history;
      vi. Financial status/history;
      vii. Educational history;
      viii. Employment history;
      ix. Criminal history, legal status; and
x. Previous SUD treatment history.

b) Treatment plans shall be developed with the beneficiary and include:
   i. A problem statement for all problems identified through the assessment whether addressed or deferred;
   ii. Goals to address each problem statement (unless deferred);
   iii. Action steps to meet the goals that include who is responsible for the action and the target date for completion;
   iv. Typed or legibly printed name, signature, and date of signature of primary counselor, beneficiary, and medical director or LPHA;
   v. All treatment plans shall be reviewed in accordance with CCR Title 22 requirements and updated to accurately reflect the beneficiary’s progress or lack of progress in treatment.

c) Progress notes shall document the beneficiary’s progress toward completion of activities and achievement of goals on the treatment plan.

d) Discharge documentation shall be in accordance with CCR Title 22 51341.
   i. A copy of the discharge plan shall be given to the beneficiary.

Monthly/Quarterly Status Reports
Programs shall be responsible for data collection and completion of the Monthly or Quarterly Status Report (MSR/QSR). Due date for submission shall be directed by the program COR. All sections of the report must be completed. In addition to outcome measures and compliance, programs that provide SUD treatment are required to report Charitable Choice referrals and specific staff licensure/certifications.

Quality Assurance Review (QAR)
The State can decertify a provider who fails to comply with certain DMC requirements or for fraud or failure to take corrective actions as ordered by the State. The QAR process was put in place as a mechanism to avoid potential State disallowances and provider decertification.

The reviews consist of QM staff facilitated reviews on site at each provider location and self-reviews conducted by providers. The review assesses provider compliance with DMC Standards specified in Title 22 of the Californian Code of Regulations, including service timelines and quality of services. Any provider not meeting Title 22 Standards is directed to take corrective action.

Quality Assurance Review (QAR) – QM Reviews
Providers will be assessed and identified with a risk-rating based on compliance and disallowance rates with prior reviews. This risk rating will determine the frequency of QAR conducted by QM staff as well as number of charts reviewed.

- High – Newly certified or disallowance and/or compliance rates are greater than 35%
  - Frequency - Monthly
  - Charts – Between 10-15 (depending on size)
- Medium – Disallowance and/or compliance rates are between 10-35%
  - Frequency - Bimonthly
  - Charts – Between 15-20 (depending on size)
- Low – Disallowance and/or compliance rates are less than 10%
Quality Assurance Review (QAR) - Provider Self-Reviews

Programs shall conduct monthly QAR. Client names will be selected by QM staff and provided to each program by the 1st of every month. Programs shall complete the tool, billing summary and attestation form, and submit to QM for review by the 20th of each month. Any tools missing information will be returned to the program for correction.

QAR Results and Billing Corrections

Results from both reviews shall be returned to each provider within 14 days. If applicable, billing corrections are due to QM within 14 days of receiving the results. For more information on the billing correction process, see Provider Requirements in section F.

Client Chart/Medical Record Review – SUD Residential

SUD Residential programs do not currently participate in the QAR process. BHS SUD QM Specialists are assigned to provide ongoing monitoring and technical assistance to SUD Residential programs in the DMC-ODS. Monitoring activities include on-site discussions or TA on documentation standards, chart reviews for documentation standard compliance, billing reviews to assure all services are billable per regulation, and clinical chart review for adherence to ASAM principles and Evidence Based Practices. SUD QM will work with residential programs regularly to meet program specific needs.

Medication Monitoring

The County of San Diego Quality Management Unit will also conduct annual program site reviews and results will be forwarded to appropriate program COR’s. The annual program compliance site review will include a medication monitoring component, as applicable. Program’s policies, procedures and practices will be evaluated and reviewed to ensure proper compliance with State and Federal regulations regarding prescription medication storage, handling, disposal and dispensing; maintenance of a current Drug Diversion Control Plan; and documentation of initial and on-going staff training relevant to Medication Assisted Treatment (MAT), if applicable. Any areas of concern will be reviewed and may result in issuing program corrective action and resolution.

Prescribers are required to report dispensing of Schedule II-V drugs to the CURES 2.0 database within one working day. The prescriber must consult the patient activity report obtained from the CURES 2.0 database to review a patient’s controlled substance history for the past 12 months before prescribing a Schedule II, III, or IV controlled substance to the patient for the first time and at least every 4 months thereafter if the prescriber renews the prescription and the substance remains part of the treatment of the patient.

State and County regulations require all organizational providers with programs prescribing medication in the course of their services to have a medication monitoring system. Out of County Providers shall adhere to their own County’s Medication Monitoring process.

OTP/NTP services and regulatory requirements shall be provided in accordance with Title 9, Chapter 4.

The provider shall implement mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs. The IA requires all counties to have a medication monitoring process (Reference: IA Exhibit A, Attachment I A1 Program Specifications, Quality Management Program and Requirement for Services).
The primary purpose of medication monitoring is to ensure the most effective treatment. Areas monitored include:

- Medication rationale and dosage consistent with community standards
- Appropriate labs
- Consideration of physical health conditions
- Effectiveness of medication(s) prescribed
- Adverse drug reactions and/or side effects
- Evidence of signed informed consent
- Client adherence with prescribed medication and usage
- Client medication education and degree of client knowledge regarding management of medications.
- Adherence to state laws and guidelines

Within the County of San Diego BHS system of care, programs are required to review one percent (1 %) of their active medication caseload each quarter, with a minimum of one chart reviewed. Closed cases, cases in which the client has not returned for recent services and clients that are not receiving medication are not to be reviewed. The sample shall include representation from all physicians who prescribe.

The Medication Monitoring Committee may be comprised of two or more representatives from different disciplines but at least one of the members must be a physician. Physicians may not review their own prescribing practices. It is the program's responsibility to assure that there is another physician to review the charts. The Medication Monitoring Committee function shall be under the supervision of a person licensed to prescribe or dispense prescription drugs.

Contracted providers are required to perform the first-level screening of medication monitoring for their facility. Programs will use the Medication Monitoring Report, Medication Monitoring Screening tool and the Medication Monitoring Feedback Loop (McFloop) for their screening. If a variance is found in medication practices, a McFloop form is completed, given to the physician for action, and then returned to the Medication Monitoring Committee for approval.

**QI Medication Monitoring Report**

- Address all applicable prompts on the form, for example program name, date, contract, DMC ID, quarter.
- Under the Description of Activities Section, all fields must be completed.
- Enter a number for the deficiencies for each no answer found on the tool.

**QI Report Instructions**

Deficiencies are when questions on the tool are answered with a "No". Deficiencies or "No's" are totaled by type of variance. For example, if you reviewed 10 charts, and one chart had a variance for variance #2, then a "1" would be entered in the variance 2 box. If three charts had a variance for variance #6, then a "3" would be entered in variance 6 box. Keep in mind when filling out the forms

- Email/fax the Medication Monitoring Report to SUD QM.
- Do not submit your Medication Monitoring tools or approved McFloop forms. Keep these forms on file at your clinic.
- If you have any unapproved McFloop forms, send in by secure email or by fax (619-236- 1953)
as they contain PHI.

- At the time of your Medical Record Review, QM Specialists will review your medication monitoring submissions for the last quarter, if the submission falls into the quarterly submission time.

Results of medication monitoring activities are reported quarterly to the QM unit by the 15th of each month following the end of each quarter (First quarter due October 15, second quarter due January 15, third quarter due April 15 and fourth quarter due July 15). All programs shall have a procedure in place to ensure the following:

- Signed and updated consents are completed and filed in the hybrid record in a timely manner.
- Labs are ordered and those results are returned in a timely manner. Programs shall ensure that lab results have been reviewed and filed in the hybrid record in a timely manner.
- Ensure there is enough follow up with clients/family members in keeping their appointments for labs.

The QM Unit evaluates the reports from the providers for trends, compiling a summary report submitted to the Quality Review Council (QRC), Program Monitor/COR, and the Pharmacy and Therapeutics Standards and Oversight Committee (P&T) quarterly. If a problematic variance trend is noted, the report is forwarded to the Assistant Clinical Director for recommendations for remediation. Programs with severe or recurrent problems will have additional reviews and/or recommendations for a quality improvement plan.

Note: Medication Monitoring process requires that a staff physician not review their own charts. For programs that have only 1 doctor. Contact your COR for approval to have the staff physician review their own chart. CC QI Matters to coordinate CORS approval.

Program Integrity Process and Monitoring
It is recommended that programs have an Internal Compliance Program that:

- Is commensurate with the size and scope of their agency. Further, contractors with more than $250,000 annually in agreements with the County must have a Compliance Program that meets the 42 CFR guidelines:
  - Development of a Code of Conduct and Compliance Standards.
  - Assignment of a Compliance Officer, who oversees and monitors implementation of the compliance program.
  - Design of a Communication Plan, including a Compliance Hotline, which allows workforce members to raise grievances and concerns about compliance issues without fear of retribution.
  - Creation and implementation of Training and Education for workforce members regarding compliance requirements, reporting, and procedures.
  - Development and monitoring of Auditing Systems to detect and prevent compliance issues
  - Creation of Discipline Processes to enforce the program.
  - Development of Response and Prevention mechanisms to respond to, investigate, and implement corrective action regarding compliance issues.

- All Programs, regardless of size and scope, shall have processes in place to ensure at the least the
following standards:

- Staff shall have proper credentials, experience, and expertise to provide client services.
- Staff shall document client encounters in accordance with funding source requirements and County of San Diego Health and Human Services policies and procedures.
- Staff shall bill client services accurately, timely, and in compliance with all applicable regulations and HHSA policies and procedures.

- Also, all programs shall have processes for:
  - Staff to promptly elevate concerns regarding possible deficiencies or errors in the quality of care, client services, or client billing.
  - And for Staff to act promptly to correct problems if errors in claims or billings are discovered.

- Program Reporting of Fraud, Waste and Abuse
  - Concerns about ethical, legal, and billing issues, (or of suspected incidents of fraud, waste and/or abuse) should be reported directly to the HHSA Agency and Compliance Office (abbreviated ACO) by phone at 619-338-2807, or by email at Compliance.HHSA@sdcounty.ca.gov.
  - Or you may report to the Compliance Hotline at 866-549-0004
  - Additionally, contact your program COR immediately, as well as the SUD QM team at QIMatters.HHSA@sdcounty.ca.gov to report any of these same concerns, or suspected incidents of fraud, waste, and/or abuse.

- Paid Claims Verification - Verification of paid claims is an important means of monitoring for instances of fraud, waste and/or abuse. The County requires that each program develop a P & P on Paid Claims Verification – which is how programs will verify whether services reimbursed by Drug Medi-Cal were actually provided to clients.
  - Programs must submit their Policy and Procedure for Paid Service Verification to BHS SUD QM. These are filed to help assist with monitoring activities.

- Monitoring:
  - Programs are expected to conduct their own regular program integrity activities and to maintain records for QM audit purposes.
  - The BHS SUD QM team will run reports regularly on random samples of clients, comparing billing entered to supporting documentation in the system (such as ASAM risk ratings/levels of care determinations). This will help to identify any potential issues (such as data entry errors, any obvious discrepancies between LOC documentation and services provided, etc.) so that the SUD QM team will be able to provide ongoing technical assistance to programs.
  - The BHS QI team will provide tip sheets for programs to run regular SanWITS reports to help with their own internal monitoring processes.
Department of Health Care Services (DHCS) Reviews

There are three divisions within DHCS related to SUD services:

- SUD Compliance - responsible for licensing and certification
- SUD Performance Management - responsible for Post Service/Post Payment (PSPP) reviews, Post Service/Pre-Payment (PSPP), and annual contract monitoring of the County of San Diego.
- Audits and Investigations

The mission of Audits and Investigations (A&I) is to ensure the fiscal integrity of the health programs administered by the Department of Health Care Services (DHCS) and ensure quality of care provided to the beneficiaries of these programs. The overall goal of A&I is to improve the efficiency, economy, and the effectiveness of DHCS and the programs it administers. To carry out its mission A&I will:

- Perform special audits as needed by DHCS program managers, executive staff, California Health and Human Services Agency (CHHS), or the Governor's Office.
- Perform internal audits of DHCS organizations to ensure that various internal controls are operating and effective.
- Perform medical reviews of Medi-Cal and public health providers.
- Provide technical assistance (financial and medical) in the development and expansion of the Managed Care program.
- Identify and investigate Medi-Cal beneficiary and provider fraud and abuse, emphasizing fraud prevention.
- Participate in the development or modification of DHCS policies.

A&I is divided with three branches along with Internal Audits. In addition, the division includes the Administrative Management Services Section (AMSS) and Information Technology Unit (ITU) which provides centralized administrative functions and technology services to A&I, respectively.

- Financial Audits Branch (FAB) ensures, through financial audits, that payments made to providers of Medi-Cal or other State or federally funded health care programs are valid, reasonable, and in accordance with laws, regulations, and program intent.
- Investigations Branch (IB) is mandated by the Code of Federal Regulations and California State law as the organization responsible for investigating allegations of beneficiary fraud and abuse of the Medi-Cal program.
- Medical Review Branch (MRB) is charged with the responsibility of performing federal mandated post service, post payment utilization reviews.
- Internal Audits (IA) is an independent organization housed within A&I that is charged with department-wide program audit responsibilities.

Other units within DHCS may also conduct audits or reviews (for example, the Licensing and Certification units of DHCS). When a program is contacted by DHCS for any type of review, be it a scheduled or unannounced visit, it is expected that the program will immediately notify the program COR and the BHS SUD QM unit. The QM can be notified via email at QIMatters.HHSA@sdcountry.ca.gov

If a Corrective Action Plan (CAP) is required for any type of review, programs are to submit drafts directly to the BHS SUD QM unit for review and technical assistance. Once finalized, the BHS SUD QM unit will
submit the CAP to DHCS on behalf of the program and will follow-up with the program periodically for monitoring of CAP implementation and continued technical assistance until the CAP is fully implemented.

Post Service Post Payment (PSPP) Reviews
PSPP reviews involve chart reviews by DHCS staff at the program location. When documentation does not meet Title 22 requirements, and/or other relevant regulations, standards, and State-County contract requirements, recovery of funding (via recoupment) can occur.

The review process involving DHCS, the Program COR and the SUD Quality Management (QM) unit is as follows:

- DHCS SUD Performance Management Unit will contact the DMC certified SUD program one week prior to the scheduled PSPP review.
- Program will contact the program COR and the QM SUD unit to notify them of the review.
- DHCS will conduct an Entrance Conference the first day of the review to discuss the review purpose and process, and request charts for the review. The program COR (or designee) and QM SUD unit designee will attend, if possible.
- DHCS will conduct an exit conference with a summary of findings on the last day of the review. The COR or their designee and QM SUD designee will attend the exit conference, if possible.
- DHCS will send a final PSPP Report to the SUD provider and to the QM SUD unit. DHCS may request a Corrective Action Plan (CAP). BHS QM SUD unit has 60 calendar days from the date of the letter to return the CAP to DHCS SUD Performance Management.

- QM coordinates the whole process and is responsible for initially contacting the provider via e-mail to inform them of the 30-day requirement to submit the draft of the CAP to QM. Technical assistance is available for programs from the BHS SUD QM unit in drafting the CAP.
- The program will write an initial draft of the CAP and send it to QM for review within 30 days of the final PSPP Report. Then, QM will forward the draft of the CAP to the COR for review and feedback. QM will continue to provide technical assistance as necessary to the provider.
- After the CAP is “final approved” by the COR and the QM unit, QM staff will write and sign the cover letter for the CAP. The cover letter and CAP is sent to DHCS via encrypted email. The email communication will include a CC to the COR, the Provider Program Manager and the QI Chief.
- The County is responsible to ensure the CAP is completed and submitted within the 60 calendar day time requirement. In rare instances, if additional time is needed, an extension may be requested by the County.
- Providers shall forward all DHCS correspondence associated with the CAP to the County.
- Upon DHCS approval of the CAP submitted, the provider shall continue to work the County regarding an Implementation Plan and the County may provide additional technical assistance.
- The provider shall maintain records verifying that actions denoted in the CAP are being aptly adhered to.
- Providers shall provide the County annually documentation exhibiting that the provider is complying with implementation of the DHCS-approved CAP.
- Documentation of any and all evidence referred to in the DHCS-approved CAP must be submitted to the County; including but not limited to:
QUALITY MANAGEMENT

- Copy of DMC Certification
- Revised and/or New Form Templates (different than what was submitted with the CAP)
- Revised and/or New Policy and Procedures (different than what was submitted with the CAP)
- Documentation of compliance to policy and procedures (i.e., supervision, chart utilization reviews, monthly reports, etc.)
- List of direct services staff with credentials and hours of work per week. This request includes copies of licenses and certifications for Licensed Professionals of the Healing Arts (LPHA) and SUD Counselors - both certified and registered and the full time equivalent (FTE) spent in direct service for each staff person. The list must include all staff, and includes staff who no longer work for the organization but who provided services during the specified time frame of the review
- Templates of all forms related to the client files (Health Questionnaire and Screening, Intake, Diagnosis Determination/Medical Necessity, Treatment Plans, Discharge Summary & Plan)
- Copy of Group sign-in sheets
- Copy of a random sample of requested charts which includes: Intake/Assessment, Medical Records & Health Questionnaire, Medical Necessity, Stay Reviews, Treatment Plan(s), Progress Notes, Discharge Plan, Discharge Summary
- Copy of staff training agendas, training material and staff training sign-in sheets, and
- Copy of internal monitoring reports that reflect monitoring activities for the specified review period

Post Service Pre-Payment (PSPP) Reviews
Post Service Pre-Payment reviews, formally known as DMC Monitoring Reviews, differ from PS Post Payment reviews in that there is no financial recovery (i.e. recoupment) associated with these types of reviews. Rather, they are conducted as part of the DHCS requirement to provide programmatic, administrative, and fiscal oversight of statewide DMC SUD services. The Post Service Pre-Payment reviews include an on-site review of certain DMC charts, employee files, policy and procedures, and the physical location of the program. These monitoring reviews are a helpful resource to programs as technical assistance for compliance and recommendations is provided directly to programs by DHCS staff.

The review process involving DHCS, the program COR and the SUD QM unit is as follows:

- DHCS DMC Monitoring Unit will contact the DMC certified SUD program approximately two weeks prior to the scheduled Post Service Pre Payment review.
- DHCS will notify the program of the types of materials to make available for the review (i.e. Policies and Procedures, copies of staff certifications/licenses, internal monitoring reports, etc., and will provide forms for completion prior to the review.
- Program will contact the program COR and the QM SUD unit to notify them of the review.
- The DHCS analyst will conduct an Entrance Conference the first day of the review to discuss the review purpose and process. The program COR (or designee) and QM SUD unit designee will attend, if possible.
- The DHCS analyst will conduct an exit conference on the last day with a summary of findings.
- The COR or their designee and QM SUD unit designee will attend.
- The DHCS analyst will send a final Monitoring Report to the Provider and to the QM SUD unit.
DHCS may request a Corrective Action Plan (CAP). **BHS has 60 calendar days from the date of the report to return the CAP to the DHCS DMC Monitoring Unit.**

- QM coordinates the whole process and is responsible for initially contacting the provider via e-mail to inform them of the 30-day requirement to submit the draft of the CAP to QM. Technical assistance is available for programs from the BHS SUD QM unit.
- The program will write an initial draft of the CAP and send it to QM for review within 30 days of the final Monitoring Report. Then, QM will forward the draft of the CAP to the COR for review and feedback.
- After the CAP is “final approved” by the COR and the QM unit, QM staff will write and sign the cover letter for the CAP. The cover letter and CAP is sent to DHCS via encrypted email. The email communication will include a CC to the COR, the Provider Program Manager, and the QI Chief.
- The County is responsible to ensure the CAP is completed and submitted within the 60-calendar daytime requirement. In rare instances, if additional time is needed, an extension may be requested by the County.

**Appeals**

The County may appeal DMC dispositions concerning demands for recovery of payment and/or programmatic deficiencies of specific claims (such as those resulting from a PSPP review). Such appeals shall be handled as follows:

**Requests for first-level appeals**
- The County shall initiate action by submit a letter on the official stationery of the County and it shall be signed by an authorized representative of the County.
- The letter shall identify the specific claim(s) involved and describe the disputed (in)action regarding the claim. Letter sent to:
  
  Division Chief DHCS SUD-PPFD  
  P.O. Box 997413, MS-2621  
  Sacramento, CA 95899-741

The County may initiate a second level appeal to the Office of Administrative Hearings and Appeals (OAHA).
- The second level process may be pursued only after complying with first-level procedures and only when:
  - DHCS has failed to acknowledge the grievance or complaint within 15 calendar days of its receipt, or
  - The County is dissatisfied with the action taken by DHCS where the conclusion is based on DHCS’ evaluation of the merits.
- The second-level appeal shall be submitted to the Office of Administrative Hearings and Appeals within 30 calendar days from the date DHCS failed to acknowledge the first-level appeal or from the date of DHCS’ first-level appeal decision letter.
- All second-level appeals made in accordance with this section shall be directed to:
  Office of Administrative Hearings and Appeals  
  1029 J Street, Suite 200, MS 0016  
  Sacramento, CA 95814

In referring an appeal to the OAHA, the County shall submit all of the following:
• A copy of the original written appeal sent to DHCS.
• A copy of the DHCS report to which the appeal applies.
  o The appeal process listed here shall not apply to those grievances or complaints arising from the financial findings of an audit or examination made by or on behalf of DHCS pursuant to Exhibit B of the Intergovernmental Agreement.
  o State shall monitor the provider’s compliance with County utilization review requirements, as specified in the Intergovernmental Agreement (Article III.EE.) Counties are also required to monitor the subcontractor provider’s compliance pursuant to Article III.AA of this Intergovernmental Agreement. The federal government may also review the existence and effectiveness of DHCS’ utilization review system.
  o The County shall, at a minimum, implement and maintain compliance with the requirements described in Article III.PP of the Intergovernmental Agreement for the purposes of reviewing the utilization, quality, and appropriateness of covered services and ensuring that all applicable Medi-Cal requirements are met.
  o The County shall ensure that subcontractor provider sites shall keep a record of the beneficiaries/patients being treated at that location.
  o The County and provider shall retain beneficiary records for a minimum of 10 years, in accordance with 438.3(h), from the finalized cost settlement process with DHCS. When an audit by the Federal Government or DHCS has been started before the expiration of the 10-year period, the beneficiary records shall be maintained until completion of the audit and the final resolution of all issues.

Additional Review Considerations
Per DHCS, programs shall keep sufficient financial records and statistical data to support year-end documents filed with DHCS. Programs shall include in any contract with an audit firm a clause to permit DHCS access to the working papers of the external independent auditor.

Follow-up and Monitoring
Programs will be asked to provide a summary follow-up report to QM of their monitoring efforts and results of their corrective action plans. Once notified via email, they shall provide a summary report to QM within seven calendar days.

Serious Incident Reporting (SIR)
Serious incidents are defined as incidents that have a direct or indirect impact on the community, patients, staff, and/or the SUD treatment provider agency as a whole and are required to be investigated and evaluated at the provider agency level. This information should be used on a routine basis to improve accessibility, health and safety, and address other pertinent risk management issues.

An incident that may indicate potential risk/exposure for the County – operated or contracted provider (per Statement of Work), client or community shall be reported to the BHS Quality Management (QM) Unit. There are two types of reportable incidents:

• Serious Incidents are reported to the BHS QM Unit
• Unusual Occurrences are reported directly to the program’s COR.

Serious Incident Categories
• Incident reported in the media/public domain (e.g. on television, newspaper, internet)
• Suicide attempt by client that requires medical attention or attempt is potentially fatal and/or
significantly injurious.

- Death of client by suicide (includes overdose by alcohol/drugs/medications, etc.)
- Death of client under questionable circumstances (includes overdose by alcohol, drugs, medications, etc.)
- Death of client by homicide
- Alleged homicide attempt on a client (client is victim)
- Alleged homicide attempt by a client (client is perpetrator)
- Alleged homicide committed by a client (client is perpetrator)
- Injurious assault on a client (client is victim) occurring on the premises of the program resulting in death, severe physical damage and/or loss of consciousness, respiratory and/or circulatory difficulties requiring hospitalization.
- Injurious assault by a client (client is perpetrator) occurring on the premises of the program resulting in severe physical damage and/or loss of consciousness, respiratory and/or circulatory difficulties requiring hospitalization.
- Tarasoff Notification, the duty to protect intended victim, is made to the appropriate person(s), police, or other reasonable steps have been taken to protect the intended victim. Note: Serious Incident Report of Finding not required unless indicated.
- Tarasoff Notification, the duty to protect intended victim, is received by the program that a credible threat of harm has been made against a staff member(s) or program and appropriate safety measures have been implemented. Note: Serious Incident Report of Finding not required unless indicated.
- Serious allegations of or confirmed inappropriate staff (includes volunteers, interns) behavior such as sexual relations with a client, client/staff boundary issues, financial exploitation of a client, and/or physical or verbal abuse of a client.
- Serious physical injury to a client involving extreme physical pain, substantial risk of death or protracted loss or impairment of a bodily member, limb, organ, or of mental faculty (i.e. fracture, loss of consciousness), or requiring medical intervention, including but not limited to, hospitalization, surgery, transportation via ambulance, or physical rehabilitation.
- Adverse medication reaction resulting in severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization.
- Medication error in prescription or distribution resulting in severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization.
- Apparent overdose of alcohol/illicit or prescriptions drugs, whether fatal or injurious, requiring medical attention.
- Other

**Reporting**

All providers are required to report serious incidents involving clients in active treatment or whose discharge from services has been 30 days or less. Required reports shall be sent to the QM Unit who will review, investigate as necessary, and monitor trends. The QM team will communicate with the program’s COR and BHS management. The provider shall also be responsible for reporting serious incidents to the appropriate authorities. After review of the incident, QM may request a corrective action plan. QM is responsible for working with the provider to specify and monitor the recommended corrective action plan. The QI unit will monitor serious incidents and issue reports to the Quality Review Council and other identified stakeholders.

San Diego County contracted programs may use the Serious Incident RCA Worksheet (See Appendix G.1 for the Root Cause Analysis [RCA] Worksheet) or some other process that is approved by their Legal Entity. It is strongly recommended that programs not choosing to use the Serious Incident RCA Worksheet
ensure that the process they do use incorporates best practices for their analysis of findings. Technical assistance is available through the BHS QM Unit by email at QIMatters.HHSA@sdcounty.ca.gov. RCA training is also offered on a quarterly basis.

Reporting Procedures

1. Upon knowledge of incident, program shall report the incident and all known details to the SIR Line at 619-584-3022.
2. All providers are required to report serious incidents involving clients in active treatment or whose discharge from services has been 30 days or less.
3. A Level One serious incident shall be reported to the SIR Line immediately upon knowledge of the incident and followed up with the written SIR report to QM no later than 24 hours.
4. A Level Two serious incident shall be reported to the SIR Line no later than 24 hours of knowledge of the incident and followed up with the written SIR report to QM within 72 hours.
5. In the event of a serious incident, the client’s medical record/s will immediately be safeguarded by the program manager or designee. Program manager shall review chart as soon as possible. The client medical record shall not be accessed by unauthorized staff not involved in the incident.
6. All program staff will maintain confidentiality about client and serious incident. The serious incident should not be the subject of casual conversation among staff.
7. All serious incidents shall be investigated and reviewed by the program. The program shall submit a complete Report of Findings (SIROF) to QM within 30 days of knowledge of the incident. (See Appendix G.2 for the SIROF Form)
8. Tarasoff incidents do not require a SIROF unless the Program Manager, after review, has concluded one is indicated due to a systemic or client related treatment issue.
9. An SIR is never to be filed in the client’s medical record. A Serious Incident Report shall be kept in a separate secured confidential file.
10. A serious incident that results in 1) a death by suicide or 2) an alleged client committed homicide will automatically trigger a chart review by the QM Unit and require the completion of a Root Cause Analysis (RCA) within 30 days of knowledge of the incident.
11. The Action Items because of the RCA shall be summarized and submitted to the QM unit with 30 days of knowledge of the incident. Do not submit the RCA worksheet, only a summary of action items.

Residential Requirement to Report to DHCS

Certain Incidents must also be reported by Residential SUD Programs to DHCS; these incidents include the following:
- Death of any resident from any cause – even if death did not occur at facility
- Any facility related injury of any resident which requires medical treatment
- All cases of communicable disease reportable under Section 3125 of the Health and Safety Code or Section 2500, 2502, or 2503 of Title 17, California Administrative Code shall be reported to the local health officer in addition to the Department
- Poisonings
- Natural disaster
- Fires or explosions which occur in or on the premises

Residential programs must report the incident via phone, as well as submission of form DHCS 5079 titled “Unusual Incident/Injury/Death Report” (please refer to the form for further instructions). Outpatient programs are not required to report incidents to DHCS but may wish to do so and may utilize the same process of reporting. These incidents shall be reported to DHCS as follows:
a. Programs must make a telephonic report to DHCS Complaints and Counselor Certification Division at (916) 322-2911 within one (1) working day.
b. The telephonic report must be followed with a written report to DHCS within seven (7) days of the event.
c. Death reports must be submitted via fax to the DHCS Complaints and Counselor Certification Division at (916) 445-5084 or by email to DHCSLCBcomp@DHCS.ca.gov

Serious Incident Classifications
Serious incidents shall be classified into two levels with Level One being most severe and Level Two less severe.

Level One
The Level One Serious Incident is the most severe type. A level one incident must include at least one of the following:

- Any event that has been reported in the media/public domain (television, newspaper, internet), current or recent past, regardless of type of incident.
- The event has resulted in a death or serious physical injury on the program’s premises.
- The event is associated with a significant adverse deviation from the usual process for providing behavioral health care.

A Level One serious incident shall be reported to the QM SIR Line at 619-584-3022 immediately upon knowledge of the incident. The provider shall complete and fax the Serious Incident Report (See Appendix G.3 for the SIR Form) to the QM Unit within 24 hours of knowledge of incident.

Level Two
A Level Two Serious Incident is any serious incident that does not meet the criteria of a Level One serious incident.

A Level Two serious incident shall be reported to the QM SIR Line at 619-584-3022 no later than 24 hours of knowledge of the incident. The provider shall complete and fax the Serious Incident Report to the QM Unit within 72 hours of knowledge of incident.

Level One Serious Incident Reporting on Weekends and Holidays
Level One Serious Incidents are required reporting for Legal Entity (LE) behavioral health programs on weekends and holidays to the QM Unit and Designated County Staff. This requirement does not apply to Level Two serious incidents.

Follow this procedure for reporting a Level One Serious Incident on Weekends and Holidays:

1. For a Level One Serious Incident, call the QM SIR Line and report the incident.
2. Each LE will identify key Senior Level staff (1-3) that are designated as the main contact person(s) for their programs needing to report a Level One incident on weekends and holidays. This LE designated staff will report the Level One incident by calling or leaving a message with all required information including a call back number for the County Designated Staff. Each LE will be provided the contact phone numbers of the County Designated Staff.
3. Program staff should only be reporting the Level One Serious Incident to their LE designated staff. Program staff should not be directly contacting the County Designated Staff.
4. Report Level One Serious Incidents to the County Designated Staff on weekends and holidays between the hours of 8:00am – 8:00pm (reporting hours). If you have a Serious Incident that occurs outside of reporting hours, then report the Serious Incident on the next or same day during reporting hours. This requirement is only for Level One Serious Incidents.

5. Weekend Coverage is defined as Saturday and Sunday. Holiday Coverage is defined as any designated County Holiday.

County designated staff are identified in priority contact order as:

1. Adult SOC Deputy Director – Adult Providers
2. CYF SOC Deputy Director – Child Providers
3. Director, BHS (third back-up)

Clinical Case Reviews
Under the direction of the BHS Clinical Director, a clinical case review convenes regularly to review cases involving a death by suicide, homicide, and other complex clinical issues. The purpose of the review is to identify systemic trends in quality and/or operations that affect client care. Identified trends are utilized to provide opportunities for continuous quality improvement. Program shall comply with requests for client records that are reviewed in clinical case conference.

Stakeholders, including BHS Director, CORs, Deputy Directors, QI Chief, Program Managers, County or Contractor QI staff, or other designated staff may make a request at any time for a clinical case review. Specific requests for case reviews should be coordinated through the QM Unit by contacting QIMatters.HHSA@sdcounty.ca.gov.

Privacy Incident Reporting (PIR) for Staff and Management
The Compliance Office has transitioned to an online web-form version of the HHSA Privacy Incident Report (PIR). All suspected and actual privacy incident reports must be submitted via the online web portal effective August 1, 2018. As of 8/1/2018, the PIR Word document will no longer be accepted.

- To access the landing page and link for the web-form please click here. To open the web-form, click the hyperlink Submit a Privacy Incident Report from the landing page.
- The online web-form is self-explanatory. Staff that have been completing the Word document version of the PIR will recognize the fields and be familiar with the information requested.
- Upon submitting the online web-form, the submitter will receive an email with a PIR Tracking Number (PIR—####) and Access Code ID#. Use this information to access & update pending PIRs until the report is complete.
  - Please reference the PIR Tracking Number provided in the subject line of the email received when communicating with the Compliance Office regarding reported incident, including providing additional requested information, draft incident notification letters, etc.
- ACO will reach out to Contractors/Vendors/Business Associates (BA) to advise of the new process.
  - These external customers will be advised to begin transitioning to the online web form version of the HHSA Privacy Incident Report (PIR) throughout the month of July 2018.
- Please refer to Appendix G.4 for the updated Privacy Incident Reporting process flowchart.

Note: San Diego County contracted providers should work directly with their agency’s legal counsel to determine external reporting and regulatory notification requirements. Additional compliance and privacy resources are available at: http://www.sandiegocounty.gov/hhsa/programs/sd/compliance_office.
Unusual Occurrence Reporting
An unusual occurrence is reported directly to the COR/Program Monitor with 24 hours of knowledge of the incident. An unusual occurrence is defined as an incident that may indicate potential risk/exposure for the County – operated or contracted provider (per Statement of Work), client or community that does not meet the criteria of a serious incident. Unusual occurrences may include but are not limited to:

- Alleged child abuse
- Police involvement
- Inappropriate sexual behavior
- Self-injury
- Physical injury
- Physical abuse
- AWOL
- Fire setting
- Poisoning
- Major accident
- Property destruction
- Epidemic or other infectious disease outbreak
- Loss or theft of medications from facility

Safety and Security Notifications to Appropriate Agencies
When an Unusual Occurrences is identified, the appropriate agencies shall be notified within their specified timeline and format:

- Child and Elder Abuse Reporting hotlines.
- Tarasoff reporting to intended victim and law enforcement
- Law enforcement (police, sheriff, school police, agency security, military security/Naval Investigative Service, etc.) for crime reporting or requiring security assistance and inquiries.
- Every fire or explosion which occurs in or on the premises shall be reported within 24 hours to the local fire authority or in areas not having an organized fire service, to the State Fire Marshall.

Child, Youth and Family (CYF) Additional Reporting
CYF providers may notify other outside agencies who serve the client upon consideration of clinical, health and safety issues. Notification should be timely and within 24 hours of knowledge of the incident. These agencies include but are not limited to:

- Children Welfare Services
- Probation Officer
- Regional Center
- School District
- Therapeutic Behavioral Services (TBS)
- Other programs that also serve the client

Reportable issues may include:

- Health and safety issues
- A school suspension
- A student is taken to a hospital due to an injury or other medical issue which occurs at the program site or when the TBS worker is present
- A referral for acute psychiatric hospital care
An issue with direct service provider staff, which may lead to worker suspended or no longer providing services
A significant problem arising while TBS worker is with the child

Consumer Grievances, Appeals, and State Fair Hearings
The County of San Diego is committed to providing a fair, impartial, and effective process for resolving client grievances in compliance with all Federal and State regulations for substance use disorder services. The Grievance/Appeals and State Fair Hearing processes are available for all clients, their authorized representative, or providers acting on behalf of the client and with the client’s written consent (“involved parties”) to utilize. All SUD treatment providers must also have policies and procedures in place for collecting/logging, reviewing, and acting upon all client grievances or appeals. The process should be clear and transparent to all clients and providers and should be integrated into the provider’s quality assurance processes. At all times, grievance and appeal information must be readily available for clients without the need for request. (42 CFR §438.228)

The Grievance/Appeals and State Fair Hearing process is designed to:
- Provide a grievance/appeals and State Fair Hearing process adhering to Federal and State regulations
- Provide straightforward client/provider access
- Support and honor the rights of every client
- Be action-oriented
- Provide resolution within State established timeframes
- Encourage effective grievance resolution at program level
- Improve the quality of SUD services for all County of San Diego residents

Providers shall have self-addressed stamped envelopes (CCHEA and JFS will provide upon request), posters, brochures, grievance/appeal forms (available on the Optum website) in all threshold languages to include interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. These materials shall be displayed in a prominent public place. The client shall not be discouraged, hindered, or otherwise interfered with when seeking or attempting to file a grievance/appeal. The client is also not required to present a grievance/appeal in writing and shall be assisted in preparing a written grievance/appeal, if requested. Providers shall inform clients, their authorized representative, or the provider acting on behalf of the client, about their right to file a grievance with assistance from one of the County’s contracted advocacy organizations listed below (42 CFR §438.406):

**Jewish Family Services, Patient Advocacy Program (JFS)**
(For inpatient or residential SUD services)
1-800-479-2233 or 619-282-1134
Email: jfsonline@jfssd.org

**Consumer Center for Health, Education, and Advocacy (CCHEA)**
(For outpatient SUD services)
1-877-734-3258
TTY-1-800-735-2929

Advocacy Services and Records Requests
In accordance with the Code of Federal Regulation (CFR) Title 42, Part 438, Subpart F – Grievance System, the JFS Patient Advocacy Program and CCHEA are required to conduct grievance investigations and
appeals pursuant to State and Federal law. These processes may include, but are not limited to, consulting with facility administrators, interviewing staff members, requesting copies of medical records, submitting medical records to independent clinical consultants for review of clinical issues, conducting staff member trainings, suggesting policy changes, submitting requests for Plans of Correction (POC), and preparing resolution letters.

There are mandated timelines for grievances and appeals. Providers’ quick and efficient cooperation will ensure compliance with these requirements. When requested, SUD providers shall provide copies of medical records to the JFS Patient Advocacy Program and CCHEA within seven (7) calendar days from the date of the medical record request. The Advocacy Agencies will provide the program with a signed release of information from the client with the request. For more information, please review the following memo on the Optum DMC-ODS page: Patient Advocacy Services for BHS – Records Requests.

Process Definitions (Title 42 CFR § 438.400 (b))

- **Grievance** is an expression of dissatisfaction about any matter other than an adverse benefit determination as defined below (under appeal). Grievances may include, but are not limited to: the quality of care of services provided, aspects of interpersonal relationships, such as rudeness of a provider or employee, failure to respect the rights of the client regardless of what remedial action is requested, including the client’s right to dispute an extension of time proposed by the plan to make an authorization decision. A grievance can be filed at any time, orally or in writing. (42 CFR § 438.402)

- **Grievance Exemption** is when grievances are received over the telephone or in-person that are resolved to the client’s satisfaction by the close of the next business day following receipt are exempt from the requirement to send a written acknowledgment and disposition letter. Note: Grievances received via mail are not exempt from the requirement to send an acknowledgment and disposition letter in writing. If a complaint is received pertaining to an Adverse Benefit Determination, as defined under 42 CFR Section 438.400, the complaint is not considered a grievance and the exemption does not apply.

- **Appeal** means a review of an adverse benefit determination or “action” which may include:
  - Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
  - The reduction, suspension, or termination of a previously authorized service.
  - The denial, in whole or in part, of payment for a service.
  - The failure to act within the timeframes regarding the standard resolution of grievances and appeals.
  - The failure to provide services in a timely manner.
  - The denial of a client’s request to dispute financial liability.

- **Grievance and appeal system** are the processes the county and providers implement to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.

- **State Fair Hearing** is a legal process that includes an impartial hearing and ruling by an administrative law judge. A Medi-Cal beneficiary is required to exhaust the SUD problem resolution process prior to requesting a State Fair Hearing and only a Medi-Cal beneficiary may request a state fair hearing.
In many cases, a responsible and reasonable resolution can be achieved through an informal and professional discussion between the client and the provider, either verbally or in writing. However, additional action in the form of a grievance or appeal may be necessary to offer the client, or if requested by the client. In accordance with 42 CFR and Title 9, the County of San Diego SUD Quality Management (QM) team has implemented a SUD Provider Grievance/Appeals and State Fair Hearing process for when client grievances cannot be resolved informally. Timelines for acknowledgement of receipt of grievances/appeals and resolution, are highlighted within the tables below. An opportunity for provider appeals has been added in addition to clinical review of grievances and appeals concerning clinical issues.

**Provider Program Grievance Process**

Per DHCS requirements, the County must have a process in place to ensure all SUD program clients grievances are reported and investigated per regulations.

Program and clients are encouraged to resolve grievances at a program level. (Note: Grievances received over the telephone or in-person by a program that are resolved to the beneficiary’s satisfaction by the close of the next business day following receipt are exempt from the requirement to send a written acknowledgment and disposition letter.) Additionally, programs should refer the client to the appropriate advocacy program for further assistance in finding a resolution to their grievance. If resolution to the client’s satisfaction has not occurred by close of the next business day following receipt of a verbal, written, or phone contact grievance, and/or the client refuses to utilize the advocacy organization, programs must notify County SUD QM within 72-hours of receipt of the grievance. Unresolved client grievances should be reported to the program’s COR. They are also to be recorded on a SUD Complaint/Grievance Report Form and sent to BHS SUD QM within 72-hours (see Appendix G.5 for the SUD Complaint Form) of receipt of the grievance. Completion of this form is to be done by the program with or without the client present.

Programs are required to have policies and procedures in place to address and track all client grievances. Tracking shall include, at a minimum:

- Client initials,
- Date of the grievance,
- Who received grievance,
- How the grievance was made (verbally, in writing, etc.),
- The nature of the grievance,
- How the program responded to the grievance,
- If the grievance was resolved to the client’s satisfaction by the close of the next business day following receipt, and if unresolved,
- If client was provided information for the appropriate advocacy agency.

Review of Grievance policies and procedures as well as tracking logs will be part of annual site visits by BHS COR and/or BHS SUD QM.

County of San Diego SUD QM or the appropriate advocacy program shall acknowledge all client grievances, in writing, to the client, within five calendar days. BHS SUD QM will record all SUD Complaint/Grievance Report Forms received, and monitor adherence to process regulations internally or through collaboration with the appropriate advocacy agency until client/program resolution occurs. The BHS SUD QM will submit a report to DHCS within two business days from completion of the grievance.
investigation with outcome. Should a client initiate a grievance directly to BHS, the client will be reminded about their right to file a grievance with assistance from one of the County’s contracted advocacy organizations (e.g., JFS or CCHEA). If the client refuses to utilize the advocacy organization, then the SUD QM unit will send the beneficiary acknowledgement of receipt of the grievance as described above, and contact both the provider and the provider’s COR to initiate an investigation and facilitate a resolution within process timeframes as described below.

**Grievance Process and Timeframes**
A grievance can be filed at any time. A resolution must occur within 60 days (but many will be resolved sooner) from receipt of grievance to resolution. Federal regulations allow the County of San Diego DMC-ODS (“The Plan”) to extend the timeframe for an additional 14 calendar days if the beneficiary requests the extension or the Plan shows (to the satisfaction of DHCS, upon request) that there is need for additional information and how the delay is in the beneficiary’s interest. A grievance is defined as an expression of dissatisfaction about any matter other than an “adverse benefit determination.” JFS Patient Advocacy facilitates all grievance process for clients within inpatient facilities and 24-hour residential facilities. CCHEA facilitates the grievance process for clients seeking/receiving services within outpatient programs and all other SUD services. Advocacy services will provide the client written acknowledgement of receipt of a grievance within five days of receipt of the grievance. Providers will be contacted within two business days of written permission from the client to represent him/her. To maintain compliance within mandated federal timelines, providers shall work closely with the advocacy organization to find a mutually agreeable solution for grievance resolution. Should a grievance or appeal focus on a clinical issue, then CCHEA and the JFS Patient Advocacy Program will utilize a clinician with the appropriate clinical credentials and treatment expertise to review and render a decision regarding the case.

Grievance tracking logs from JFS and CCHEA are sent monthly to the County SUD QM unit and include at minimum:

- Date of receipt of the grievance
- Client name/identifying number
- Nature of the grievance
- Resolution
- Name of representative who received and resolved the grievance

County of San Diego SUD QM will maintain, review, and provide ongoing monitoring of all logged grievances as protocol for its continual quality assurance and management process.

<table>
<thead>
<tr>
<th>Description</th>
<th>Receipt of Notification</th>
<th>Written Decision Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Grievance</strong></td>
<td>Postmarked within five (5) calendar days from receipt of a grievance.</td>
<td>Within 60 calendar days of receipt of a grievance with possible 14-day extension days if the beneficiary requests the extension or the Plan shows (to the satisfaction of DHCS, upon request) that there is need for additional information and how the delay is in the beneficiary’s interest.</td>
</tr>
</tbody>
</table>
### Standard Appeal

Appeals are a formal process of challenging denial decisions involving, but not limited to DMC eligibility, services, or level of care decisions.

*Must be filed within 60 calendar days from the date on the written decision notification/Notice of Adverse Benefits Determination (NOABD)*

**Postmarked within five (5) calendar days of appeal by advocacy organization.**

Within 30 calendar days of receipt of an appeal. Plans may extend the resolution timeframes for appeals by up to 14 calendar days if either of the following two conditions apply: a. The beneficiary requests the extension; or, b. The Plan demonstrates, to the satisfaction of DHCS upon request, that there is a need for additional information and how the delay is in the beneficiary’s best interest. Adverse determinations must include information to client re: fair hearing, how to file, right to request and receive benefits, costs, etc. (as specified in DHCS Information Notice 18-010E).

### Expedited Appeal

The expedited resolution of appeals begins when it is determined (in response to a request from the patient or patient representative), or the provider indicates (in making the request on the patient’s behalf), that taking the time for a standard resolution could seriously jeopardize the patient’s life, health, or functional status.

Appeals for initial residential authorizations and medication-assisted treatment will routinely be expedited.

*If request for expedited resolution of an appeal is denied, it will be transferred to the timeframe for standard resolution. Written notification of this change to a standard appeal process will be provided within 72 hours.*

Within 72 hours of receipt of an expedited appeal, it must be resolved and notice provided to the client.

### Appeal Process Timeline:

- **Filing:** Within 60 calendar days from the date on the Notice of Adverse Benefit Determination (NOABD).
- **Decision:** Within 30 calendar days from receipt of appeal. Plans may extend the resolution timeframes for appeals by up to 14 calendar days if either of the following two conditions apply: a. The beneficiary requests the extension; or, b. The Plan demonstrates, to the satisfaction of DHCS upon request, that there is a need for additional information and how the delay is in the beneficiary’s best interest.

Oral and/or written appeals are reviews of actions by the county regarding provision of services through an authorization process, including:

- Reduction/limitation or delay of services
- Reduction, suspension or termination of a previously authorized service
• Denial of, in whole or part, payment for services
• Failure to provide services in a timely manner
• Grievance, appeal or expedited appeal was not resolved in time

Advocacy services will provide the beneficiary written acknowledgement of receipt of an appeal postmarked within (5) calendar days of receipt of the appeal. The advocacy organization will contact the provider within two (2) business days of receiving written permission from the client to represent him/her. The advocacy organization shall investigate the appealed matter and make a recommendation to the county. The County will review the recommendations of the advocacy organization and make a decision on the appealed matter.

Note: A decision by a counselor to limit, reduce, or terminate a client’s service is considered a clinical decision and cannot be the subject of an appeal; however, it can be grieved.

**Expedited Appeal Process**
Timeline: Decision: Decision: Within 72 hours. Plans may extend the timeframe for expedited appeals resolution by 14 calendar days in accordance with federal regulations [Title 42, CFR, Section 438.408(d)(2)(ii)].

Should a standard appeal process jeopardize a client’s life, health, or functioning, an expedited appeal may be filed by the advocacy organization on behalf of the client. Notification to the provider by the advocacy organization will occur in less than (2) business days. A decision by the County with notification to affected parties will occur within (72) hours after receipt of the expedited appeal request.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Timeline</th>
<th>Reference/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the timeline for submission of an Appeal?</td>
<td>Within 60 days of Notification of Action-Denial (date on letter). Orally or in writing.</td>
<td>42 CFR §438.402(c)(2)(ii)</td>
</tr>
<tr>
<td>Timeline for notification of receipt of appeal {Acknowledgement Letter from JFS (residential or inpatient program clients) or CCHEA (outpatient program clients),]</td>
<td>Standard</td>
<td>(5) business days</td>
</tr>
<tr>
<td></td>
<td>Expedited</td>
<td>If the county plan decides the appeal does not qualify as an expedited appeal, notification is (2) business days.</td>
</tr>
<tr>
<td>Timeline for submission of State Fair Hearing Appeal</td>
<td>Within 120 days after Denial of Appeal</td>
<td>Plan must notify beneficiaries of resolution within (90) days of date of the request for the hearing. For expedited State Fair Hearings, the Plan must notify beneficiaries of resolution within (3) working days of the date of the request for the hearing. (42 CFR§431.244(f)(2)).</td>
</tr>
</tbody>
</table>

Note: County of San Diego SUD QM will maintain, review, and provide ongoing monitoring of all logged standard and expedited appeals as part of its continual quality review process.
State Fair Hearings (42 CFR §438.402(c))

Medi-Cal beneficiaries must exhaust the County’s appeal process prior to request for a State Fair Hearing. A beneficiary has the right to request a State Fair Hearing only after receipt of notice that the County is upholding an Adverse Benefit Determination. Beneficiaries may request a State Fair Hearing within 120 calendar days from the date of the NAR (Notice of Appeal Resolution).

A request for a State Fair Hearing may occur if:

- Appeals are not wholly resolved
- If a provider/contractor fails to adhere to the notice and timing requirements per 42CFR§438.408
- After exhausting the grievance process regardless of receipt of a Notice of Adverse Benefit Determination
- Denial of services due to not meeting medical necessity criteria
- Services are not provided in a timely manner
- County denial of provider request for beneficiary treatment

County of San Diego SUD QM will maintain, review, and provide ongoing monitoring of all logged State Fair Hearing requests as part of its continual quality review process.

Written requests for a State Fair Hearing:

State Hearing Divisions, California Dept. of Social Services
P.O. Box 944243, Mail Station 9-17-37
Sacramento, California 94244-2430
1-800-952-5253
TDD 1-800-952-8349

Provider Appeal Process

If a provider and advocacy organization cannot successfully resolve a client’s grievance or appeal, the advocacy organization will issue a finding to be sent to the client, provider, and County, which may include the need for a Plan of Correction to be submitted by the provider to the County within 10 days. In the rare occurrence when the provider disagrees with the disposition of the grievance/appeal and/or does not agree to write a Plan of Correction, the provider may write to the County within 10 days, requesting an administrative review. The County shall have the final decision about needed action.

Monitoring the Beneficiary and Client Problem Resolution Process

The County shares concern with providers regarding areas affecting improvement in client access to services and improved quality of care in all services provided. County SUD QM staff will monitor and review program and advocacy organization grievance/appeal/state fair hearing logs/records and view feedback from the grievance and appeal process as a reflection of potential problems with service effectiveness and/or efficiency, and as an opportunity for positive change. Depending on the nature of the grievance, more targeted follow up at the provider level may be needed, including concerns inherent in service access and delivery which may become part of the ongoing contract monitoring and/or credentialing process. The method of feedback, review, and quality review monitoring can more efficiently address needed improvements in system access, delivery, and quality of service for all clients.

Client Notice of Adverse Benefit Determination (NOABD)

An Adverse Benefit Determination is defined as one which encompasses all previous elements of “Action” under federal regulations with the addition of language that clarifies the inclusion of determinations involving medical necessity, appropriateness and setting of covered benefits, and financial liability. An
Adverse Benefit Determination is defined to mean any of the following actions taken by a provider or the County:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting or effectiveness of a covered benefit
- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service
- The failure to provide services in a timely manner
- The failure to act within the required timeframes for standard resolution of grievances and appeals
- The denial of a beneficiary’s request to dispute financial liability.

Beneficiaries must receive a written NOABD when the Program/Plan takes any of the actions described above. The Program/Plan must give beneficiaries timely and adequate notice of an adverse benefit determination in writing, consistent with the requirements in 42 CFR §438.10.

All SUD providers shall follow procedures for issuing a written NOABD and “Your Rights” Form for Medi-Cal beneficiaries per 42 CFR §438.10 to include notification timeframes per 42 CFR §438.404(c). A NOABD must explain the following:

- The adverse benefit determination made, or the Plan intends to make
- Clear and concise explanation of the reason for the decision
- A description of the criteria used; medical necessity criteria, processes, strategies, or evidentiary standards used
- The beneficiaries right to be provided upon request, and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the NOABD
- The beneficiaries right to request a second opinion and/or appeal of the adverse benefit determination and/or right to a State Fair Hearing once the process is exhausted, to include assistance through the process
- Procedures/methods by which the beneficiary/provider can exercise appeal rights
- Circumstances under which an appeal process can be expedited/how to request it
- Beneficiaries right to have benefits continue pending resolution of the appeal
- To request such, and under what circumstances the beneficiary may be required to pay the costs of these services.

Issuing of an NOABD begins the 120-day period that a beneficiary has to file for a State Fair Hearing.

Provider Process When Issuing a NOABD

The following procedures shall be followed by providers when issuing a NOABD:

- A NOABD and “Your Rights” form shall be issued to a Medi-Cal beneficiary following a SUD assessment when it is determined by the provider that the beneficiary does not meet medical necessity criteria, resulting in a denial of services
- The appropriate NOABD shall be offered to the beneficiary with explanation per regulations with “Your Rights” form
- In accordance with Federal regulations, the NOABD shall be hand delivered on the date of the notice or deposited with the US Postal Service in time for pick-up no later than (2) business days of the decision by the provider
County of San Diego SUD programs shall have a written policy and procedure addressing the collecting, storing, filing, and mailing of Notice of Adverse Benefit Determinations. It is recommended that programs maintain all Notice of Adverse Benefit Determinations in a confidential location at the program site for no less than ten (10) years after discharge for adults. For minors, records are to be kept until they have reached the age of 18, plus seven (7) years.

- All SUD programs shall maintain a monthly NOABD Logs on program site
- Programs shall include in their NOABD Logs:
  - Date NOABD was issued
  - Beneficiary identification number
  - Beneficiary response, requests, provisions for second opinions, initiation of grievance/appeal procedure, and/or request for a State Fair Hearing if known
- NOABD Logs will be maintained at program site
- Logs to contain copies of each NOABD and “Your Rights” forms attached
- Log to reflect “NO NOABD ISSUED” if none are issued within a month
- Program’s NOABD Log will be used by the program as a reference to accurately complete the Quarterly Status Report (QSR).
- NOABD Logs must be available for review at COR or SUD QM request.

Types of Notice of Adverse Benefit Determination (NOABD) and Notice of Appeal Resolution (NAR)

NOTE: There are some cases in which a Notice of Adverse Benefit Determination may not be received; in which case, the beneficiary/provider can still file an appeal with the county plan. You can request a State Fair Hearing when this occurs.

- Notice of Adverse Benefit Determination – Denial of authorization for requested services
- Notice of Adverse Benefit Determination – Denial of payment for a service rendered by a provider
- Notice of Adverse Benefit Determination – Modification of requested services
- Notice of Adverse Benefit Determination – Termination of a previously authorized service
- Notice of Adverse Benefit Determination – Delay in processing authorization of services
- Notice of Adverse Benefit Determination – Failure to provide timely access to services
- Notice of Adverse Benefit Determination – Dispute of financial liability
- Notice of Appeal Resolution (NAR) – Formal letter informing a beneficiary that an Adverse Benefit Determination has been overturned or upheld.


Client Rights

Programs shall inform clients of their seven (7) personal rights at an AOD certified program; this is documented in the client file as a signed acknowledgement that the client understands their rights during treatment. In addition to these rights, if the client is a Medi-Cal beneficiary, the client is entitled to additional rights. Clients are to review these additional rights in the Drug Medi-Cal Organized Delivery System Beneficiary Handbook offered to the client at the time of admission to the program. They will also sign a form acknowledging they were offered the Beneficiary Handbook.

Client Satisfaction

An annual survey conducted by UCLA as part of the DMC-ODS Waiver, will be conducted for adolescent and adult SUD treatment programs. Specific instructions on the designated period for conducting the
surveys, as well as data collection methods, will be specified by UCLA and communicated to programs via the BHS Performance Improvement Team. This will generally take place sometime during the October of each year.
H. ADMINISTRATIVE OVERSIGHT

DHCS Reporting Requirements

CalOMS Tx

CalOMS Treatment (CalOMS Tx) is California's data collection and reporting system for substance use disorder (SUD) treatment services. All certified facilities are required to adhere to mandated reporting by DHCS. “Any Provider that receives any public funding for SUD treatment services and all Opioid Treatment Program (OTP) Providers must report CalOMS Treatment data for all of their consumers receiving treatment, whether those individual consumer services are funded by public funds or not. Providers will collect consumer data at admission and at discharge or administrative discharge from the same treatment program. Data will also be collected annually as an annual update for consumers in treatment for over twelve (12) months” (CalOMS Treatment Data Dictionary, 2018).

DHCS has established data standards intended to provide direct providers with clear direction on submitting complete and accurate CalOMS Tx data in a timely manner. Compliance with these data standards is required for DHCS to more effectively achieve CalOMS treatment data collection and outcome measures and objectives:

- Timeliness of Data
- Completeness of Data
- Accuracy of Data

It is a State requirement for all facilities to submit client data monthly. Best practice is to enter client data as soon as it is obtained. See Appendix H.1 for the BHS CalOMS process.

Currently DHCS offers a comprehensive training through their website. This is only accessible via user login. Users interested in this training must contact the SanWITS Support Desk for assistance.

CalOMS Resources:
- CalOMS Data Compliance Standards
- CalOMS Tx Data Collection Guide
- CalOMS Tx Data Dictionary
- CalOMS Tx FAQs

DATAR

The Drug and Alcohol Treatment Access Report (DATAR) is the Department of Health Care Services (DHCS) system to collect data on treatment capacity and is considered a supplement to the California Outcomes Measurement System (CalOMS) client reporting system. Federal regulations require that each state develop a Capacity Management Program to report alcohol and other drug programs treatment capacity, to ensure the maintenance of the reporting, and to make that information available to the programs. DATARWeb is an application developed by DHCS for that purpose. DATAR assists in identifying specific categories of individuals awaiting treatment and identifies available treatment facilities for these individuals.

DATAR has information on the program’s capacity to provide different types of Substance Use Disorder (SUD) treatment to clients and how much of the capacity was utilized that month. All SUD treatment providers that receive SUD treatment funding from DHCS are required to submit capacity information.
online at the DATARWeb site to DHCS each month. Per County regulations, this is due by the 7th of every month. In addition, certified Drug Medi-Cal providers and Licensed Opioid Treatment Programs (OTP) must report, whether or not they receive public funding.

It is a State requirement for all facilities to submit statistics monthly. See Appendix H.2 for the monthly BHS DATAR Process.

Currently DHCS does not offer training for DATAR. See Appendix H.3 for the BHS DATAR tip sheet which defines DATAR reporting requirements.

For account creation, password reset, or general DATAR issues, contact the County’s DATAR analyst at SUD_MIS_Support.HHSA@sdcounty.ca.gov.

**DATAR Resources:**
- [DATAR](#)
- [DATARWeb](#)
- [DATARWeb Manual](#)

**BHS Reporting Requirements**

**SanWITS**

Web Infrastructure for Treatment Services (WITS) is a collaborative information technology approach to the planning, administration, and monitoring of Substance Abuse Treatment Programs. SanWITS is San Diego’s version of WITS. Sponsored by State Substance Use Disorder Agencies and SAMHSA’s Center for Substance Abuse Treatment (CSAT), WITS is designed to meet the growing demand to capture client treatment data, share information among agencies, and satisfy mandatory government reporting requirements. The application was developed using the rules set forth by 42 CFR Part 2 and HIPAA.

SanWITS is used to collect CalOMS, Drug Medi-Cal (DMC) billing claims and other special population data. Both billing claims and units of service require the creation of an encounter. Encounters are the individual client services that have been delivered and documented within a treatment episode. Encounters shall be identified as either DMC Billable, County Billable, or Non-Billable. Refer to Provider Services Guide for more information on services and visit types available to create encounters.

Contracted treatment providers are set up by agency and facility to ensure users have access to only the information they need to do their job.

SanWITS is in the process of being developed into a full Electronic Health Record (EHR) for the County of San Diego’s DMC-ODS and is scheduled to rollout during fiscal year 2020-2021. Programs are encouraged to consider appropriate steps to prepare staff and communicate with the SanWITS Support Desk regarding EHR Readiness and Basic Computer Skills. While the County is working toward interoperability with other systems, providers with their own EHR will need processes to accommodate dual entry of client data.

Quarterly meetings are held for all SanWITS users by the MIS team. The purpose of these meetings is to discuss data entry requirements, error trends, CalOMS compliance, and DMC Billing. Contact the SanWITS Support Desk to be added to be added to the meeting distribution list.
Trainings are held monthly for basic SanWITS and SSRS. Additional trainings for newly added modules will be scheduled as needed.

- The County’s SanWITS trainings are mandatory for all SanWITS users prior to receiving access to SanWITS. SanWITS users will also be able to schedule training online.

**SanWITS Resources:**
- SanWITS Support Desk
- SanWITS Support Desk Phone: 619-584-5040
- SanWITS Support Desk Fax: 1-855-975-4724
- SanWITS Users Guide

**DMC Billing**
All DMC Billing shall be captured in and released to the County Clearinghouse through SanWITS. Having one system to collect both data sets ensures that DMC claims will always be accompanied by a CalOMS data set.

Trainings and technical assistance are available for new and existing users. Contact the Billing Unit at ADSBillingUnit.HHSA@sdcounty.ca.gov to request training and technical assistance.

**DMC Billing Resources:**
- DMC Billing Manual 2019
- Billing Unit Support Desk email
- County of San Diego Behavioral Health Services Drug Medi-Cal Organizational Providers Billing Manual

**Reporting Provider Changes**
County Administration and DMC Certified Providers are responsible for maintaining accurate records with DHCS. As a provider, you are responsible for notifying the following County entities when provider changes occur:

- SanWITS Support Desk
- QM Support Desk
- Assigned program COR

Notify the following County entities by email when changes outlined below occur:

- When the Provider applies for any new or additional services by location;
- If there is any change in status to its AOD or DMC certification status by the State;
- If there is any change in ownership or executive management;
- If there is any change in Medical Director or their DMC approved status.

**Reporting Capacity**
Providers shall notify the COR when programs are under 90% of their contracted capacity or when an access time list has been started.
Reporting Non-CalOMS Data
Providers shall enter various non-CalOMS data into SanWITS to comply with County Substance Use Disorders Services data system requirements. This data includes information for special populations as well as non-billable encounters.

Data Entry Standards
Data entry standards are required in order to decrease variance in provider operations within the DMC-ODS, and to create effective monitoring and billing processes. Refer to the SanWITS Data Entry Standards Memo for more information.

Technology Requirements
Providers shall maintain technology that facilitates the collection, maintenance, and reporting of data necessary to comply with the County of San Diego and California Department of Health Care Services data requirements. Provider's computer-based data collection, maintenance, and reporting systems shall comply with current County and State standards.

Providers shall have at least one computer with internet access. Treatment data shall be entered electronically into SanWITS; DATAR data shall be entered into DATARWeb; other required reports and forms shall be submitted electronically to the SanWITS Support Desk.

All providers shall be capable of transmitting and receiving information through email. Communications to the provider regarding compliance issues, system related issues, and requirements are sent through email from the MIS unit. Providers need to maintain an email address and shall notify the COR or COR’s designee and the MIS unit of any change in email addresses within two business days of the effective date of the change. The MIS unit can be notified of email updates by calling the help desk at 619-584-5040 or emailing SanWITS Support Desk.

All electronic provider files containing DHCS PHI or PI and stored on removable media or portable devices shall be encrypted with a FIPS 140-2 certified algorithm.

All providers are required to maintain a functioning voicemail that operates 24/7 for those times when a staff is not available to answer in person. Outgoing voicemail message should include directions for accessing emergency services, as per community healthcare standards, including directing clients to the Access and Crisis Line (888-724-7240) for 24/7 access to a counselor, or if in need of referrals.

County TLS Email Encryption
The county has Transport Layer Security (TLS) available for sending encrypted email through a secured connection. This means when a TLS connection is established with a vetted County business partner, all email communication sent between the County and the business partner will be automatically encrypted in transit over the internet through the secured connection. Refer to Appendix H.4 and Appendix H.5 for more information about TLS and how to initiate the process for your agency.

Electronic Health Records
DHCS requires that programs utilizing an Electronic Health Record (EHR) have the following available to DHCS staff during an audit, licensing, or certification review:

- Physical access to the EHR system
- Adequate computer access to the EHR needed for the audit or review
- Access to printers and capability to print necessary documents
• Technical assistance as requested
• Scanned documents, if needed, that are readable and complete

Additionally, DHCS requires programs using an EHR to obtain a signed “Electronic Signature Agreement” from all users who will be signing financial, program or medical records with an electronic signature. This agreement should include, among other things, that the signer has an obligation to protect their electronic signature (id/password), to keep their sign-in information secret and to not share the information, and to notify appropriate program staff if it is stolen, lost, compromised, unaccounted for, or destroyed.

Programs should contact their County BHS COR to notify them if they are planning to implement an EHR as BHS is required to certify that the system used meets DHCS standards.

For more information, see ADP Bulletin 10-01 and its exhibits.
I. RESOURCES

Laws and Regulations

Federal
- 42 CFR part 438 Managed Care
- Health Insurance Portability and Accountability Act (HIPAA)
- Title VI of the Civil Rights Act of 1964, Section 2000d, as amended, prohibiting discrimination based on race, color, or national origin in federally funded programs.
- Title VIII of the Civil Rights Act of 1968 (42 USC 3601 et seq.) prohibiting discrimination on the basis of race, color, religion, sex, handicap, familial status or national origin in the sale or rental of housing.
- The Age Discrimination Act of 1975 (45 CFR Part 90), as amended (42 USC Sections 6101-6107), which prohibits discrimination on the basis of age.
- Age Discrimination in Employment Act (29 CFR Part 1625)
- Title I of the Americans with Disabilities Act (29 CFR Part 1630).
- Title I of the Americans with Disabilities Act (28 CFR Part 35) prohibiting discrimination against the disabled by public entities.
- Title III of the Americans with Disabilities Act (28 CFR Part 36) regarding access.
- The Rehabilitation Act of 1973, as amended (29 USC Section 794), prohibiting discrimination on the basis of individuals with disabilities.
- Executive Order 11246 (42 USC 2000(e) et seq. and 41 CFR Part 60) regarding nondiscrimination in employment under federal contracts and construction contracts greater than $10,000 funded by federal financial assistance.
- Executive Order 13166 (67 FR 41455) to improve access to federal services for those with limited English proficiency.
- The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism.
- Section 1557 of the Consumer Protection and Affordable Care Act.
- Record requirements for providers are to retain, as applicable, the following information: consumer grievance and appeal records in 42 CFR §§438.416, and the data, information, and documentation specified in 42 CFR §§438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.
- Center for Medicare and Medicaid Services
- Social Security
- Office of Inspector General Exclusion List
- GSA Excluded Parties Listing System (debarment)
- Trafficking Victims Protection Act of 2000

State of California
- California Code of Regulations
- California Code of Regulations, Title 9 – Rehabilitation and Developmental Services, Division 4 – Department of Alcohol and Drug Programs, Chapter 4 – Narcotic Treatment Programs
- California Code of Regulations (CCR) Title 9 Counselor Certification
- Title 9, Division 4, Chapter 8, commencing with Section 10800.
SUD Provider Operations Handbook

RESOURCES

- Fair Employment and Housing Act (Government Code Section 12900 et seq.) and the applicable regulations promulgated thereunder (California Administrative Code, Title 2, Section 7285.0 et seq.).
- **California non-discrimination act.** Title 2, Division 3, Article 9.5 of the Government Code, commencing with Section 11135.
- **California Welfare & Institutions Code**
- **California Board of Behavioral Sciences**
- **California Board of Psychology**
- **Voter Registration Services**

**Department of Health Care Services (DHCS)**
- **DHCS General Website**
- **DMC-ODS**
- **Drug Medi-Cal Special Terms and Conditions** (Note: Refer to pages 96-128 and 384-415 for the DMC-ODS system. (Updated June 1, 2018)
- **Department of Health Care Services (DHCS) Perinatal Practice Guidelines FY18/19**
- **DHCS Youth Treatment Guidelines, 2002**
- **Alcohol and/or Other Drug Program Certification Standards, 2017**
- **Drug Medi-Cal Billing Manual**
- **CalOMS**
- **DATAR**

**County of San Diego Resources**
- County of San Diego General [website](#)
- Covered California [website](#)
- Medi-Cal Enrollment [website](#)

**Behavioral Health Services**
- BHS [website](#)
- BHS Administration (619) 563-2700
- Quality Management Email QIMatters.hhsa@sdcounty.ca.gov
- Quality Management Fax (619) 236-1953
- Serious Incident Reporting (SIR) Phone (619) 584-3022
- Performance Improvement Team [BHSQIPIT@sdcounty.ca.gov](#)
- SanWITS Support Desk Email SUD_MIS_Support.HHSA@sdcounty.ca.gov
- SanWITS Support Desk Phone (619) 584-5040
- SanWITS Support Desk Fax (855) 975-4724
- SUD Billing Unit Email [ADSBillingUnit.HHSA@sdcounty.ca.gov](#)
- BHS DMC-ODS System of Care [website](#)
- BHS DMC-ODS Email [Info-DMC-ODS.HHSA@sdcounty.ca.gov](#)
- **RIHS**
Community Client Resources

Client Advocacy Organizations
- Consumer Center for Health Education and Advocacy (877) 734-3258
- Jewish Family Services Patient Advocacy Program (800) 479-2233

Interpreter Services
- Deaf Community Services (619) 398-2441
- Videophone (619) 550-3436
- Interpreter’s Unlimited (858) 451-7490

Administrative Services Organization (ASO)
- Optum San Diego
- Access and Crisis Line (ACL) (888) 724-7240

Client Services Database
- 211 San Diego
- County of San Diego Behavioral Health Services Provider Directory

Other Resources
- American Society of Addiction Medicine (ASAM)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- California Institute for Behavioral Health Solutions (CIBHS)
- California Consortium of Addiction Programs and Professionals (CCAPP)
- California Association of DUI Treatment Programs (CADTP)
SUDPOH

Appendix
## ASAM Criteria Dimensions at a Glance

<table>
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<tr>
<th>DIMENSION #</th>
<th>DIMENSION DESCRIPTION</th>
<th>ASSESSMENT &amp; TREATMENT PLANNING FOCUS</th>
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<tr>
<td>Dimension 1</td>
<td>Acute Intoxication and/or Withdrawal Potential</td>
<td>Assessment for intoxication and/or withdrawal management. Withdrawal management in a variety of levels of care and preparation for continued SUD services.</td>
</tr>
<tr>
<td>Dimension 2</td>
<td>Biomedical Conditions and Complications</td>
<td>Assess and treat co-occurring physical health conditions or complications. Treatment provided within the level of care or through coordination of physical health services.</td>
</tr>
<tr>
<td>Dimension 3</td>
<td>Emotional, behavioral, or Cognitive Conditions and Complications</td>
<td>Assess and treat co-occurring diagnostic or sub-diagnostic mental health conditions or complications. Treatment provided within the level of care or through coordination of mental health services.</td>
</tr>
<tr>
<td>Dimension 4</td>
<td>Readiness to Change</td>
<td>Assess stage of readiness to change. If not ready to commit to full recovery, engage into treatment using motivational enhancement strategies. If ready for recovery, consolidate and expand action for change.</td>
</tr>
<tr>
<td>Dimension 5</td>
<td>Relapse, Continued Use, or Continued Problem Potential</td>
<td>Assess readiness for relapse prevention services and teach where appropriate. If still at early stages of change, focus on raising consciousness of consequences of continued use or problems with motivational strategies.</td>
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<tr>
<td>Dimension 6</td>
<td>Recovery/Living Environment</td>
<td>Assess need for specific individualized, family, or significant other housing, financial, vocational, educational, legal, transportation, childcare or other needs that may help/hinder recovery.</td>
</tr>
</tbody>
</table>
APPENDIX A.2 – CYF Guidance for TRC Sites

Date: January 18, 2019
CYF Memo: # 06-18/19
To: CYF Substance Use Disorder (SUD) Teen Recovery Center (TRC) Providers
From: Yael Koenig, CYF Deputy Director
Re: DMC-ODS Updated Guidance for TRC Sites

Teen Recovery Centers (TRCs) have been designed to include one (1) TRC primary site, and at least two (2) TRC school or ancillary sites within each regionally based TRC contract. It is required that all TRC sites, both TRC primary sites and TRC school sites or ancillary sites, are DMC-certified.

On July 1, 2018, CYF TRCs became part of the San Diego DMC-ODS. Each DMC-certified site has a unique DMC facility ID, CalOMS number, and independently assigned capacity in SanWITS and DATAR. DMC-certified TRC school sites are required to follow all rules, regulations, and DMC-ODS Special Terms and Conditions (STCs), to include regulations which prohibit clients from receiving services at more than one DMC certified facility. This guidance, as applied to TRCs, means that a client can only be seen at the location where they were admitted, and cannot receive services at other DMC-certified sites. Although it may be convenient for a TRC to serve clients at multiple locations within the TRC contract, this is not allowed.

CYF recognizes the unique challenge TRC programs may encounter, at times, when program staff cannot access TRC school sites due to holiday closures, summer break, and/or unique situations where the students are not allowed on campus due to disciplinary action or other reasons. To assist TRC programs with navigating these situations, BHS has provided the following guidelines:

- **Clients admitted to a TRC school site shall utilize that site’s specific facility ID and CalOMS number for SanWITS documentation.**
- **Clients admitted to a TRC school site may receive services at the TRC primary site, on occasion, when the TRC school site is not available due to school closures, holiday, summer break, or other reasons as indicated by documentation in progress note (such as school suspension or expulsion). Group services may not be mixed with clients who are admitted to the TRC primary site and the TRC school site.**
- **When a service is provided to a client admitted to the TRC school site at the TRC primary site, the service location shall be documented as “in the community.” As with all services that are provided in the community, documentation shall explain how program staff maintained the client’s privacy in accordance with 42 CFR.**
- **Clients admitted to TRC primary sites shall not receive services at TRC school sites, due to campus regulations.**
- **If a client admitted to a TRC primary site attends a school which provides TRC school-site services and wishes to receive services at the TRC school-site, client shall be discharged from the TRC primary site as “referred” and admitted to the TRC school-site as a transfer.**
- **TRC ancillary sites that are not located on school campuses shall follow all guidelines listed above.**

If your TRC program provided services that are outside of the guidelines listed above between July 1, 2018, and present, please notify BHS by sending a list of these encounter IDs to the BHS contacts listed below in one (1) email by 01/30/2019. DO NOT SEND PHI.

BHS QM (Elia.Shapira@sdcournty.ca.gov)
BHS MIS (SUD_MIS_Support@sdcounty.ca.gov)
BHS COR (Wendy_Maramba@sdcounty.ca.gov or Kimberly.Pauly@sdcounty.ca.gov)

For questions, input, or concerns, please contact your assigned COR.
Abuse - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Admission – When the program determines that an individual is appropriate for the program and completes and signs all required paperwork including consent to recovery/treatment form and confidentiality release.

Adolescents – Clients between the ages of twelve and under the age of twenty-one.

Adverse benefit determination - In the case of an MCO, PIHP, or PAHP, any of the following:

1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
2) The reduction, suspension, or termination of a previously authorized service.
3) The denial, in whole or in part, of payment for a service.
4) The failure to provide services in a timely manner, as defined by the state
5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.
7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Alcohol and drug free – Free of the use of alcohol and/or the illicit use of drugs.

Alcohol and drug free environment – An environment that is free of the use of alcohol and/or the illicit use of drugs and promotes alcohol and other drug free activities.

Alcohol and/or other drug program certification standards – The most current State of California Department of Alcohol and/or other Drug Program Certification Standards, established to ensure an acceptable level of service is provided to program participants.

Ancillary Service – Additional outside services which provide resources that meet the educational, vocational, health, social, and other needs required to support the participant’s recovery.

Appeal – A request for review of an adverse benefit determination.

Assembly Bill 109 (AB109) – Legislation that was passed for adult parolees, shifting supervision from the State to the County.

Assessment – An in-depth review including level of care assessment and participant strengths and needs to provide baseline information regarding life domains, i.e., substance use disorder, medical, employment, legal, social, psychological, family, environment and special needs. The diagnostic tool is based on the American Society of Addiction Medicine Patient Placement Criteria Third Revision, Revised 2014 (ASAM). The BHS-approved substance use disorder assessment tools are the Addiction Severity Index (ASI) and the Youth Assessment Index (YAI).

Authorization - The approval process for DMC-ODS Services prior to the submission of a DMC claim is the approval process for DMC-ODS Services prior to the submission of a DMC claim.

Available Capacity - means the total number of units of service (bed days, hours, slots, etc.) that a Contractor actually makes available in the current fiscal year.
Bed day – A day and night of a residential substance use disorder program with treatment services provided to a resident that occupies a designated general population bed. Residential programs may only claim for a bed day if a minimum one hour of activity/activities as listed in DHCS Information Notice 18-001 is provided.

Beneficiary - A person who: (a) has been determined eligible for Medi-Cal; (b) is not institutionalized; (c) has a substance-related disorder per the current "Diagnostic and Statistical Manual of Mental Disorders (DSM)" criteria; and (d) meets the admission criteria to receive DMC covered services.

Beneficiary Handbook - The state developed model enrollee handbook.

Board of Directors – The governing body that has full legal authority for governing the operations of substance use disorder programs.

Calendar Week - The seven-day period from Sunday through Saturday.

Care Coordination – Bringing together various providers and information systems to coordinate health services, client needs, and information to help better achieve the goals of treatment and care.

Case Management – A service to assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.

Certified Provider - A substance use disorder clinic location that has received certification to be reimbursed as a DMC clinic by the state to provide services as described in Title 22, California Code of Regulations, Section 51341.1.

Client file – The file that contains the information required by the established standards for each client upon admission to a program.

Cognitive Behavioral Therapy – A short-term, goal-oriented psychotherapy treatment that takes a hands-on, practical approach to problem-solving. Cognitive behavioral therapy (CBT) focuses on exploring relationships between a person's thoughts, feelings and behaviors. During CBT a therapist will actively work with the client to uncover unhealthy patterns of thought and how they may be causing self-destructive behaviors and beliefs. By addressing these patterns, the client and therapist can work together to develop constructive ways of thinking that will produce healthier behaviors and beliefs.

Collateral Services – Sessions with therapists or counselors and significant persons in the life of a beneficiary, focused on the treatment needs of the client, focused on the treatment needs of the client in terms of supporting the achievement of the client's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the beneficiary. Collateral services are an important means of connecting with the significant persons (as described above) as part of gathering information for assessment, as part of educating how best to support the client’s recovery, etc. The client may be present, but it is not a requirement that the client is present.

COMPAS – Correctional Offender Management Profiling for Alternative Sanction, adult risk and needs assessment.

COSDBHS – County of San Diego Behavioral Health Services; COSD is used interchangeably.

Co-Occurring Disorder – A concurrent substance use and mental disorder.

Corrective Action Plan - The written plan of action document which the Contractor or its subcontracted service provider develops and submits to DHCS to address or correct a deficiency or process that is non-compliant with laws, regulations or standards.

Crisis Intervention Services – A contact between a therapist or counselor and a beneficiary in crisis. Services shall focus on alleviating crisis problems. “Crisis” means an actual relapse or an unforeseen event
or circumstance, which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to stabilization of the beneficiary’s emergency situation.

Cultural Competency – A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family member providers, and professionals that enables that system, agency or those professionals, consumer, and family member providers to work effectively in cross-cultural situations.

Culturally and Linguistically Appropriate Services (CLAS) – Established by the federal Office of Minority Health (OMH) the Cultural and Linguistically Appropriate Services (CLAS) standards ensure equal access to quality care by diverse populations.

Days – “Days” means calendar days, unless otherwise specified.

Dedicated Capacity - The historically calculated service capacity, by modality, adjusted for the projected expansion or reduction in services, which the Contractor agrees to make available to provide DMC-ODS services to persons eligible for Contractor services.

Delivery System - DMC-Organized Delivery System is a Medi-Cal benefit in counties that choose to opt into and implement the Pilot program. DMC-ODS shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in a county that opts into the Pilot program. Upon approval of an implementation plan, the state shall contract with the county to provide DMC-ODS services. The county shall, in turn, contract with DMC certified providers or provide county-operated services to provide all services outlined in the DMC-ODS. Counties may also contract with a managed care plan to provide services. Participating counties with the approval from the state may develop regional delivery systems for one or more of the required modalities or request flexibility in delivery system design or comparability of services. Counties may act jointly in order to deliver these services.

Discharge Services – The process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services.

Discharge Plan – An individual plan of action to support recovery after an individual has been discharged from a treatment program.

Discharge Summary – The report that must be completed, within thirty (30) days following the discharge of any client.

Drug-Free Birth – A birth that occurs while a woman is in treatment, and the baby is free of all drugs.

Drug Medi-Cal (DMC) Program - The state system wherein beneficiaries receive covered services from DMC-certified substance use disorder treatment providers.

Drug Medi-Cal Organized Delivery System (DMC-ODS) - DMC-Organized Delivery System is a Medi-Cal benefit in counties that choose to opt into and implement the Pilot program. DMC-ODS shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in a county that opts into the Pilot program. Upon approval of an implementation plan, the state shall contract with the county to provide DMC-ODS services. The county shall, in turn, contract with DMC certified providers or provide county-operated services to provide all services outlined in the DMC-ODS. Counties may also contract with a managed care plan to provide services. Participating counties with the approval from the state may develop regional delivery systems for one or more of the required modalities or request flexibility in delivery system design or comparability of services. Counties may act jointly in order to deliver these services.

Drug Medi-Cal (DMC) Termination of Certification - The provider is no longer certified to participate in the Drug Medi-Cal program upon the state’s issuance of a Drug Medi-Cal certification termination notice.
Drug Testing – A process to collect blood, saliva, or urine to determine the presence of alcohol or illicit drugs in an individual’s system verified by a certified laboratory. Drug testing shall be conducted in conjunction with treatment.

Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) - The federally mandated Medicaid benefit that entitles full-scope Medi-Cal-covered beneficiaries less than 21 years of age to receive any Medicaid service necessary to correct or ameliorate a defect, mental illness, or other condition, such as a substance-related disorder, that is discovered during a health screening.

Education and Job Skills - Linkages to life skills, employment services, job training, and education services.

Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1) Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
2) Serious impairment to bodily functions.
3) Serious dysfunction of any bodily organ or part.

Emergency Services - Covered inpatient and outpatient services that are as follows:

1) Furnished by a provider that is qualified to furnish these services under this Title.
2) Needed to evaluate or stabilize an emergency medical condition.

Evidence-Based Practice(s) – Practices that have been implemented and are supported by evidence. Providers will be expected to implement, at a minimum, the two EBPs of Motivational Interviewing (MI) and Relapse Prevention. Other EBPs include cognitive behavioral therapy, trauma informed treatment, family therapy and psychoeducation.

Face-to-Face – A service occurring in person.

Family Support - Linkages to childcare, parent education, child development support services, and family and marriage education. Family support is only available under Recovery services.

Family Therapy – Including a beneficiary’s family members and loved ones in the treatment process, and education about factors that are important to the beneficiary’s recovery as well as their own recovery can be conveyed. Family members may provide social support to beneficiaries, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.

Fraud - An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or state law.

Gender Identity - One's innermost concept of self as male, female, a blend of both or neither – how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different from their sex assigned at birth.

Grievance – An expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision.

Grievance and Appeal System - The processes the MCO, PIHP, or PAHP implements to handle appeals.
of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.

**Group Counseling** – Contacts in which one or more therapists or counselors treat two or more clients at the same time with a maximum of 12 in the group, focusing on the needs of the individuals served. A beneficiary that is 17 years of age or younger shall not participate in group counseling with any participants who are 18 years of age or older. However, a beneficiary who is 17 years of age or younger may participate in group counseling with participants who are 18 years of age or older when the counseling is at a provider's certified school site.

**Hospitalization** - When a patient needs a supervised recovery period in a facility that provides hospital inpatient care.

**Illicit Use of Drugs** – The use of any substance defined as a drug in Section 11014, Chapter 1, Division 10 of the Health and Safety Code, except:

- Drugs or medications prescribed by a physician or other person authorized to prescribe drugs, pursuant Section 4036, Chapter 9, Division 2 of the Business and Professions Code and used in the dosage and frequency prescribed; or
- Over-the-counter drugs or medications used in the dosage and frequency described on the box, bottle, or package insert.

**Imminent Danger** – Imminent danger has the following three components:

- A strong probability that certain behaviors will occur (e.g., continued alcohol or drug use or relapse or non-compliance with psychiatric medications)
- The likelihood that these behaviors will present a significant risk of serious adverse consequences to the individual and/or others (as in a consistent pattern of driving while intoxicated)
- The likelihood that such adverse events will occur in the very near future
- In order to constitute “imminent danger” all three elements must be present.

**Individual Counseling** – Contact between a beneficiary and a therapist or counselor. Services provided in-person, by telephone or by telehealth qualify as Medi-Cal reimbursable units of service and are reimbursed without distinction.

**Intake** – The process of determining a beneficiary meets the medical necessity criteria and a beneficiary is admitted into a substance use disorder treatment program. Intake includes the evaluation or analysis of the cause or nature of mental, emotional, psychological, behavioral, and substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for substance use disorder treatment and evaluation.

**Intensive Outpatient (IOS) Services** – (ASAM Level 2.1) Structured programming services consisting primarily of counseling and education about addiction-related problems a minimum of nine (9) hours with a maximum of 19 hours per week for adults, and a minimum of six (6) hours with a maximum of 19 hours per week for adolescents. Services may be provided in any appropriate setting in the community. Services may be provided in-person, by telephone or by telehealth. Services may be provided in-person, by telephone, or by telehealth, and in any appropriate setting in the community.

**Job Readiness Education** – Educational sessions focused on teaching the resident how to write a resume, search for, attain, and maintain employment in the community–at–large.

**Justice Override** – A client is court-ordered or probation-recommended to residential treatment but client is not assessed to meet ASAM criteria for residential LOC.

**Licensed Practitioner of the Healing Arts (LPHA)** – Includes: Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed
Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians includes: Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

**Managed Care Organization** - An entity that has, or is seeking to qualify for, comprehensive risk contract under this part, and that is-

1) A Federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of this chapter; or
2) Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions:
   a. Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.

**Medical Necessity and Medically Necessary Services** - SUD treatment services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of a disease, illness or injury consistent with and 42 CFR 438.210(a)(4) or, in the case of EPSDT, services that meet the criteria specified in Title 22, Sections 51303 and 51340.1.

**Medical Necessity Criteria** - Adult beneficiaries must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, and must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria. Youth under 21 may be assessed to be at risk for developing a substance use disorder, and if applicable, must meet the ASAM adolescent treatment criteria. Beneficiaries under age 21 are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, beneficiaries under age 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health.

**Medical Director** - Physician licensed by the Medical Board of CA or Osteopathic Medical Board of CA.

**Medical Psychotherapy** - A type of counseling service that has the same meaning as defined in 9 CCR § 10345.

**Medication Assisted Treatment (MAT)** - The use of prescription medications, in combination with counseling and behavioral therapies, to provide a whole-person approach to the treatment of substance use disorders (SUD). Research shows that a combination of MAT and behavioral therapies is a successful method to treat SUD. There are different doors through which beneficiaries in need of MAT enter the Medi-Cal system.

**Medication Services** – Medication Services including MAT, will be discussed and offered as a concurrent treatment option for individuals with an alcohol- and/or opioid-related SUD condition. The prescription or administration of MAT, and the assessment of side effects and/or impact of these medications, should be conducted by staff lawfully authorized to provide such services within their scope of practice and licensure.

**Memoranda of Understanding (MOU)** – Written agreement between entities, individuals, programs, and/or others that specifies mutual understanding of responsibility.

**Methadone** – An opiate agonist medication that has been approved for use in narcotic replacement therapy.

**Minor** – Individuals under the age of 18 years old.
Modality - Necessary overall general service activities to provide substance use disorder services as described in Division 10.5 of the HSC.

Motivational Interviewing – Motivational Interviewing focuses on exploring and resolving ambivalence and centers on motivational processes within the individual that facilitate change. The method differs from more “coercive” or externally driven methods for motivating change as it does not impose change (that may be inconsistent with the person's own values, beliefs or wishes); but rather supports change in a manner congruent with the person's own values and concerns.

Naltrexone Treatment Services - An outpatient treatment service directed at serving detoxified opiate addicts by using the drug Naltrexone, which blocks the euphoric effects of opiates and helps prevent relapse to opiate addiction.

Network - The group of entities that have contracted with the PIHP to provide services under this Agreement.

Network Provider - Any provider, group of providers, or entity that has a network provider agreement with a MCO, PIHP, PAHP, or a subcontract, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state’s contract with an MCO, PIHP or PAHP. A network provider is not a subcontractor by virtue of the network provider agreement.

Non-participating provider - A provider that is not engaged in the continuum of services under this Agreement.

Non-Perinatal Residential Program - Services are provided in DHCS licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria. These residential services are provided to the non-perinatal population and do not require the enhanced services found in the perinatal residential programs.

Notice of Adverse Benefit Determination - A formal communication of any action and consistent with 42 CFR 438.404 and 438.10.

Observation - The process of monitoring the beneficiary’s course of withdrawal. It is to be conducted as frequently as deemed appropriate for the beneficiary and the level of care the beneficiary is receiving. This may include but is not limited to observation of the beneficiary’s health status.

Opioid (Narcotic) Treatment Program (OTP) - An outpatient clinic licensed by the state to provide narcotic replacement therapy directed at stabilization and rehabilitation of persons who are opiate-addicted and have a substance use diagnosis.

Out-of-Network Access – A provider who is not on the County of San Diego DMC-ODS plan’s list of providers.

Outpatient Services - (ASAM Level 1.0) outpatient service directed at stabilizing and rehabilitating persons up to nine hours of service per week for adults, and less than six hours per week for adolescents.

Outreach To Person Who Inject Drugs - Per 42 US Code section 300x-21, “outreach to persons who injects drugs” are activities that encourage individuals in need of such treatment to undergo treatment.

Overpayment - Any payment made to a network provider by a MCO, PIHP, or PAHP to which the network provider is not entitled to under Title XIX of the Act or any payment to a MCO, PIHP, or PAHP by a state to which the MCO, PIHP, or PAHP is not entitled to under Title XIX of the Act.

Participating Provider - Providing research-based education on addiction, treatment, recovery and associated health risks.
Patient Education – Providing research-based education on addiction, treatment, recovery and associated health risks. Note: Patient Education and Client Education are used interchangeably.

Payment Suspension - The Drug Medi-Cal certified provider has been issued a notice pursuant to W&I Code, Section 14107.11 and is not authorized to receive payments after the payment suspension date for DMC services, regardless of when the service was provided.

Peer Support – Peers give and receive nonprofessional, nonclinical assistance to achieve long-term recovery for beneficiaries. The support is provided by individuals who have experiential knowledge. Peers provide assistance to promote a sense of belonging within the community. Another critical component that peers provide is the development of self-efficacy through role modeling and assisting peers with ongoing recovery through mastery of experiences and finding meaning, purpose, and social connections in their lives.

Perinatal Services – Covered services as well as mother/child habilitative and rehabilitative services; services access (i.e., provision or arrangement of transportation to and from medically necessary treatment); education to reduce harmful effects of alcohol and drugs on the mother and fetus or infant; and coordination of ancillary services (Title 22, Section 51341.1(c) 4).

Physician - A Doctor of Medicine or osteopathy legally authorized to practice medicine or surgery in the State in which the function is performed.

Physician Consultation - Services are to support DMC physicians with complex cases, which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.

Physician Services - Services provided by an individual licensed under state law to practice medicine.

Prepaid Inpatient Health Plan (PIHP) - An entity that: (1) Provides services to enrollees under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use State Plan payment rates. (2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) Does not have a comprehensive risk contract.

Post-Partum – As defined for DMC purposes, means the 60-day period beginning on the last day of pregnancy, regardless of whether other conditions of eligibility are met. Eligibility for perinatal services shall end on the last day of the calendar month in which the 60th day occurs.

Post Service Post Payment (PSPP) Utilization Review – The review for program compliance and medical necessity conducted by the state after service was rendered and paid. The Department may recover prior payments of Federal and state funds if such a review determines that the services did not comply with the applicable statutes, regulations, or terms as specified in Article III.PP of this Agreement.

Post Service Pre Payment (PSPP) Utilization Review - Formally known as DMC Monitoring Reviews, differ from PS Post Payment reviews in that there is no financial recovery (i.e. recoupment) associated with these types of reviews. Rather, they are conducted as part of the DHCS requirement to provide programmatic, administrative, and fiscal oversight of statewide DMC SUD services. The Post Service Pre-Payment reviews include an on-site review of certain DMC charts, employee files, policy and procedures, and the physical location of the program.

Primary Care - All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the state in which the practitioner furnishes them.

Provider – Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the state in which it delivers the services.
Program Fee – A fee charged to the client for program services. Fees may NOT be charged to CalWORKs or Drug Medi-Cal clients (except Medi-Cal beneficiaries with a share of cost).

Quality Assessment/Utilization Review (QA/UR) – Reviews of physicians, health care practitioners and providers of health care services in the provision of health, care services and items for which payment may be made to determine whether:

1) Such services are or were reasonable and medically necessary and whether such services and items are allowable.
2) The quality of such services meets professionally recognized standards of health care.

Recertification - The process by which the DMC certified clinic is required to submit an application and specified documentation, as determined by DHCS, to remain eligible to participate in and be reimbursed through the DMC program. Re-certification shall occur no less than every five years from the date of previous DMC certification or re-certification.

Recovery Monitoring - Recovery coaching, monitoring via telephone and internet. Recovery monitoring is only available in Recovery services.

Recovery Plan – A written document, completed by the client after consultation with staff, detailing client’s individual goals with specific services and activities outlined, including beginning and end dates. They shall be kept in the client file.

Recovery Services – Services and activities that support and promote a drug and alcohol-free lifestyle, develop life skills, and engage participants in recovery.

Rehabilitation Services - Includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under state law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level.

Relapse – A single instance of a beneficiary's substance use or a beneficiary's return to a pattern of substance use.

Relapse Prevention - Learning and practicing coping skills, building community connections, relapse prevention, self-efficacy, and an improved ability to structure and organize tasks of daily living.

Relapse Trigger - An event, circumstance, place or person that puts a beneficiary at risk of relapse.

Residential Treatment Services - A non-institutional, 24-hour non-medical, short-term residential program of any size that provides rehabilitation services to beneficiaries. Each beneficiary shall live on the premises and shall be supported in their efforts to restore, maintain, and apply interpersonal and independent living skills, and access community support systems. Programs shall provide a range of activities and services. Residential treatment shall include 24-hour structure with available trained personnel, seven days a week, including a minimum of five (5) hours of clinical service a week to prepare beneficiary for outpatient treatment.

Safeguarding Medications - Facilities will store all resident medication and facility staff members may assist with resident’s self-administration of medication.

Service Area - means the geographical area under Contractor’s jurisdiction.

Staff – A paid individual who, by virtue of education, training and/or experience, provides services that may include listening, advice, opinion, and/or instruction to an individual or group to allow participants an opportunity to explore problems related directly or indirectly to alcohol and/or other drugs.

Structured activities – Assessment, individual and group counseling family therapy, patient education,
collateral services, crisis intervention, treatment planning, transportation services to and from medically necessary treatment, and discharge services.


**SUD Counselor** – Provide counseling services such as intake, assessment of need for services, treatment planning, recovery planning, individual or group counseling to participants, patients, or residents in any substance use disorder (SUD) program licensed or certified by DHCS are required by the State of California to be certified.

**Telehealth between Provider and Beneficiary** - Office or outpatient visits via interactive audio and video telecommunication systems.

**Telehealth between Providers** - Communication between two providers for purposes of consultation, performed via interactive audio and video telecommunications systems.

**Temporary Suspension** - The provider is temporarily suspended from participating in the DMC program as authorized by W&I Code, Section 14043.36(a). The provider cannot bill for DMC services from the effective date of the temporary.

**Threshold Language** - Language that has been identified as the primary language, as indicated on the Medi-Cal Eligibility System (MEDS), of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area. In San Diego County the threshold languages are English, Tagalog, Spanish, Arabic, Farsi and Vietnamese.

**Transportation Services** - Provision of or arrangement for transportation to and from medically necessary treatment.

**Trauma-Informed** – Awareness and understanding of the prevalence of historical and current trauma, its impact on clients and a further commitment to not re-traumatize or do further harm through interventions, policies, or procedures.

**Trauma-Informed Services** – All components of a given service system that have been reconsidered and evaluated in light of a basic understanding of the role that violence plays in the lives of people seeking mental health and SUD services.

**Treatment Planning** – The provider (SUD counselor or LPHA) shall prepare an individualized written treatment plan, based upon information obtained in the intake and assessment process. The development and update timeframes of treatment plans will depend on the level of care in which treatment is delivered.

**Tuberculosis (TB) Disease [Active]** – Persons who have active TB usually have symptoms. TB is a disease of the lungs or larynx that can be transmitted when a person with the disease coughs, sings, laughs, speaks, or breathes.

**Tuberculosis (TB) Infection** – Individual may not have symptoms of the disease; the infected person generally has a positive TB skin test (TST) and a normal chest x-ray. Infection may be recent or present for a long period of time.

**Unit of Service** – means:

1) For case management, intensive outpatient treatment, outpatient services, Naltrexone treatment services, and recovery services contact with a beneficiary in 15-minute increments on a calendar day.

2) For additional medication assisted treatment, physician services that includes ordering, prescribing, administering, and monitoring of all medications for substance use disorders per visit or in 15-minute increments.
3) For narcotic treatment program services, a calendar month of treatment services provided pursuant to this section and Chapter 4 commencing with 9 CCR § 10000.

4) For physician consultation services, consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists in 15-minute increments.

5) For residential services, providing 24-hour daily service, per beneficiary, per bed rate.

6) For withdrawal management per beneficiary per visit/daily unit of service.

**Urgent Care** - A condition perceived by a beneficiary as serious, but not life threatening. A condition that disrupts normal activities of daily living and requires assessment by a health care provider and if necessary, treatment within 48 hours.

**Utilization** - The total actual units of service used by beneficiaries and participants.

**Volunteer** – An individual that is an unpaid staff member.

**Warm Handoff** – When a treatment agency, case manager, counselor, etc. refers a client for additional services related to their treatment. This is not a simple referral but entails going the extra step to ensure that the client feels supported and is not left to their own devices. An example is when a counselor calls another counselor, introduces the client to the counselor, and then sets up a meeting between the client and new counselor. The client will go into the meeting having already been introduced to the new counselor.

**Withdrawal Management** - Detoxification services provided in either an ambulatory or non-ambulatory setting consistent with the level of care criteria to DMC ODS beneficiaries.
## Withdrawal Management Standards

<table>
<thead>
<tr>
<th>Topic</th>
<th>Timelines/Forms</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Admit/Assessment</strong>&lt;br&gt;First Face to Face contact with the client. This starts the timeline requirements.</td>
<td>Completed with SUD Counselor and/or LPHA within 24 Hours of admission:&lt;br&gt;- Initial LOC Assessment&lt;br&gt;- Risk Assessment&lt;br&gt;- Health Questionnaire&lt;br&gt;- TB Screening Form</td>
<td>• Review all acknowledgements, financial info, releases and consents.&lt;br&gt;• Complete Initial LOC Assessment with Risk Assessment, Health Questionnaire, and TB Screening to determine level of care (LOC).&lt;br&gt;• Face to Face interaction between SUD Counselor and LPHA.</td>
</tr>
<tr>
<td><strong>Other WM Admission Procedures</strong></td>
<td>At Admission must provide withdrawal management interventions and complete for initial 24 hours:&lt;br&gt;&lt;br&gt;<strong>WM Observation Log</strong>&lt;br&gt;(Observation - The process of monitoring the client’s course of withdrawal. It is to be conducted as frequently as deemed appropriate for the client, and at least every 30 minutes for the first 24 hours. This may include but is not limited to observation of the client’s health status.)&lt;br&gt;- Observation can be done up to 72 hours or longer according to the client’s needs and current withdrawal symptoms.&lt;br&gt;- At 24 hours, trained staff assess client symptoms and determine whether the frequency of the observations will be continued, reduced, or discontinued.</td>
<td>• Complete substance(s) specific withdrawal management scoring tool at admit and as required thereafter. (Program decides appropriate tools to use depending on substance used)&lt;br&gt;• Closely observe client for withdrawal symptoms as clinically appropriate 24-72 hours from admission.&lt;br&gt;• Complete Withdrawal Management Observation Log for at least the initial 24 hours.&lt;br&gt;• At 24 hours from admission and at least every 24 hours until the determination is made to discontinue observations, staff select an Observation Status that specifies whether observations will be continued, decreased, or discontinued and document the reason for the selected Observation Status based on symptomatology and protocols approved by the Medical Director.</td>
</tr>
</tbody>
</table>
## Withdrawal Management Standards

| Withdrawal Management (WM) Treatment Plan, Diagnosis and Medical Necessity (use of ASAM LOC, DSM 5 Dx) | These 2 forms are be completed within 72 hours of admission:  
- DDN  
- WM Treatment plan  
  This form is completed prior to a planned discharge and/or at maximum of 7 days from admission to withdrawal management:  
- Level of Care Recommendation |  
| LPHA establishes medical necessity criteria via DSM 5 and ASAM LOC.  
- LPHA must document the criteria met specific to the substance use disorder diagnosis.  
- Complete individualized WM Treatment Plan by SUD Counselor and/or LPHA  
- Tx Plan signed by client as soon as clinically appropriate (or document why client did not sign)  
- Client offered MAT services whenever appropriate.  
- LOC Recommendation is used to assist the client with transition to the appropriate next level of care. |

| Withdrawal Management (WM) Programs: Physical Examination Requirements | WM programs must follow these physical examination requirements within the timeline of 72 hours from admission to program:  
- Program MD review of results of a physical examination conducted within the past 12 months; or provide a physical examination of the client (if the program is IMS certified).  
- If the physical examination results are not reviewed within 72 hours or the client has not had a physical examination within the past 12 months or within 72 hours from admission, the treatment plan must include a goal for the client to obtain a physical examination. This is required even if the program is unable to assist in completing the goal during the | The Physical Exam requirements can be satisfied in these 3 ways:  
- Documentation of physical exam results within the last 12 months, and results are reviewed by the MD within 72 hours of admission.  
- Goal to obtain a physical exam on the Treatment Plan (MD can perform the exam at the program. Residential must have IMS certification for this option)  
- Physical exam completed while at program, and MD reviews and signs/dates the physical exam. (Printed name/signature and date need to be adjacent and done within 72 hours of admission. A stamped signature is not acceptable.) |

June 4, 2020
## Withdrawal Management Standards

<table>
<thead>
<tr>
<th>Category</th>
<th>Requirement</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidental Medical Services (IMS)</td>
<td>Complete within 72 hours from admission:</td>
<td>• Face to Face assessment by Medical Doctor or Healthcare Practitioner (must be within scope of practice)</td>
</tr>
<tr>
<td>(Recommended but not required)</td>
<td>• DHCS 4026 Form (IMS Certification) (See DHCS Info Notice 18-031 for IMS guidelines)</td>
<td></td>
</tr>
<tr>
<td>Drug Toxicology Testing and Screening</td>
<td>Upon admission and per program policies complete:</td>
<td>• Breathalyzer</td>
</tr>
<tr>
<td></td>
<td>• Drug Test and Results Log</td>
<td>• Urine Screening</td>
</tr>
<tr>
<td>Centrally Stored Medications</td>
<td>Throughout the client’s stay, complete:</td>
<td>• Blood Testing</td>
</tr>
<tr>
<td></td>
<td>• Centrally Stored Medication and Destruction Record</td>
<td>• Document results and reporting</td>
</tr>
<tr>
<td>Disposal of Client Medications</td>
<td>Within 30 Days of discharge</td>
<td>• Documents and documentation of results must be filed in client chart.</td>
</tr>
<tr>
<td>Medication Self-Administration</td>
<td>Admission throughout client stay</td>
<td>• Medication storage requirements within Federal, State and local regulations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Proper storage and handling of Schedule II-IV Medications</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diversion Control Policy and staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Disposal of unclaimed medications</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Policy and Procedure in place for a disposal plan that follows Federal, State and local regulations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Inventory of prescribed and over the counter medication with required information upon admission.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medication times logged/monitored</td>
</tr>
</tbody>
</table>
## Withdrawal Management Standards

| Naloxone                      | Permitted at all residential and AOD treatment programs | • Recorded, stored and destroyed in same manner as Rx medications.  
|                              |                                                        | • Administering staff competency per AOD standards.  
|                              |                                                        | • Stocking doses  
|                              |                                                        | • Policies, procedures and protocols.  
| **Summary of Clinical Services** | Daily documentation and evidence of clinical services (e.g., Groups have sign-in sheets):  
|                              | • WM Daily Progress Note, or  
|                              | • SUD Treatment Progress Note | • Clinical services to be documented using observation logs, WM Daily PN or SUD Treatment PN and group sign-in sheets. There must be a note present for each day of service.  
|                              |                                                        | • In WM, the expectation is monitoring the client for safety during the withdrawal process. Once observation can be discontinued, the client can participate in the milieu. The standard is that a daily progress note document what is happening with the client, and what service the program provided to assist the client on that day (not a minimum number of contact hours).  
|                              |                                                        | • Programs are encouraged to consult with the MD for continuing observation when the client reports continued symptoms. This should be documented in the progress notes.  
|                              |                                                        | • The narrative section of the WM Daily Progress note is intended to summarize the day. Providers should not itemize each service in this section. Respond to each prompt so as to meet the minimum standard requirements.  

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**June 4, 2020**
## Withdrawal Management Standards

| Group Sign in Sheet | - Use the group sign in sheet form to document attendance at each group session (See SUDPOH Appendix D.4).  
|                     | - The group sign in sheet must be completed and signed the same day the group was provided. |
| Discharge Plan      | - The topic and start/end time must be documented on this sheet and must match the topic and start/end time documented on the service record portion of the progress note (don’t forget to add AM/PM).  
|                     | - Client’s full (first and last) printed names must be adjacent to their signature. The SUD or LPHA printed name must be adjacent to their signature and date signed. |
| Discharge Summary   | - Assist client in preparing for relapse triggers and how to avoid them, along with support plan that includes referrals for ongoing care and resources.  
|                     | - Must be signed and dated by counselor and client with a copy offered to the client and original placed in the client record.  
|                     | - Reminder, ASAM LOC Recommendation form is completed prior to a planned discharge.  
|                     | - Written summary of the treatment episode including duration of treatment, reason for discharge, whether voluntary or involuntary, discharge prognosis and disposition.  
|                     | - Complete CalOEMS Discharge in SanWITS.  
|                     | - Use CalOEMS Administrative Discharge, if client has left treatment and cannot be interviewed.|

Completed prior to a planned discharge.
## Withdrawal Management Standards

<table>
<thead>
<tr>
<th>Staffing plan that includes Nursing (Recommended but not required)</th>
<th>Admission throughout client stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>• When 24/7 nursing staff is not used/available, providers are expected to implement policies and procedures that have been developed with the Medical Director that includes, at a minimum, working collaboratively with emergency departments and primary care physicians to ensure that the client is safe to receive treatment at the WM program.</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX B.2 – ASAM Level of Care Determination Guidelines

ASAM Level of Care (LOC) Determination Guidelines (1 of 2)

As emergency needs come first, the highest severity problem (with specific attention to Dimensions 1, 2 and 3) should guide the client’s entry point into the treatment continuum. Then, the least intensive level of care that can safely and effectively help the client meet identified needs guides the LOC determination. This brief overview is not intended to replace the use of the comprehensive admission criteria as described in “The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition, 2013.”

<table>
<thead>
<tr>
<th>ASAM Levels of Withdrawal Management</th>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
</table>
| Ambulatory WM without Extended Onsite Monitoring (Outpatient) | 1-WM  | Mild withdrawal but is at minimal risk of severe withdrawal syndrome and is assessed as likely to complete needed WM and to enter into continuing treatment or self-help recovery as evidenced by meeting one of these criteria:  
  - Has an adequate understanding of ambulatory WM and has expressed commitment to enter such a program, or  
  - Has adequate support services to ensure commitment to completion of WM and entry into ongoing treatment or recovery, or  
  - Is willing to accept a recommendation for tx (i.e. MAT) or to attend outpatient sessions/self-help |
| Ambulatory WM with Extended Onsite Monitoring (Outpatient) | 2-WM  | Moderate withdrawal requiring extended WM support and supervision; at night, has supportive living situation; likely to complete WM as evidenced by meeting the first criteria and either of the three remaining criteria:  
  - Client/supports clearly understand instructions for care and are able to follow instructions, and  
  - Has an adequate understanding of ambulatory WM and has expressed commitment to enter such a program, or  
  - Has adequate support services to ensure commitment to completion of WM and entry into ongoing treatment or recovery, or  
  - Evidences willingness to accept a recommendation for treatment once withdrawal has been managed (for example, to attend outpatient sessions or self-help groups) |
| Clinically Managed Residential WM | 3.2-WM | Moderate-severe withdrawal, but needs 24-hour support because of inadequate home supervisor or support structure, as evidenced by meeting one of these three criteria:  
  - Recovery environment is not supportive of WM and entry into treatment, and the client does not have sufficient coping skills to safely deal with the problems in the recovery environment, or  
  - Has a recent history of WM at less intensive levels of service that is marked by inability to complete WM or to enter into continuing addiction treatment, and the client continues to have insufficient skills to complete WM, or  
  - Has demonstrated an inability to complete WM at a less intensive level of service, as manifested by continued use of other-than-prescribed drugs or other mind-altering substances. |
| Medically managed Intensive Inpatient WM | 4-WM  | Level 4 is the only available level of care that can provide the medical support and comfort care needed, as evidenced by one of these:  
  - WM regimen or a client’s response to that regimen requires monitoring or intervention more frequently than hourly, or  
  - Need for WM or stabilization while pregnant, until she can be safely treated in a less intensive level of care. |

Note: Clients may be in a level of Withdrawal Management and another LOC at the same time.

Revised May 2018
ASAM Level of Care (LOC) Determination Guidelines (2 of 2)

Please note these are guidelines and not rules as clinical judgment should always be utilized when determining an ASAM LOC.

- Risk rating of “0” OR “1” in all
- Risk rating of “0” OR “1” in Dimensions 1 & 2
- Risk rating of “1” OR “2” in Dimension 3
- Risk rating of “2” OR “3” in Dimensions 4, 5, OR 6
- Risk rating of “2” OR “3” in Dimension 4
- Risk rating of “3-4” in Dimensions 5 & 6
- Risk rating of “3-4” in Dimension 5
- Risk rating of “3-4” in Dimension 6
- Risk rating of “2-3” in Dimension 3
- Risk rating of “3-4” in Dimension 4
- Risk rating of “3-4” in Dimension 5
- Risk rating of “3-4” in Dimension 6
- Risk rating of “2-3” in Dimension 1
- Risk rating of “0-1” in Dimensions 2 & 3
- Risk rating of “0” OR “1” in Dimensions 2-4
- Risk rating of “0” OR “1” in Dimension 5
- Risk rating of “0” OR “1” in Dimension 6
- Physiologically dependent on opioids & requires OTP to prevent withdrawal (Dimension 1)

ASAM Level 1
Outpatient Treatment

ASAM Level 2.1
Intensive Outpatient Treatment

ASAM Level 3.1
Clinically Managed Low-Intensity Residential Treatment

ASAM Level 3.1
Clinically Managed Population-Specific High-Intensity Residential Treatment

ASAM Level 3.5†
Clinically Managed High-Intensity Residential Treatment

ASAM Level 3.2-WM
Clinically Managed Residential Withdrawal Management

ASAM Level 4
Medically Managed Intensive Inpatient Services***

OTP/NTP Level 1

LOC Determination is always based on clinical judgment regarding client needs in all ASAM dimensions. The following are only recommendations.

These recommendations do not replace use of complete admission criteria. Staff must be trained in ASAM prior to determining medical necessity.

* For adults - if stable, a co-occurring capable program is appropriate. If not stable, a co-occurring enhanced program is required.
† For adolescents, withdrawal (or risk of withdrawal) is being managed concurrently at another level of care.
** For adults, a co-occurring enhanced setting is required for those with severe and chronic mental illness.
†† For adolescents, mild to moderate withdrawal or risk, but does not need pharmacological management or frequent medical or nursing monitoring.
*** If the client’s only severity is in Dimensions 4-6 without high severity in Dimension 1, 2, and/or 3, then the client is not appropriate for this level of care.

Revised May 2018
Appendix B.3 – DMC-ODS Staff Service Categories

DMC-ODS Staff Service Categories

<table>
<thead>
<tr>
<th></th>
<th>MD</th>
<th>LPHA</th>
<th>SUD Counselor</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MD ONLY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician-to-Physician Consultation</td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>NTP Medication Psychotherapy</td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td><strong>LPHA and MD ONLY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intake and Assessment Review / Approval</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Medication Services</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Treatment Planning Review / Approval</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Family Therapy</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td><strong>MD, LPHA and SUD COUNSELOR</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intake and Assessment with Co-Signature</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Individual and Group Counseling</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Treatment Planning Services</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Patient Education</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Collateral Services</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Crisis Intervention Services</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Discharge / Referral Services</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Withdrawal Management Services</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Case Management Services</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Recovery Services</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>

DMC-ODS Staff Definitions

**MD:** Physicians are a sub-category of the LPHA definition and must be licensed, registered, certified, or recognized under California State scope of practice statutes. Physicians shall provide services within their individual scope of practice.

**Licensed Practitioner of the Healing Arts (LPHA):** Professional staff must be licensed, registered, certified, or recognized under California State scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Non-Physician LPHAs include: Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

**SUD Counselor:** Staff who provide counseling services in a licensed or certified Substance Use Disorder (SUD) program must be appropriately registered and/or certified at all times with one of the following DHCS approved certifying organization:

- California Association of DUI treatment Programs (CATP)-certified Alcohol & Other Drug Counselor
- California Consortium of Addiction Programs and Professions (CCAPP)
- California Association for Drug/Alcohol Educators (CAADE)
RECOVERY SERVICES TRANSITION FLOWCHART
Client completed treatment in:

- Residential
- Outpatient
- OTP

Within same program

1. Current LOC program enrollment ended in SanWITS
2. D/C in CDM - DO NOT CLOSE case
3. Add new program enrollment for RS in SanWITS (for clients who engage in Recovery Services)
4. Minimum 3 attempts to engage client within 30 days

To another program

Current program (prior to discharge):
1. Phone call to new provider
2. Schedule an appt within 10 days of discharge
3. D/C in CDM & close episode in SanWITS.
4. Fax required documents to new provider prior to the scheduled appointment*

No new intake paperwork required.
Review treatment plan, ASAM LOC and DDN

New Program:
1. Review previous program documents*
2. If client is a no show to appt, minimum 3 attempts to engage client within 30 days
3. Complete admission/intake documents
   - Financial Eligibility
   - Consents
   - 42 CFR
   - Risk Assessment
   - HIFAA/NPP
   - TB Screening
   - If more than 90 days from the last treatment episode, complete the Initial LOC Assessment on date of intake

Within 30 days of admission, complete:
- New DDN
- TEA
- Recovery Plan

Every 90 days:
- TEA
- Updated Recovery Plan

*Documents to be faxed to the new program: Intake/Assessment, most recent Treatment Plan, DDN, ASI/YAI, most recent ASAM LOC, Risk Assessment, Health Questionnaire, Discharge Summary, and Discharge Plan.

Please Note: Clients in Recovery Services may not participate in the same group as the Outpatient or Residential LOC clients.
APPENDIX B.5 – Recovery Residences – Supplemental Funding Guidelines

Recovery Residences—Supplemental Funding

OUTPATIENT PROGRAMS

- Primary mechanism by which to access supplemental Recovery Residence funds

- Client must be actively receiving Outpatient Treatment / Intensive Outpatient or Recovery Services under BHS SUD contract, at minimum weekly

- Client must have a specific and measurable housing goal on the Treatment Plan/Recovery Plan reviewed at timelines indicated in the provider’s contract, and when clinically indicated.

- County funds a maximum of $40/day

- Client must contribute a minimum of 30% of net (take home) monthly income, including state/federal benefits

- Contract allocation: Separate RR cost center with dedicated funding

- RR cost center funding shall be allocated exclusively to the RR cost center for direct payments to RR facilities, and alternatives such as hotels, motels, etc.

- RR cost center funding may not be used for Program costs such as salaries & benefits, operating expenses, and/or indirect costs

- Contractor to have a tracking mechanism for RR utilization

- Contractor to refer to & align with SUDPOH

RECOVERY RESIDENCES (RR)

- Program’s tracking of supplemental funding to include adherence to maximum daily allocations, as well as total spending of cost center/line item

- Program’s written policy and procedure(s) (P&P) outlines coordination of care, RR payment (no direct payment to clients) & management of RR budget allocation

- Program’s written P&P to guide RR selection. Programs may utilize BHS RR oversight contract (CHIP RRA)

- Program's reimbursement is based on a client's actual use of RR bed; no reimbursements for unused RR bed days

- Program may not use RR that provides treatment services

- Utilization of RRs should be case-by-case, depending on client need when other safe housing options are not readily available

- Inform COR when using other types of immediate short-term/time limited housing (e.g., motel)

- Use County-provided RR Tracking Log and submit supporting documents with monthly invoice

RESIDENTIAL PROGRAMS

- Every effort should be made to connect clients to an Outpatient Program to access Recovery Residence funds

To obtain Recovery Residence through the Residential Program:

- Client does not meet ASAM criteria for Residential or Outpatient Services OR

- Client meets Outpatient service criteria but declines if either conditions are met, RR funds shall be for direct payments to RR facilities, and alternatives such as hotels, motels, etc. RR funds may not be used for Program costs such as salaries & benefits, operating expenses, and/or indirect costs.

- Client must be actively receiving Recovery Services at minimum weekly

- Client must be informed of expanded Recovery Residence benefits through Outpatient Programs

- Client must have a specific and measurable housing goal on the Treatment Plan/Recovery Plan reviewed at timelines indicated in the provider’s contract, and when clinically indicated

- County funds a maximum of $40/day

- Client must contribute a minimum of 30% of net (take home) monthly income, including state/federal benefits

- Contract allocation: Line item within primary cost center and funding

- Contractor to have a tracking mechanism for RR utilization

- Contractor to refer to & align with SUDPOH

This document is a training tool and is subject to change. Please refer to SUDPOH for current processes, rates, and expanded details.

Version 9 (02.11.20)

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Appendix B.5
Local PC 1000 Guidelines Summary
California Penal Code Section 1000 (PC 1000) establishes the authority for counties to create drug diversion programs for eligible participants who are referred from a court. A referral will be made to a County certified PC 1000 Drug Diversion program when a participant is eligible and suitable for the PC 1000 program. Persons who have a need for Substance Use Disorder (SUD) treatment, and who have private insurance, will be referred to their healthcare provider. The criminal charge is dismissed, pursuant to statute, if the participant successfully completes the program and complies with the conditions established by the court.

Two-Track Drug Diversion Process
The PC 1000 Two-Track Drug Diversion Program is intended to provide participants with either education on substance use or treatment for a diagnosed substance use disorder (SUD). The Drug Medi-Cal Organized Delivery System, and changes in state law, bring about the following changes to providers: 1) elimination of the AIDS education component, 2) maintenance of the education track, and 3) addition of a treatment track. The education track will continue at the existing sites, and on September 1, 2019, the new treatment track will be available at the six Regional Recovery Centers. All participants will be assessed SUD need through the American Society for Addiction Medicine (ASAM) criteria. If participant is assessed as having a need for treatment, they will only participate in the treatment track.

Orientation and Enrollment
Program shall enroll individuals referred to their program and site using the BHS-550 Referral Form or have been issued a referral to attend PC 1000 Drug Diversion by another California county. Participants shall be enrolled no later than 14 days past the date specified on the referral form. The orientation shall explain the PC 1000 Program Guidelines and Participant Standards document. Program shall enroll a participant by completing the PC1000 Orientation Checklist.

Leave of Absence (LOA)
Participants may request a leave of absence (LOA) whenever they are unable to attend any two consecutively scheduled program activities. To request a LOA, the participant shall submit a written request including the following information:
- The name of the participant
- The reason for requesting the LOA
- The beginning and end dates for the LOA

Program shall require the participant to request prior approval unless participant is unable to due to circumstances beyond their control. When participant requests retroactive approval, the written request shall document the circumstances that prevented the participant from requesting prior approval. Participants are allowed a total of 4 absences during the duration of the program and a 5th absence will result in dismissal and referral back to Court. Program shall require each participant to make up all absences. Time on LOA shall not count toward the minimum 3 months (12 weeks) required participation.

Inter-Program Transfer
A participant transferring to another PC 1000 Two-Track Drug Diversion Program in the County shall report to the receiving program within 28 days of cessation of services by the sending program. Notification of transfer shall be provided to the Court by the sending program using the County of San Diego PC 1000 Pre-Trial Diversion Program Participant Status Report (BHS-550PSR). The receiving program shall notify the sending program and the Court of the participant's enrollment or non-enrollment.

Participant Grievance Process
Program shall develop a process and procedure to address participant grievances. The plan must outline the steps for filing a grievance and the time frame required for a response.
### Reporting Responsibilities

#### Program Reporting
- Program shall report the following participant information within 2 working days of deadline to the Court:
  - Confirmation of enrollment by required date
  - Successful completion
  - Satisfactory participation
  - Failure to complete or participate and reason

#### County Reporting
- Program shall submit the following reports to Behavioral Health Services (BHS):
  - Monthly Status Report
  - Monthly DATA set as specified by BHS
  - Quarterly revenue/expense report, Administration Fee Reporting Form and the Administration fee

#### Client Participation
Adequate participation is required for both PC 1000 Education and Treatment Tracks. For the Education Track, participants are required to complete 20 hours of classes. For the Treatment Track, participants are required to complete a minimum of 20 hours of treatment. Thresholds for unsatisfactory participation may include the following:
- Failure to comply with program rules and regulations.
- Positive drug test, failure to submit to a drug test or coming to program under the influence of alcohol or other drugs.
- Exceeding 5 unexcused absences.
- Failure to maintain contact with the program for 28 or more consecutive days.
- Failure to contact receiving program within 28 days of transfer
- Participant is physically or verbally abusive or threatening to program staff or other program participants. Program may refuse to reinstate a participant dismissed on this basis; a statement to that effect shall be included in the dismissal notice sent to the Court.

Unsatisfactory participation should be reported to the Court. The participant may be dismissed from the Education Track; however, this does not mean they are dismissed from the PC 1000 program. Clinical assessments should inform recommendation to dismiss clients, alternative referral to treatment, or change the level of care. Recommendation for dismissal or alternative referrals shall be reported on the PC 1000 Pretrial Diversion Program Participant Status Report and returned to the Court. The participant may also be dismissed from the Treatment Track. In such a case, they would not be eligible for the Education Track, and would therefore be dismissed from the PC 1000 program.

#### Education Track

**Educational Sessions**
The program shall schedule and provide ten (10) 2-hour and 10-minute educational sessions (20 hours total) scheduled once per week for (10) consecutive weeks. Each education session shall be limited to no more than 30 program participants. Each education session shall consist of:
- 90 minutes of educational activities
- 10-minute break
- 30-minute educational group discussion on the topic
- Individual completion of educational summary for each session

All programs shall utilize an approved curriculum that includes, but is not limited to the following educational topics:
- Understanding use and addiction
- Risk of legal issues and physical health
• Risk to family and employment
• Substance use disorder relapse warning signs and triggers
• Recovery skills including anger management and communication skills
• Recovery planning, relapse prevention, and abstinence
• Rewards of recovery

All programs shall develop lesson plans for each educational session that includes:
• Goals and objectives of each session
• Outline of the information to be covered
• Handouts, audiovisual aids, and/or guest speakers
• Educational sessions shall be scheduled to reasonably accommodate day/evening participant needs.

Each education session shall be limited to no more than 30 program participants. Participants shall complete a questionnaire on each education session.

**Drug Testing**
Baseline drug test shall be administered at program admittance. Collection shall be observed; therefore, both male and female staff shall be available. Urinalysis shall be a full panel drug screen. Program shall develop and implement a protocol for observed collection, testing, confirming, documenting, and reporting participant drug test results and shall submit the protocol to the COR for approval. Protocol shall protect against the falsification and/or contamination of any urine samples.

Baseline test may show a positive result and the participant shall not be dismissed. Subsequent drug tests shall be random. If the level remains steady or increases, this shall be considered a positive drug test and the participant shall be released from education track and re-assessed for treatment track. Notification shall be provided to the Court using the County of San Diego PC 1000 Diversion Program Participant Status Report.

**Referral to Ancillary Services**
Program shall refer participants to ancillary services such as withdrawal management, mental or physical health agencies, family counseling, and residential treatment/recovery services based on assessed need. Referral shall be voluntary.

**Program Fees and Refunds**
Program shall charge only those program fees established and approved by the COR. Standard fee/payment schedule shall be applied. See PC 1000 Education Track Program Fee document. At the time of transfer or program dismissal of a participant, program shall calculate the value of services provided, based on the cost per unit of service, and compare that total to the fees paid to date by the participant. Any fees paid more than the value of services provided shall be refunded to the participant within 60 days of the date of program dismissal or within 14 days from the date of transfer.

**Participant Records**
Program shall establish a participant case file to include all relevant material and documentation for each participant. Participant files shall be retained for a minimum of 48 months from the date of the last program activity. A summary of all program services, absences, fees/charges and fees paid shall be reflected in each participant file. At minimum, the participant case file shall contain:
• Supplemental documents
• Record of attendance at program services and self-help groups
• Referrals to support services
• Face-to-face contacts with staff
• Drug test results
• Fee collection status
• Exit plan

Appendix C.1
Outcomes Objectives

**Completion**
A minimum of 55% of clients enrolled will complete the PC 1000 Education Track, as measured by completing all required program services and paying in full all assessed program fees.

**No New Arrests**
A minimum of 90% of all participants who successfully complete the PC 1000 Education Track shall have no new arrests, excluding minor traffic offenses, while in the program. This is measured by participant self-report and is documented at their final service in the program.

The full program guidelines can be found at: Optum link
# APPENDIX D.1 - SUD Residential Clinical Documentation & Authorization Request Timelines

## SUD Residential Clinical Documentation and Authorization Request Timelines Quick Guide

<table>
<thead>
<tr>
<th>Forms/Documentation To Complete</th>
<th>Date Forms/Documentation Due For Chart</th>
<th>Date To Submit Authorization Request To Optum</th>
<th>Optum Determination Turnaround Time</th>
<th>Length Of Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Level of Care Assessment</td>
<td>Intake/Day of Admission</td>
<td>Within 24 hours of Admission</td>
<td>24 Hours</td>
<td>Initial authorization for 15 days</td>
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<tr>
<td>• Optum Fax Cover Sheet</td>
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</tr>
<tr>
<td>Initial Treatment Plan</td>
<td>By 10 days after Admission</td>
<td>On or before day 10</td>
<td>5 Calendar Days</td>
<td>Continuing authorization for 75 days</td>
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<tr>
<td>• ASAM Level of Care Recommendation</td>
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<tr>
<td>• ASI or YAI</td>
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<tr>
<td>• Diagnosis Determination Note</td>
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<tr>
<td>• Optum Fax Cover Sheet</td>
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<tr>
<td>*HRA</td>
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<tr>
<td>*Health Questionnaire (required if Dimension 2 risk rating is greater than 0)</td>
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<tr>
<td>Updated Treatment Plan #1</td>
<td>Within 30 days from client/counselor signature on Initial Treatment Plan (No later than day 40).</td>
<td>If updated treatment plan indicates a step-up or step-down in residential level of care recommendation, the authorization must be modified, and program would submit the updated treatment plan/ASAM LOC Recommendation form to Optum</td>
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<td>N/A</td>
</tr>
<tr>
<td>• ASAM Level of Care Recommendation</td>
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<td>• Optum Fax Cover Sheet</td>
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</tbody>
</table>
| Updated Treatment Plan #2       | Within 30 days from client/counselor signature on Updated Treatment Plan #1 (No later than day 70). | If requesting extension-submit documentation to Optum by day 80.  
• For Adolescent programs-submit by day 30 | 5 Calendar Days | Extension authorization for 30 days |
| • ASAM Level of Care Recommendation |                                      |                                              |                                     |                                          |
| • Optum Fax Cover Sheet         |                                        |                                              |                                     |                                          |
| • Most Recent Diagnosis Determination Note |                                      |                                              |                                     |                                          |
| Discharge Plan/Summary          | At Discharge                            | At Discharge                                 | At Discharge                        | N/A                                      |
| • Optum Fax Cover Sheet         |                                        |                                              |                                     |                                          |

Please Note: For Perinatal programs requesting authorization beyond 90 days, the program will submit continuing requests for authorization in 30 day increments until the client discharges or has reached 60 days postpartum. Optum is available for consultation at any time during the process.

*Required as part of complete assessment. Optional for submission to Optum for authorization

BHS/SUD Revised 11-6-2018
Navigating the Optum Website: A Tip Sheet for SUD Service Providers

The Optum website is an efficient way for County Quality Management (QM) to post important documents and communications for providers. To access SUD program specific information, follow the steps below:

1. Go to https://www.optumsandiego.com

2. On the home screen, select the County Staff & Providers button on the top of the page:

3. A drop-down menu will display. Select the option for Drug Medi-Cal Organized Delivery System:

4. This will launch a page with several tabs at the top. There are three tabs relevant for SUD Service providers: SUDPOH, SUDURM, and Communications:

   a. **SUDPOH** tab is for the “Substance Use Disorder Provider Operations Handbook” and recent updates with the handbook
   b. **SUDURM** tab is for the “Substance Use Disorder Uniform Record Manual”, also known as the “Client File”
   c. **Communications** tab is for QM memos sent to both mental health and SUD programs

5. Within a tab, you can select a header to change how postings are arranged:
   a. Clicking on the **Name** header will re-alphabetize the list of documents.
   b. Clicking on the **Date** header will re-order the postings by date they were posted.

6. There is also a **Search** feature at the top right of the website to help locate documents.

7-02-2018
## DSM-5 Substance Use Diagnosis Guide

### Severity Levels
- MILD: Presence of 2-3 DSM-5 criteria symptoms
- MODERATE or SEVERE: Presence of 4-5 DSM-5 criteria symptoms

### Specifiers
- Early Remission: 3 months to 1 year with no presence of DSM-5 criteria symptoms
- Sustained Remission: 1 year or more with no presence of DSM-5 criteria symptoms
- In Controlled Environment: Individual is in an environment where access to substances are restricted

### DMC Approved Billable Codes

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<th>SUBSTANCE</th>
<th>DSM-5 Diagnosis Label</th>
<th>ICD-10 Codes</th>
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<td>Cocaine</td>
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<tr>
<td></td>
<td>Cocaine Withdrawal</td>
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</tr>
</tbody>
</table>

Example: Beer, liquor

Example: Heroin, Hydrocodone (Norco, Vicodin), Oxycodone (OxContin, Percocet), Morphine, Hydromorphone (Dilaudid), Codeine (cough syrup), Meperidine (Demerol), Fentanyl, etc.

Example: Marijuana and marijuana-related products

Example: Benzo diazepines (Xanax, alprazolam), Ativan (lorazepam), Valium (diazepam), Klonopin (clonazepam); Barbiturates (pentobarbital, secobarbital, etc.), Ambien (zolpidem), Lunesta (eszopiclone), Sonata ( zaleplon), Imrress (zopiclone), Z-drugs, etc.
### Amphetamine-Type Substance

Example: Methamphetamine (crystal meth, crank, speed, tweek, glass, etc.)

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<thead>
<tr>
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<tr>
<td>Amphetamine-Type Substance Withdrawal</td>
<td>F15.23</td>
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</tbody>
</table>

### Other or Unspecified Stimulant

Example: Ritalin (methylphenidate), Adderall (dextroamphetamine/amphetamine), Vyvanse, (lisdexamfetamine), etc.

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<thead>
<tr>
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<th>Code</th>
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### Phencyclidine

Example: PCP (phencyclidine)

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<tr>
<td>Phencyclidine (PCP) Intoxication without Use Disorder</td>
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</tbody>
</table>

### Other Hallucinogen

Example: LSD (acid), Ecstasy (MDMA), Ketamine, magic mushrooms (Psilocybin), Peyote (Mescaline), etc.

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Code</th>
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</table>

### Inhalant

Example: Glues, spray cans, etc.

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<tr>
<td>Inhalant Intoxication with Use Disorder, MODERATE or SEVERE</td>
<td>F18.229</td>
</tr>
<tr>
<td>Inhalant Intoxication without Use Disorder</td>
<td>F18.929</td>
</tr>
</tbody>
</table>

### Other (or Unknown) Substance

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other (or Unknown) Substance Use Disorder, MILD</td>
<td>F19.10</td>
</tr>
<tr>
<td>Other (or Unknown) Substance Use Disorder, MODERATE or SEVERE</td>
<td>F19.20</td>
</tr>
<tr>
<td>Other (or Unknown) Substance Use Disorder, Mild in early or sustained REMISSION</td>
<td>F19.11</td>
</tr>
<tr>
<td>Other (or Unknown) Substance Use Disorder, Moderate or Severe in early or sustained REMISSION</td>
<td>F19.21</td>
</tr>
<tr>
<td>Other (or Unknown) Substance Intoxication with Use Disorder, MILD</td>
<td>F19.129</td>
</tr>
<tr>
<td>Other (or Unknown) Substance Intoxication with Use Disorder, MODERATE or SEVERE</td>
<td>F19.229</td>
</tr>
<tr>
<td>Other (or Unknown) Substance Withdrawal</td>
<td>F19.239</td>
</tr>
</tbody>
</table>
# Group Counseling Sign-In Sheet

<table>
<thead>
<tr>
<th>Agency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Program</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Start Time</th>
<th>End Time</th>
<th>Topic</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Participant Printed Name</th>
<th>Participant Signature</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
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<tr>
<td>2.</td>
<td></td>
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<tr>
<td>3.</td>
<td></td>
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<tr>
<td>4.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
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<tr>
<td>6.</td>
<td></td>
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<tr>
<td>7.</td>
<td></td>
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<td>8.</td>
<td></td>
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<tr>
<td>9.</td>
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<tr>
<td>10.</td>
<td></td>
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</tr>
<tr>
<td>11.</td>
<td></td>
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</tr>
<tr>
<td>12.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LPHA and/or Counselor(s) Printed Name(s)</th>
<th>LPHA and/or Counselor(s) Signature(s)*</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*By signing the sign-in sheet, the LPHA(s) and/or counselor(s) attest that the sign-in sheet is accurate and complete. **NOTE:** the LPHA(s) and/or counselor(s) conducting the session must print their name, sign, and date the sign-in sheet on the same day of the session.
## Tip Sheet: Required Policies and Procedures & Where to Locate in SUDPOH

<table>
<thead>
<tr>
<th>Topic of Policy/Procedure</th>
<th>SUDPOH Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure trauma-informed treatment approaches integrating into P &amp; Ps</td>
<td>Section A: County of San Diego DMC-ODS</td>
</tr>
<tr>
<td>Group counseling in the community</td>
<td>Section B: Continuum of Care and Services</td>
</tr>
<tr>
<td>Ensure P&amp;P practices consistent with the requirement to adhere to CLAS Standards</td>
<td>Section A: County of San Diego DMC-ODS</td>
</tr>
<tr>
<td>Care transition/care coordination process consistent with SUDPOH</td>
<td>Section A: County of San Diego DMC-ODS</td>
</tr>
<tr>
<td>Screening for emergency medical conditions/emergency medical care (with crisis referral procedure)</td>
<td>Section D: Service Delivery</td>
</tr>
<tr>
<td>Provider role as a community referral source</td>
<td>Section D: Service Delivery</td>
</tr>
<tr>
<td>Monitoring of Missed Scheduled Appointments (consistent with SUDPOH requirements for both new referrals and current clients)</td>
<td>Section D: Service Delivery</td>
</tr>
<tr>
<td>Eligible Populations &quot;target populations&quot; policies, procedures and protocols.</td>
<td>Section D: Service Delivery</td>
</tr>
<tr>
<td>Continuing Services Justification</td>
<td>Section D: Service Delivery</td>
</tr>
<tr>
<td>Client Discharge</td>
<td>Section D: Service Delivery</td>
</tr>
<tr>
<td>Written admission and readmission criteria for determining client eligibility and medical necessity.</td>
<td>Section D: Service Delivery</td>
</tr>
<tr>
<td>Admission P&amp;Ps ensure services to target population, comply with non-discrimination, compliance with entry criteria (residential – include acceptance of residents)</td>
<td>Section E: SUD Program Requirements</td>
</tr>
<tr>
<td>Federal and State Health and Human Services priority populations and entry criteria</td>
<td>Section D: Service Delivery</td>
</tr>
<tr>
<td>Medical Director to develop and implement medical policies/standards for the program.</td>
<td>Section E: SUD Program Requirements</td>
</tr>
<tr>
<td>Workforce members’ code of conduct</td>
<td>Section E: SUD Program Requirements</td>
</tr>
<tr>
<td>Sanctions for violations of unauthorized release of confidential client health information</td>
<td>Section E: SUD Program Requirements</td>
</tr>
<tr>
<td>Written policies regarding appropriate supports to clients during a relapse episode.</td>
<td>Section E: SUD Program Requirements</td>
</tr>
<tr>
<td>Safety regarding the use of prescribed medications by a program client</td>
<td>Section E: SUD Program Requirements</td>
</tr>
<tr>
<td>Residential programs – provisions for safeguarding residents’ property</td>
<td>Section E: SUD Program Requirements</td>
</tr>
<tr>
<td>Residential programs – refund policy (as part of Facilities admission agreement)</td>
<td>Section E: SUD Program Requirements</td>
</tr>
</tbody>
</table>

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Tip Sheet: Required Policies and Procedures & Where to Locate in SUDPOH

<table>
<thead>
<tr>
<th>Topic of Policy/Procedure</th>
<th>SUDPOH Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employees, subcontractors, subcontractor employees, and volunteers adhere to the highest ethical and legal conduct, and Volunteer Staff requirements P&amp;P</td>
<td>Section E: SUD Program Requirements</td>
</tr>
<tr>
<td>P&amp;P to ensure staff awareness of full compliance with Trafficking Victims Protection Act</td>
<td>Section E: SUD Program Requirements</td>
</tr>
<tr>
<td>3.2 WM Programs – P&amp;Ps that include working collaboration with emergency departments and primary care physicians for client admit/safe return to WM</td>
<td>Section E: SUD Program Requirements</td>
</tr>
<tr>
<td>Internal quality assurance and improvement controls, activities, and maintain internal systems of controls and monitoring to ensure that all aspects of the program.</td>
<td>Section G: Quality Management</td>
</tr>
<tr>
<td>Fiscal and accounting P&amp;Ps (including policies on preventing Fraud, Waste and Abuse)</td>
<td>Section G: Quality Management</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>Section G: Quality Management</td>
</tr>
<tr>
<td>Programs are required to have policies and procedures in place to address and track all client complaints/grievances.</td>
<td>Section G: Quality Management</td>
</tr>
<tr>
<td>Collecting, storing, filing, and mailing of Notice of Adverse Benefit Determinations.</td>
<td>Section G: Quality Management</td>
</tr>
<tr>
<td>Personnel Policies meeting all requirements in SUDPOH</td>
<td>Section G: Quality Management</td>
</tr>
<tr>
<td>Medication Monitoring (storage, handling, disposal, dispensing, etc.)</td>
<td>Section G: Quality Management</td>
</tr>
<tr>
<td>Program Integrity</td>
<td>Section G: Quality Management</td>
</tr>
<tr>
<td>Paid Claims (or “Paid Service”) Verification</td>
<td>Section G: Quality Management</td>
</tr>
<tr>
<td>Supervision Related Monitoring of ASAM and EBPs</td>
<td>Section G: Quality Management</td>
</tr>
</tbody>
</table>

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APPENDIX E.2 – BHS Health, Safety, and Appearance Standards

BHS Health, Safety and Appearance Standards
Substance Use Disorder Program Facilities
Health, Safety, and Appearance Standards, HHSA: ADS 1077

For All Facilities:

1. All areas shall be kept clean.

2. All areas shall be free of health risks, i.e. vermin and their residue, contaminated water, noxious odors, and accumulated dirt. Maintenance supplies, especially toxic materials, shall be stored appropriately in secured areas.

3. Refrigerators, microwaves, coffeemakers, and any other appliances used for food preparation shall be cleaned and maintained regularly. All food items shall be stored appropriately.

4. Wastebaskets, trash cans, dumpsters, etc. shall be emptied regularly and cleaned and disinfected as necessary. Areas surrounding trashcans and dumpsters shall also be cleaned and maintained.

5. All occupied areas shall have adequate ventilation and reasonable interior temperatures (64-85 degrees).

6. All sites shall have a fully equipped first aid kit, posted emergency exit plan, up-dated fire extinguishers, and smoke and carbon monoxide detectors.

7. All electrical wiring shall be free of safety hazards and meet appropriate codes. Electrical supply cabinets must be locked/secured to prevent access by clients, children, and visitors.

8. All floors and walkways shall be intact, level, and free of all tripping hazards and other obstructions.

9. Lighting shall be adequate inside and outside the facility during all seasons of the year.

10. Boxes, records, papers, and other supplies shall be neatly kept in appropriate storage areas. None of these items shall be allowed to obstruct passage by clients, staff, or visitors.

11. Smoking, if allowed by the program, shall occur only in designated outdoor smoking areas with adequate disposal receptacles away from public entrances and exits and areas where children and youth may be present.

12. Roof, walls, ceilings, and floors shall be maintained in good condition, i.e. no peeling paint, rotting wood, etc. They shall be free of mold and mildew, water damage, and rust.

13. All furniture shall be in good repair and suitable to the program’s services.

14. All decorative art shall be intact, secured, and well maintained.

15. Entrances shall be identified.

16. Window treatments shall be in good repair.

17. Emergency, fire, and safety procedures and exit maps shall be in view.
Appendix E.3 – Witnessed Collection

Witnessed Collection
(from Adult Drug Court Best Practice Standards, Volume II – Text Revision. National Association of Drug Court Professionals, Alexandria, Virginia. Copyright 2018, Text Revision, National Association of Drug Court Professionals)

Drug Court participants and probationers acknowledge engaging in widespread efforts to defraud drug and alcohol tests. These efforts include, but are not limited to, consuming excessive water to dilute the sample (dilution), adulterating the sample with chemicals intended to mask a positive result (adulteration), and substituting another person’s urine or a look-alike sample that is not urine, such as apple juice (substitution) (Cary, 2011; McIntire & Lessenger, 2007). Collectively, these efforts are referred to as tampering. In focus groups, Drug Court participants reported being aware of several individuals in their program who tampered with drug tests on more than one occasion without being detected by staff (Goldkamp et al., 2002).

The most effective way to avoid tampering is to ensure that sample collection is witnessed directly by a trained and experienced staff person (ASAM, 2013; Cary, 2011). If substitution or adulteration is suspected, a new sample should be collected immediately under closely monitored conditions (McIntire et al., 2007). Staff members should be trained in how to implement countermeasures to avoid tampered test specimens. Examples of such countermeasures include searching participants’ clothing for chemical adulterants or fraudulent samples, requiring participants to leave outerwear outside of the test-collection room, and putting colored dye in the sink and toilet to prevent water from being used to dilute test specimens (McIntire & Lessenger, 2007).

If substitution or other efforts at tampering are suspected for a urine specimen, it may be useful to obtain an oral fluid specimen immediately as a secondary measure of substance use. Generally speaking, observing the collection of oral fluid closely is easier than for the collection of urine, and oral fluid tests are less susceptible to dilution than urine tests (Heltsley et al., 2012; Sample et al., 2010). However, because oral fluid testing has a shorter detection window than urine testing, a negative oral fluid test would not necessarily rule out recent drug use or the possibility of a tampered urine test.

Because specialized training is required to minimize tampering of test specimens, under most circumstances participants should be precluded from undergoing drug and alcohol testing by independent sources. In exigent circumstances, such as when participants live a long distance from the test collection site, the Drug Court might designate independent professionals or laboratories to perform drug and alcohol testing. As a condition of approval, these professionals should be required to complete formal training on the proper collection, handling, and analyses of drug and alcohol test samples among Drug Court participants or comparable criminal justice populations. Drug Courts are also required to follow generally accepted chain-of-custody procedures when handling test specimens (ASAM, 2013; Cary, 2011; Meyer, 2011). Therefore, if independent professionals or laboratories perform drug and alcohol testing, they must be trained carefully to follow proper chain-of-custody procedures.
Homeless Outreach Worker (HOW)
Service Model & Data Collection Flow

Outreach & Engagement
- Complete screening tool for all contact with individual
- Information complete to best of ability
- Form in monthly Data Collection Log to COR and designated HOW Team

Enrolled
- Individuals who agree to engaging services with HOW Team
- Keep with client chart (HMIS or paper file)
- If client enrolls in program, facilitate warm hand-off with program staff

Short Term CM Services
- Scheduled or unscheduled
- Services and referrals
- Document services in program note

Documentation/Outcomes
- HMIS-County (All)
- Center Community Behavioral Health (Mental Health)
- Paper Chart
- Reminder: all contacts should have the screening tool

Rev 7.17.19 bh
Appendix E.4
APPENDIX E.5 – How to Access RIHS Trainings

How to Access RIHS Trainings

There are resources on RIHS to assist your program with DMC-ODS topics (such as DMC-Certification and ASAM)

To access the RIHS website:

1. go to their link: https://theacademy.sdsu.edu/programs/rihs/
2. Sign in where indicated
   (if you do not have an account, select the “Request an Account” link immediately under the sign in link)
3. Once you’ve signed in, you will see a magnifying glass icon at the top right hand of the screen. Select this to locate the session you want
4. The above step launches the search field. Enter a brief description of what you are looking for and select “All Results” or hit the “Enter” key on your keyboard.
5. Training sessions matching your search word(s) will display. Register by selecting the drop down arrow under the “Select” button, then selecting the “Register” option
6. A screen launches that indicates you are registered for the session. Select the “Submit” button at the bottom right of the screen
7. The session will launch. Select the “Start” button to view
   Follow the prompts to navigate the session
## APPENDIX E.6 – Program Accessibility Assessment

### A) PARKING WALKWAYS: MINIMUM CONSIDERATIONS.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>If off-street parking is available, is it as close to the accessible entrance as possible? If YES: Comment total number of total stalls, number of accessible stalls, number of van accessible stalls.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Are walkways with necessary ramps and curb cuts available from the parking area to the accessible entrance? (NOTE: The travel route should be at least 36&quot; wide)</td>
<td></td>
<td></td>
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<tr>
<td>3</td>
<td>Are designated reserved parking spaces provided for persons with disabilities?</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### B) ENTRANCES: MINIMUM CONSIDERATIONS.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Is at least one primary building entrance accessible at ground level or ramp with no steps? (NOTE: Ramp slope should not exceed 1:12.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Are accessible entrances identified with proper signage? (NOTE: A primary entrance is one that is a commonly used public entrance which does not involve transit through kitchens, storage facilities or similar areas.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Are accessible primary entrances left unlocked or are provisions made for a signaling device that is accessible if the entrance must be locked during certain hours for security purposes?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Do entrance doors have a minimum clear opening of 32&quot;?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### C) TOILET ROOMS & BATHING FACILITIES: MINIMUM CONSIDERATIONS

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Does the facility have accessible public restrooms for men and women?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Is there an accessible unisex restroom available?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Does the restroom entrance door have a minimum unobstructed opening of 32&quot;?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>If stalls are provided, are they a minimum of 36&quot; wide and 72&quot; deep, or 48&quot; wide and 57&quot; deep, and have doors with a 30&quot; unobstructed opening? (NOTE: A 32&quot; clear opening is preferred.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Is the sink rim no higher than 34&quot;?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Is the toilet seat 17&quot; to 19&quot; high?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Is there at least 29&quot; from the floor to the bottom of the sink apron (excluding pipes)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Are other fixed objects located so as not to impede wheelchair access into stalls or other facilities</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Comments:

Comments required for responses with NO.
### D) MEETING/HEARING ROOM FACILITIES: MINIMUM CONSIDERATIONS

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>Are there meeting rooms that can only be accessed by steps? <em>(NOTE: If so, identify those rooms)</em></td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>17</td>
<td>If amplifiers and/or sound equipment are used, are individual hand-held or lavalier microphones available?</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>18</td>
<td>Are provisions made for assistive listening devices upon request for persons with hearing impairments? <em>(NOTE: Assistive listening systems are available for loan at no cost from the ADP-funded Disability Access Project.)</em></td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>19</td>
<td>Can meeting room seating be arranged to accommodate persons using wheelchairs in an integrative manner?</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>20</td>
<td>Are print materials recorded for visually impaired persons?</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>21</td>
<td>Are interpreters available for persons with hearing impairments?</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
</tbody>
</table>

**Comments:** Comments required for responses to #16 with YES; required for responses to #17-21 with NO.

### E) RESIDENTIAL FACILITIES ONLY: LODGING ACCOMMODATIONS: MINIMUM CONSIDERATIONS

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>What is the total number of sleeping rooms provided?</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>23</td>
<td>How many sleeping rooms are accessible for people with mobility limitations?</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>24</td>
<td>Do entrance doors to accessible guest rooms have a minimum clear opening of at least 32&quot;?</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>25</td>
<td>Do accessible guest rooms allow sufficient turning space (5 ft. in diameter) to allow a person using a wheelchair to move about?</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>26</td>
<td>If there is a phone in the room, is there an unobstructed approach to the phone for a person using a wheelchair?</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
</tbody>
</table>

**Comments:** Comments required for responses with NO.

### F) AUXILIARY AIDS: MINIMUM CONSIDERATIONS

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>Is there a written disability admission and referral policy in place? If yes, attach a copy to this survey when it is submitted to the Department of Health Care Services.</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>28</td>
<td>Does the facility have a TDD/TTY telephone device and number for the deaf or hard of hearing?</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>29</td>
<td>If no, has staff been trained to use the California Relay System (CRS)?</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>30</td>
<td>Does the emergency alarm system have both visual and audible features?</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>31</td>
<td>If the facility has a pay phone, is TTY access available?</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>32</td>
<td>Is at least one public pay phone equipped with amplification?</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>33</td>
<td>Do televisions for client use have closed caption capability?</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>34</td>
<td>Are hearing interpreters available?</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
<tr>
<td>35</td>
<td>Are hearing interpreters part of group counseling?</td>
<td>![ ]</td>
<td>![ ]</td>
</tr>
</tbody>
</table>

**Comments:** Comments required for responses with NO.
### Nondiscrimination Questionnaire

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>36</td>
<td>Is nondiscriminatory treatment, equally afforded to other individuals, given directly or through contractual licensing or other arrangements to people with disabilities in the full and equal enjoyment of the goods, facilities, privileges, advantages, or accommodations offered?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>Are the goods, services, facilities, privileges, advantages, or accommodations provided differently or separately to individuals with disabilities and individuals without disabilities?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>Are the goods, services, facilities, privileges, advantages, and accommodations offered to individuals with disabilities in the most integrated setting appropriate to the needs of the specific individual in question?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>39</td>
<td>If separate or different programs or activities are provided to individuals with disabilities, may those individuals still participate in the activities that are not separate or different?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>Do you use, directly and/or through a contractual or other arrangements, standards, criteria, or methods of administration that do not have the effect of discrimination by others?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>Are people with friends, associates, or relatives with a disability provided foods, services, facilities, privileges, advantages, accommodations, and other opportunities on a nondiscriminatory basis?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>Do your eligibility criteria screen in, not out, individuals with disabilities (unless such criteria can be shown to be necessary for the provision of goods, services, etc., being offered)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>Are reasonable modifications made to policies, practices, or procedures when such modifications are necessary to offer goods or services, etc., to individuals with disabilities?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>Are people with disabilities included, allowed services, integrated, and otherwise treated the same as others through the provision of auxiliary aids and services?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>Are architectural and communication barriers that are structural in nature (including permanent, temporary, or moveable structures, such as furniture, equipment, and display racks) removed from existing facilities?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>Where removal of barriers is not “readily achievable” are the goods, services, etc., made available through alternative methods?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>Has new construction been designed to be readily accessible to and usable by individuals with disabilities?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>48</td>
<td>If you are altering a facility, have the alterations been made in such a manner that, to the maximum extent feasible, the altered portions of the facility are readily accessible to and usable by individuals with disabilities including individuals who use a wheelchair?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comments:** Comments required for responses with NO.
# APPENDIX E.7 – PWD Referral List

## Adult SUD Programs that Accept All Persons with Disabilities

### CENTRAL REGION

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>ASAM LOC</th>
<th>Clients Served</th>
<th>Address</th>
<th>Contact Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRASH, INC Short Term I</td>
<td>RS-3-1</td>
<td>Male</td>
<td>4161 Marlborough Ave, San Diego, CA 92105</td>
<td>(619) 282-7724</td>
</tr>
<tr>
<td>CRASH INC, Golden Hill House I</td>
<td>RS-8-1</td>
<td>Female</td>
<td>2410 E Street, San Diego, CA 92102</td>
<td>(619) 234-3434</td>
</tr>
<tr>
<td>ECS Central East Regional Recovery Center</td>
<td>OS-1, IOS-2.1</td>
<td>Coed</td>
<td>4660 El Cajon Blvd, Ste 210, San Diego, CA 92116</td>
<td>(619) 597-7335</td>
</tr>
<tr>
<td>FHCSD Solutions for Recovery</td>
<td>OS-1, IOS-2</td>
<td>Coed</td>
<td>2126 El Cajon Blvd, San Diego, CA 92104</td>
<td>(619) 875-8803</td>
</tr>
<tr>
<td>House of Haminorphosis, Inc.</td>
<td>OS-1, IOS-2</td>
<td>Coed</td>
<td>1970 Market Street, San Diego, CA 92102</td>
<td>(619) 336-9492</td>
</tr>
<tr>
<td>MHS ACTION Central</td>
<td>OS-1, IOS-2</td>
<td>Coed</td>
<td>6244 El Cajon Blvd, #12, San Diego, CA 92115</td>
<td>(619) 287-8225</td>
</tr>
<tr>
<td>Stepping Stone of San Diego</td>
<td>RS-3-1, RS-3.5</td>
<td>Coed</td>
<td>1707 Central Ave, San Diego, CA 92105</td>
<td>(619) 278-0777</td>
</tr>
<tr>
<td>UPAC Adult Alcohol and Drug Treatment Program</td>
<td>OS-1, IOS-2</td>
<td>Coed</td>
<td>35165 El Cajon Blvd, Ste 13, San Diego, CA 92104</td>
<td>(619) 511-5703</td>
</tr>
<tr>
<td>UPAC New Leaf Central</td>
<td>OS-1, IOS-2</td>
<td>Coed</td>
<td>8530 College Ave, San Diego, CA 92115</td>
<td>(619) 818-1790</td>
</tr>
<tr>
<td>Vista Hill ParentCare Central</td>
<td>OS-1, IOS-2</td>
<td>Coed</td>
<td>425 Alpha Street, San Diego, CA 92113</td>
<td>(619) 245-0166</td>
</tr>
</tbody>
</table>

### EAST REGION

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>ASAM LOC</th>
<th>Clients Served</th>
<th>Address</th>
<th>Contact Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHS ACTION East</td>
<td>OS-1, IOS-2</td>
<td>Coed</td>
<td>10201 Mission Grove Rd, Suite G, Santee, CA 92071</td>
<td>(619) 336-8888</td>
</tr>
<tr>
<td>MITE Kiya Learning Center for Women and Children</td>
<td>RS-3-1, RS-3.5, WM-3.2</td>
<td>Coed</td>
<td>2259 Skyline Drive, Lemon Grove, CA 91345</td>
<td>(619) 465-7303</td>
</tr>
<tr>
<td>MITE Adult Detox</td>
<td>WM-3.2</td>
<td>Coed</td>
<td>2259 Skyline Drive, Lemon Grove, CA 91345</td>
<td>(619) 465-7303</td>
</tr>
<tr>
<td>MITE East County Regional Recovery Center</td>
<td>OS-1, IOS-2</td>
<td>Coed</td>
<td>1385 N. Johnson Ave, El Cajon, CA 91006</td>
<td>(619) 440-4801</td>
</tr>
<tr>
<td>MITE New Connections</td>
<td>RS-3-1</td>
<td>Coed</td>
<td>2259 Skyline Drive, Lemon Grove, CA 91345</td>
<td>(619) 465-7303</td>
</tr>
<tr>
<td>San Diego Freedom Ranch</td>
<td>RS-3-1, RS-3.5</td>
<td>Male</td>
<td>1777 Buckman Springs Rd, Campo, CA 92016</td>
<td>(619) 478-5696</td>
</tr>
<tr>
<td>Vista Hill ParentCare East</td>
<td>OS-1, IOS-2</td>
<td>Coed</td>
<td>4910 Williams Ave, La Mesa, CA 91942</td>
<td>(619) 868-0200</td>
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</table>

### NORTH CENTRAL REGION

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>ASAM LOC</th>
<th>Clients Served</th>
<th>Address</th>
<th>Contact Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deaf Community Services of San Diego Signs of Life</td>
<td>OS-1, IOS-2</td>
<td>Coed</td>
<td>15145 Hotel Circle South Ste 300, San Diego, CA 92108</td>
<td>(619) 369-7441</td>
</tr>
<tr>
<td>MITE North Central Women's Recovery Center</td>
<td>OS-1, IOS-2</td>
<td>Coed</td>
<td>8665 Gibbs Drive, Ste 150, San Diego, CA 92123</td>
<td>(619) 384-6284</td>
</tr>
<tr>
<td>MHS Serial Incarcerate Program</td>
<td>OS-1, IOS-2</td>
<td>Coed</td>
<td>3340 Kemper Steet Ste 105, San Diego, CA 92110</td>
<td>(619) 523-3127</td>
</tr>
<tr>
<td>Veterans Village of San Diego</td>
<td>RS-3-1, RS-3.5</td>
<td>Coed</td>
<td>4441 Pacific Highway, San Diego, CA 92110</td>
<td>(619) 497-1142</td>
</tr>
<tr>
<td>Vista Hill North Central IRC</td>
<td>OS-1, IOS-2</td>
<td>Coed</td>
<td>1348 Midway Drive, Ste 113, San Diego, CA 92110</td>
<td>(619) 342-1939</td>
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</table>

### NORTH COASTAL REGION

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>ASAM LOC</th>
<th>Clients Served</th>
<th>Address</th>
<th>Contact Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episcopal Amity Vista Ranch</td>
<td>RS-5-3.1, RS-3.5</td>
<td>Male</td>
<td>2260 Watson Way, Vista, CA 92083</td>
<td>(760) 559-1892</td>
</tr>
<tr>
<td>Healthlighb 560 Serenity House Outpatient</td>
<td>OS-1, IOS-2</td>
<td>Coed</td>
<td>3555 Mission Ave #259, Oceanide, CA 92050</td>
<td>(760) 317-8114</td>
</tr>
<tr>
<td>MITE North Coastal Regional Recovery Center - Mission</td>
<td>OS-1, IOS-2</td>
<td>Coed</td>
<td>1701 Mission Ave Ste 310, Oceanide, CA 92054</td>
<td>(760) 711-2701</td>
</tr>
<tr>
<td>MHS Family Recovery Center</td>
<td>RS-3-1, RS-3.5, WM-3.2</td>
<td>Coed</td>
<td>11000 Sopothe Drive, Oceanide, CA 92054</td>
<td>(760) 459-4702</td>
</tr>
<tr>
<td>UPAC New Leaf North</td>
<td>OS-1, IOS-2</td>
<td>Coed</td>
<td>3623 Waring Rd, Ste D, Oceanide, CA 92056</td>
<td>(760) 295-6380</td>
</tr>
</tbody>
</table>

### NORTH INLAND REGION

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>ASAM LOC</th>
<th>Clients Served</th>
<th>Address</th>
<th>Contact Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>HealthRIGHT 360 Serenity Center</td>
<td>RS-5-3, RS-3.5, WM-3.2</td>
<td>Coed</td>
<td>1341 North Escondido Blvd, Escondido, CA 92026</td>
<td>(760) 747-3005</td>
</tr>
<tr>
<td>MITE North Inland Women/Adolescent Recovery Center</td>
<td>OS-1, IOS-2</td>
<td>Coed</td>
<td>753 Rancho Ct, Ste 4, 5, San Marcos, CA 92069</td>
<td>(760) 751-0535</td>
</tr>
<tr>
<td>MITE North Inland Regional Recovery Center</td>
<td>OS-1, IOS-2</td>
<td>Coed</td>
<td>200 E. Washington Ave #100, Escondido, CA 92025</td>
<td>(760) 741-7708</td>
</tr>
<tr>
<td>The Fellowship Center</td>
<td>RS-3-1, RS-3.5</td>
<td>Male</td>
<td>731 East Grand Ave, Escondido, CA 92025</td>
<td>(888) 533-9555</td>
</tr>
<tr>
<td>Interfaith</td>
<td>OS-1, IOS-2, RS-3.1, RS-3.5, WM-3.2</td>
<td>Coed</td>
<td>550 W. Washington, Escondido, CA 92025</td>
<td>(619) 488-6380</td>
</tr>
</tbody>
</table>

### SOUTH REGION

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>ASAM LOC</th>
<th>Clients Served</th>
<th>Address</th>
<th>Contact Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>MITE South Bay Regional Recovery Center</td>
<td>OS-1, IOS-2</td>
<td>Coed</td>
<td>1180 Third Ave, Ste C8, Chula Vista, CA 91911</td>
<td>(619) 891-1864</td>
</tr>
<tr>
<td>MITE South Bay Women's Recovery Center</td>
<td>OS-1, IOS-2</td>
<td>Coed</td>
<td>2414 Hoover Ave, Suite C, National City, CA 91350</td>
<td>(619) 338-1226</td>
</tr>
<tr>
<td>UPAC New Leaf South</td>
<td>OS-1, IOS-2</td>
<td>Coed</td>
<td>853 3rd Ave, Ste 230, Chula Vista, CA 91911</td>
<td>(619) 271-7992</td>
</tr>
</tbody>
</table>
## Youth SUD Programs that Accept All Persons with Disabilities

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>ASAM LOC</th>
<th>Clients Served</th>
<th>Address</th>
<th>Primary Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CENTRAL REGION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UPAC Teen Recovery Center</td>
<td>OS-1; IOS-2.1</td>
<td>Coed</td>
<td>3288 El Cajon Blvd, Suite 13, San Diego, CA 92104</td>
<td>(619) 521-5720</td>
</tr>
<tr>
<td>Vista Hill Teen Recovery Center</td>
<td>OS-1; IOS-2.1</td>
<td>Coed</td>
<td>220 Euclid Ave Ste 40, 50, San Diego, CA 92114</td>
<td>(619) 795-7232</td>
</tr>
<tr>
<td><strong>EAST REGION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MITE East Teen Recovery Center</td>
<td>OS-1; IOS-2.1</td>
<td>Coed</td>
<td>550 Fessler St., Suite G1, El Cajon, CA 92020</td>
<td>(619) 588-5361</td>
</tr>
<tr>
<td>MITE Adolescent Group Home East</td>
<td>RES-3.1; RES-3.5</td>
<td>Male</td>
<td>2219 Odessa Court, Lemon Grove, CA 91945</td>
<td>(619) 442-0277 ext. 121</td>
</tr>
<tr>
<td><strong>NORTH CENTRAL REGION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MITE North Central Teen Recovery Center</td>
<td>OS-1; IOS-2.1</td>
<td>Coed</td>
<td>7025 Mesa College Dr. Suite 1156, San Diego, CA 92111</td>
<td>(858) 277-4633</td>
</tr>
<tr>
<td><strong>NORTH COASTAL REGION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MITE North Coastal Teen Recovery Center</td>
<td>OS-1; IOS-2.1</td>
<td>Coed</td>
<td>3921 Waring Road, suite A&amp;D, Oceanside, CA 92056</td>
<td>(760) 726-4451</td>
</tr>
<tr>
<td><strong>NORTH INLAND REGION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MHS North Inland Teen Recovery Center</td>
<td>OS-1; IOS-2.1</td>
<td>Coed</td>
<td>340 Rancheros Drive Ste 166, San Marcos, CA 92069</td>
<td>(760) 744-3672</td>
</tr>
<tr>
<td>MITE North Inland Women &amp; Adolescent Recovery Center</td>
<td>OS-1; IOS-2.1</td>
<td>Perinatal</td>
<td>751 Rancheros Dr., Suite #5, San Marcos, CA 92069</td>
<td>(760) 761-0515</td>
</tr>
<tr>
<td><strong>SOUTH REGION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MITE Adolescent Group Home South</td>
<td>RES-3.1; RES-3.5</td>
<td>Female</td>
<td>2315 Bar Bit Road Spring Valley CA 91978</td>
<td>619-337-3830</td>
</tr>
<tr>
<td>MITE South Teen Recovery Center</td>
<td>OS-1; IOS-2.1</td>
<td>Coed</td>
<td>829 Third Avenue, Suite C, Chula Vista, CA 91910</td>
<td>(619) 691-1045</td>
</tr>
</tbody>
</table>
APPENDIX E.8 – Trauma Informed Care Code of Conduct

Trauma-Informed Care Code of Conduct

In alignment with LiveWell San Diego, the Trauma Informed Code of Conduct, facilitated by Clinton Health Matters Initiative, was developed by young adults from Project A.W.A.R.E., Just in Time for Foster Youth, and Youth Empowerment. It is a statement of their expectation about how children, youth, and families should be treated by government agencies and communities of support who interact with them. An organization that adopts the Code of Conduct commits to ensuring that its policies and staff practices meet the standards below, and has a system of accountability to make sure that this is true.

Adopting organizations commit to apply trauma-informed care practices to ensure that their interactions, behaviors, services, and communities of support are accountable to avoid worsening the effects of trauma, to support youth in building resilience, and in being balanced, healthy, and empowered. Adopting organizations view each person as creative, resourceful, whole, and more than just a number.

ADOPTING ORGANIZATIONS WILL ADHERE TO THESE PRINCIPLES:

Safety
A safe and open-minded place where I feel welcome
a. Nurtures a reliable environment with respect for privacy and self-expression
b. Maintains nonviolent environment free of intimidation
c. Respects confidentiality unless permission is given (unless someone is harming you, you are harming yourself, or you are harming someone else)

Individualized Support
Assists me and considers the factors affecting my situation
a. Implements a welcome process to the organization and community
b. Builds mutually beneficial partnerships to promote successes and coach people to reach personal goals
c. Connects people with services and partners, or offers alternatives until needs are properly addressed
d. Views each person as creative, resourceful, whole, and more than just a number

Effective Communication
Providing me with clear and consistent information
a. Ensures needs are met with an appropriate level of urgency, prioritization, and follow-through
b. Provides accessible means of communication, with appropriate measures taken for privacy (e.g. in-person, phone, email, social media)
c. Maintains transparency about the organization’s processes, and explains actions taken in any high-stress situation
d. Utilizes a process to provide constructive feedback to the organization, and ensures steps are taken for improvement when appropriate

Supportive Staff
Is kind and has a true and genuine passion for helping me
a. Integrates trauma-informed care training and awareness
b. Reflects the community served (e.g. lived experiences, ethnicity, race, gender, social status)
c. Values everyone regardless of gender, race, sexual orientation, social status, religious and personal beliefs, or culture
d. Offers a considerate, honest, and empathetic community that can be relied on
APPENDIX E.9 – SUD Credentials

SUBSTANCE USE DISORDER CREDENTIALS

CADTP Certification Levels
(Effective January 1, 2019)

Substance Use Disorder Registered Counselor (SUDRC)
Before becoming employed as a counselor in a DHCS licensed or certified program, an applicant must register with the California Association of DUI Treatment Programs (CADTP). Applicants will have five (5) years from the date of being registered as an AOD counselor to complete the certification process.

SUDCC - Substance Use Disorder Certified Counselor
- Passed the IC&RC Exam
- 315 hours of formal SUD related education
- 2080 hours of SUD related work experience (160 practicum)

SUDCC II - Substance Use Disorder Certified Counselor – Advanced Experience
- Passed the IC&RC Exam
- 315 hours of formal SUD related education,
- 5 years or 10,000 hours of SUD work experience

SUDCC III - Substance Use Disorder Certified Counselor – Advanced Experience and Bachelor Level Education
- Passed the IC&RC Exam
- Bachelor’s degree in SUD related education
- 5 years or 10,000 hours of SUD work experience

SUDCC III-CS - Substance Use Disorder Certified Counselor Clinical Supervisor
(Effective 01/01/2019: all former CAODC-CS counselors will be grandfathered to the SUDCC III-CS)
- Passed the IC&RC Exam
- Bachelor’s degree in SUD related education
- 5 years or 10,000 hours of SUD work experience which includes 2 years’ experience in the direct supervision of SUD Counselors
- Completed 40 hours of Clinical Supervisor specific education

SUDCC IV: Substance Use Disorder Certified Counselor – Advanced Experience and Master Level Education
- Passed the IC&RC Exam
- Master’s degree in formal SUD related education
- 5 years or 10,000 hours of SUD work experience

SUDCC IV-CS: Substance Use Disorder Certified Counselor Clinical Supervisor
- Passed the IC&RC Exam
- Master’s degree in formal SUD related education
- 5 years or 10,000 hours of SUD work experience which includes 2 years experience in the direct supervision of SUD Counselors
- Completed 40 hours of Clinical Supervisor specific education

Credential Verification: [http://www.cadtp.org/counselors/](http://www.cadtp.org/counselors/)

Reference: [www.cadtp.org](http://www.cadtp.org)
Alcohol and Other Drug Counselors Licensed, Certified, or Registered By CCAPP

In order to assist clients, employers, and state regulators in the verification and referral processes, CCAPP has developed "The Registry" for identifying qualified treatment professionals in good standing with the California Consortium of Addiction Programs and Professions Credentialing (CCAPP Credentialing). The term "pending" may identify one of the following: pending administrative review, nonpayment of renewal dues and/or declined credit card and/or a check provided that has been sent back with the status non-sufficient funds.

- **RADT** = Registered Alcohol and Drug Technician
- **RADT II** = Registered Alcohol and Drug Trainee II
- **CADC I** = Certified Alcohol and Drug Counselor I
- **CADC II** = Certified Alcohol and Drug Counselor II
- **CADC-CS** = Certified Alcohol Drug Counselor – Clinical Supervisor
- **LAADC** = Licensed Advanced Alcohol and Drug Counselor
- **LAADC-S** = Licensed Advanced Alcohol and Drug Counselor - Supervisor*
  
  *non-governmental license
- **IM** = Membership, this is not a credential

We also offer specialty certifications:

- **CCJP** = Certified Criminal Justice Addiction Professional
- **CCPS** = California Certified Prevention Specialist
- **CCDP** = Certified Co-occurring Disorder Professional
- **CPRS** = Certified Peer Recovery Specialist
- **CRPM** = Certified Recovery Program Manager
- **MATS** = Medication Assisted Treatment Specialist
- **IS** = Intervention Specialist
- **WTS** = Women’s Treatment Specialist

Credential Verification: [https://ccappcredentialing.org/index.php/verify-credential](https://ccappcredentialing.org/index.php/verify-credential)

Reference: [https://ccappcredentialing.org](https://ccappcredentialing.org)
CATC (I, II, III, IV, V, N) Certification Upgrades
The honorary CATC (I, II, III, IV, V, N) tiered system is designed to signify your higher level of education to employers and clients. The education requirements (in addition to the minimum 315 hours of AOD coursework) for each honorary CATC tier level are as follows:

(CATC-i)- Intern Registration

CATC I - Certificate of Completion from a 30-Unit minimum approved Alcohol and Other Drug (AOD)/Addiction Studies or Alcohol and Drug Studies (ADS) Community College Program (https://dev.caade.org/accreditation-of-colleges-career-track-programs/accreditedaodprograms/) and must be in Addiction Studies or Alcohol & Drug Studies
CATC II – Associate Degree – Degree must be from a regionally accredited college/university and must be in Addiction Studies or a related field.
CATC III - Bachelor’s Degree - Degree must be from a regionally accredited college/university and must be in Addiction Studies or a related field.
CATC IV – Master’s Degree - Degree must be from a regionally accredited college/university and must be in Addiction Studies or a related field.
CATC V – Doctoral Degree - Degree must be from a regionally accredited college/university and must be in Addiction Studies or a related field.
CATC N – Nursing Degree - Degree must be from a regionally accredited college/university and must be in Nursing

Credential Verification: http://caade.org.azurewebsites.net/searchrecordscompoundCAADE.php

Reference: https://caade.org
# DMC-ODS Medical Director Training Requirements

This is a clarification of the current Medical Director training requirements and a brief description of these trainings.

## Annual Trainings:

- **Continuing Medical Education in Addiction Medicine**: Minimum of five (5) hours of continuing medical education in addiction medicine each year.
- **Cultural Competency including CLAS**: Minimum of four (4) hours annually via RIHS, in-service, or outside trainings.
- **Perinatal Services Network Guidelines**: 20-minute webinar (Note: Perinatal Programs only)
- **Youth Treatment Guidelines**: 30-minute webinar (Note: Adolescent and Perinatal Programs only)
- **False Claims Act**: Review of County’s 14 slide PPT or comparable training of program’s choosing. Written attestation of annual review required to be maintained by program.

## One Time Trainings:

- **ASAM Training**: Completion of ASAM A, B & C (via CIBHS, California Institute for Behavioral Health Solutions) or completion of ASAM e-training Modules 1 and 2 (“Multidimensional Assessment” and “From Assessment to Service Planning and Level of Care” via the Change Companies) prior to provision of screening/intake, assessment and treatment planning services or prior to supervising staff providing these services.

If a Medical Director provides any direct service to BHS clients at a DMC-ODS facility, then there are two (2) additional training requirements as indicated below:

### Additional Annual Training:

- **Beneficiary Rights**: 45-minute webinar

### Additional One Time Training:

- **Trauma Informed Care**: RIHS 1-hour webinar or program discretion

---

*Regarding ASAM training, the County relies on the legal entities to develop their own P&Ps around MD training on ASAM, which may include that in lieu of ASAM training, addiction certified MDs may show documentation of ASAM training that may not have been through The Change Companies or CIBHS. The contract between the State and the County requires staff completing assessment/treatment planning to be ASAM-trained prior to providing services. While MDs may not be completing assessment/treatment planning, they may be making the final LOC determinations (based on information from the staff, if they are involved in that type of supervision).*

For more details and links to these trainings, please review the DMC-ODS Required Training website: [https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/dmc_ods/dmc_ods_provider/dmc_ods_quick_reference_training_guide.html](https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/dmc_ods/dmc_ods_provider/dmc_ods_quick_reference_training_guide.html)
### County of San Diego Alcohol and Drug Services
### Residential and Non-Residential Treatment Services
### Sliding Fee Scale

<table>
<thead>
<tr>
<th>Adjusted Annual Household Income</th>
<th>NON-RESIDENTIAL</th>
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<th>RESIDENTIAL</th>
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<td>Dependents</td>
<td>1</td>
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<td>$60,001-$80,000+</td>
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<td>$91</td>
<td>$83</td>
<td>$76</td>
<td>$69</td>
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</table>

Each block represents the maximum amount that can be charged to a client according to income status. The client fee rate can be negotiated down to match a clients ability to pay. Each Client fee amount shown above represents a range from the highest allowable amount to a charge of $0. Example: A Residential client, with No dependents and a $50,000 Adjusted Annual Household Income, would be charged a maximum of $450 per week, or any amount between $450 and $0, depending on the clients ability to pay. Dependents represent the number of persons dependent on the Household income, a single person with no dependents is categorized as 1. No service will be refused due to a clients inability to pay.
# APPENDIX F.2 – Gift Card Approval Form

## HEALTH AND HUMAN SERVICES AGENCY - BEHAVIORAL HEALTH SERVICES

### GIFT CARD APPROVAL FORM

**Contractor:**

**Contract #:**

**Program Name:**

**Budget Period:**

**Amendment Number:**

### GIFT CARD: Anticipated item description and purpose

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<tr>
<th></th>
<th>Quantity</th>
<th>Amount</th>
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- Have adequate internal controls and procedures in place to mitigate misappropriation of Gift Cards.
- Gift Cards maintained in a secured and locked environment accessible only to the designated Contractor employees.
- Gift Card are accounted for by receipts, tracking system and follow the Contractor’s internal purchase policies.
- Disbursement of Gift Cards are accounted for by a tracking system that indicates at a minimum: full name of the recipient, amount of the Gift Card, date disbursed, two full signatures one of which must be a Contractor employee. If both signatures are those of contract employees, one must be a supervisor.
- In the event Contractor discovers misappropriation of Gift Cards, Contractor must contact assigned BHS COR within one workday of the occurrence.
- Gift card purchase receipts, tracking log and internal policies shall be available to COR or Designee review and inspection at any time.
- Gift cards directly benefit clients and program objectives.
- Records to support the use of gift cards shall be available for in-depth review visits. Gift Cards that are not used or disbursed at the end of their original approved contract year must be justified and pre-approved (again) prior to being used in the next or any future contract year.

**Prepared By (Sign):**

**Type Name & Title:**

**Phone number:**

**COR APPROVAL:**

**Date Submitted:**

**Date Approved:**

*Note: If any revisions to this form are needed, re-submit the form (by email) to COR with requested changes.*
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</table>
## Appendix F.4 – Payment Recovery Form

### Provider Drug Medical Payment Recovery Report (Void/Disallowance)

<table>
<thead>
<tr>
<th>CLIENT NAME</th>
<th>TYPE OF REVIEW</th>
<th>REVIEW DATE</th>
<th>CLAIM FOR</th>
<th>SERVICE DATES</th>
<th>AR **</th>
<th>U/S</th>
<th>TOTAL DOLLARS ADJUSTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name, First Name</td>
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**Adjustment Reason is:**
1. Beneficiary not DRMC eligible.
2. Service not provided.
3. Service not DRMC eligible.
4. Location of service not DRMC certified.
5. Medical necessity not established.
6. DSM code not identified or incorrect.
7. Incorrect use of "Good Cause" code.
8. Admission criteria time frames not met.
9. Treatment plan time frames not met.
10. Continuing services/treatment time frames not met.

(State use only!)

| PAYMENT RECOVERY FORM (Rev. 06/19/2019) |
---|---|

Provider Authorized Signature: __________________________ Date: ___________
APPENDIX F.5 – BHS Inventory Form

<table>
<thead>
<tr>
<th>INVENTORY REPORT FORM</th>
<th>This report covers acquired items through FISCAL YEAR</th>
<th>2019-2020</th>
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</thead>
<tbody>
<tr>
<td>Contractor/Legal Entity</td>
<td>Program Name</td>
<td></td>
</tr>
<tr>
<td>County Contract #</td>
<td>Contact Person</td>
<td></td>
</tr>
<tr>
<td>Location of Property</td>
<td>Contact Phone #</td>
<td></td>
</tr>
<tr>
<td>COR</td>
<td>Contact Email</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yellow County Property Tag/Label Attached to Item? (Yes/No)</th>
<th>Property No.</th>
<th>Acquisition Date</th>
<th>Acquisition Cost</th>
<th>Description (quantity, make, model, etc.)</th>
<th>Serial No. and/or Manufacturing No.</th>
<th>Inventory Amount</th>
<th>Condition of the Item</th>
<th>Program Funding for the Item</th>
<th>Approval Date of Item Transfer or Disposition (if applicable)</th>
<th>Control # assigned by County</th>
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# APPENDIX F.6 – DPC 203 (fillable)

## TRANSFER OR DISPOSITION OF MINOR EQUIPMENT

**COUNTY OF SAN DIEGO**

Department of Purchasing and Contracting

### Table

<table>
<thead>
<tr>
<th>Property No.</th>
<th>AQL Date</th>
<th>Description</th>
<th>IT Items Only</th>
<th>Non IT Items Only</th>
<th>Serial No.</th>
<th>Listing No.</th>
<th>New Location Code</th>
<th>Item Quantity</th>
</tr>
</thead>
</table>

**Control No.**

(Assigned by Property Disposal)

---

**Contractor:**

**Program:**

**COR:**

**Signature:**

---

**Transferring/Assigning:**

**HHSA / BHS**

**ORIG. NO.:**

45290

**Property Disposal or Receiving Dept.:**

**ORG. NO.:**

Purchasing and Contracting

81665

**Printed Name of Approving Officer:**

**Date:**

**Printed Name of Approving Officer:**

**Date:**

**Signature:**

---

**Nature of Request:**

- Sale, salvage or other disposal via PSC property disposal
- Intra-departmental transfer
- Departmental minor equipment tracking

**Receiving Department Remarks:**

(Special note: All sensitive & county operational materials have been physically removed or scrubbed from the appropriate items listed above.)

**Sender’s Information:**

**Contractor Staff:**

**Phone:**

**Email:**

**Receiver’s Information (Transfers Only):**

**Contractor Staff:**

**Phone:**

**Email:**

**Receiving COR Signature:**

**Date:**

**Property Disposal or Receiving Department Remarks:**

---

I CERTIFY THAT HHSA GAVE IT VENDOR ALL LISTED IT ITEMS ABOVE FOR DISPOSAL. IF VENDOR EMPLOYEE PLEASE SIGN, PRINT YOUR NAME & DATE RECEIVED BELOW.

**Picked Up by Signature:**

**Name Printed:**

**Date Picked Up:**

**For IT Transfers Only:**

**Signature:**

**Date Completed and Returned:**

**Name Printed:**

**Date:**

---

Appendix F.6
The image contains a document titled "APPENDIX F.7 – DPC 203 Mobile Devices". The main section of the document is a form titled "TRANSFER OR DISPOSITION OF MINOR EQUIPMENT". The form includes columns for property number/inventory tag number, age date, description, listing number, new location code, and item quantity. The form also contains fields for HISA BHS, approved authorized signatures, and printed name of approving officer.

A note at the bottom of the form states: "Property disposal or receiving department remarks. All sensitive or county operational materials have been physically removed or scrubbed from the appropriate items listed above.

Appendix F.7"
## COUNTY OF SAN DIEGO
Department of Purchasing and Contracting

### DISPOSITION OF I.T. MINOR ASSET SUPPLEMENTAL

All devices must be reset to the factory default setting

<table>
<thead>
<tr>
<th>DESCRIPTION (BRAND AND MODEL)</th>
<th>SERIAL NUMBER</th>
<th>PASSWORD TO UNLOCK</th>
<th>GRANT FUNDED (Y/N)</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

## PHOTOS REQUIRED FOR APPROVAL

1. SIM cards are not required to accompany phones/devices, but will be wiped/destroyed if included.
2. Batteries MUST accompany phones when packed for shipment; devices should include all original parts.
3. Batteries may be removed from device, but must accompany the device in shipping.
4. Batteries may be taped to the exterior of the phone, which must be wrapped in paper or plastic.
5. Devices (and batteries) must be wrapped prior to placing in box to avoid breakage/damage.
6. Samsung units must remove Google.
7. Apple Units must remove iCloud/Find My Phone prior to sending.
MINOR EQUIPMENT DISPOSITION PROCESS
MOBILE DEVICES

START
Contractor identifies County-owned Mobile Device for salvage or disposal

Contractor initiates set of Mobile Devices DPC 203s (excluding Department section on DPC 203 Cover, noting Mobile Devices Recycling as Nature of Request, and listing items with required information on DPC 203 SUPPLEMENTAL)

Contractor takes group photo (JPEG) of items

Contractor forwards DPC 203s to COR

COR reviews, resolves discrepancies, signs DPC 203s, and forwards (with photos) to PPU

Stage 1 of 2
15 business days

PPU reviews form and requests resolution of any discrepancies with COR/Analyst

PPU signs DPC 203s (#9-11) and forwards to DPC for approval

CORs upload signed DPC 203s to in CAMS

COR notifies the COR that mobile device have been mailed

COR forwards mailing label barcode to contractor

PNU forwards mailing label barcode to COR

PNU contacts mobile vendor and requests mailing label barcode

DPC approves, assigns control number

END
APPENDIX G.1 - RCA Worksheet

QUALITY IMPROVEMENT ACTIVITY

Directions for Root Cause Analysis (RCA)

The goal of the RCA is to identify systemic gaps or failures in systems and processes, not to point fingers or lay blame on individuals. The RCA is not the same as the investigation into the incident, which should be completed prior to the RCA.

Instructions for conducting the RCA:

The RCA worksheet that is attached will provide a structure for completing the RCA.

After identifying the Lead, Facilitator and the Participants of the RCA, schedule at least one meeting for the RCA group to complete the following tasks:

1) The first step in completing the worksheet for the RCA is describing the serious incident. Include who was involved, services that were affected, and other details of the incident. It is recommended that the incident being reviewed be written up in a flow diagram as part of the process of describing the incident. A flow diagram is very useful in identifying gaps in systems and processes. Ask participants to come to the RCA meeting with a basic description of the incident from their perspective that includes dates and processes involved.

2) Next step is to note the participants in the RCA. Participants in the RCA may include those involved in the incident but must include those staff that are knowledgeable about the systems and processes that will be analyzed.

3) Next identify the systems and processes that will be analyzed. In general, systems and processes will be those program issues that are defined by policy and procedures. Examples of systems and processes are noted in the worksheet. Not all systems and processes will apply in every case, and there may be others that are not listed on the worksheet that arise in the course of analysis.

4) The next step is to break down each system or process into the steps involved – it is helpful to have a workflow diagram for each system or process as this can assist in uncovering gaps.

5) Identify any gaps found in the system or process design. How did the design of the system or process compare to the real event, human factors, equipment factors, controllable environmental factors, and uncontrollable external factors? It can help to think about what the system or process would “ideally” look like even if the ideal does not seem possible.

6) Identify if the finding is a “root cause” (yes or no). For each finding of root cause an analysis is to be completed. Many findings that are not a root cause themselves have “roots” that may need to be addressed. Using a “fishbone” or Ishakawa diagram can assist in identifying these “hidden roots”.

7) The next step is to note if actions will be taken to address the issues that are identified as a root cause.

8) The final element of the RCA is to note Action Plans that will be taken to address any issues that are identified as a root cause. This portion of the RCA delineates the items that are being addressed, the strategies that will be implemented, and the measures that will be used to determine the effectiveness of the plan.

Serious Incident Root Cause Analysis Worksheet- Rev 7/31/12
## QUALITY IMPROVEMENT ACTIVITY

### SERIOUS INCIDENT ROOT CAUSE ANALYSIS WORKSHEET

**Date and Time of Serious Incident:**

<table>
<thead>
<tr>
<th>(1) Summary of incident:</th>
<th>(List type of serious incident and explain what happened. Include who was involved, services impacted, including any outside parties or witnesses, details of the incident, and the outcome/injury)</th>
</tr>
</thead>
</table>
| (2) Participants:        | (List all the participants by position and title (no names) involved in the root cause analysis and action plan. Note the Lead of the RCA and the facilitator.)  
**Lead:** Facilitator:  
**Members:** Medical Director, Office Manager, Therapist, etc. |
| (3) Systems and Processes: | (Note systems and processes that were analyzed to determine proximate causes)  
List of possible systems and processes for review:  
- Assessment Process  
- Physical Assessment Process  
- Medication Protocols  
- Staffing resources  
- Security  
- Facility  
- Equipment  
- Care Coordination  
- Availability of information  
- Risk Assessment Process  
- Reception protocols  
- Control of medications, storage, access  
- Staff Training/Education  
- Policies and Procedures  
- Communications with client or family  
- Communications among staff  
- Other. |

---

Serious Incident Root Cause Analysis Worksheet - Rev 7/31/12

Appendix G.1
<table>
<thead>
<tr>
<th>(3) Note each Process to be considered for review and definition</th>
<th>(4) What are the steps in the process as designed? <em>(A flow diagram is recommended)</em></th>
<th>(5) Findings</th>
<th>(6) Root Cause?</th>
<th>(7) Take Action?</th>
<th>Action Items:</th>
<th>Measures of effectiveness:</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
CONFIDENTIAL
SERIOUS INCIDENT REPORT OF FINDINGS (SIROF)
County of San Diego Behavioral Health Services (BHS)
QM CONFIDENTIAL FAX: 619-236-1953

A SIROF shall include a thorough review of the serious incident and relevant findings and interventions/recommendations. The Report of Findings shall be submitted within 30 days of the reported incident. If a RCA was completed, then complete the RCA section only.

Program Name:  
COR:  

Client Name:  
Client Case Number:  
Date of Incident:  

RCA Required?  YES  NO  Date RCA Completed:  

For Serious Incident Reports related to an Overdose, the following is required:

1. Substance involved in the overdose:  Select One  

2. If Opioid was involved, was the client receiving Medication Assisted Treatment (MAT) services:  YES  NO  

3. If #2 is No, was the client referred to MAT:  YES, referred to:  
   □ Client Declined Referral  □ No/Other  

4. If #3 is Declined/No/Other, please explain:  

1. Serious Incident Summary of Findings: (Document the results of your investigation and analysis of the Serious Incident.)  

2. Recommendations/Planned Improvements: (Document a summary of quality/system improvements as a result of the analysis of the Serious Incident)  

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Revised 7/1/2020  

Appendix G.2
CONFIDENTIAL
SERIOUS INCIDENT REPORT OF FINDINGS (SIROF)
County of San Diego Behavioral Health Services (BHS)
QM CONFIDENTIAL FAX: 619-236-1953

A Root Cause Analysis (RCA) is required for any serious incident that results in 1) a death by suicide, 2) alleged homicide committed by client, or 3) as requested by QM. The RCA shall be completed within 30 days of the reported incident. Please complete the section below only if you have completed an RCA.

1. Was a root cause identified? □ YES □ NO

2. RCA Summary of Findings:

   [Blank space for summary]

3. RCA Summary of Action Items:

   [Blank space for summary]

Was the SIROF sent to QM within 30 days of the reported incident? □ YES □ NO

If no, why? [Blank space for response]

Report Completed By: [Signature]

This section to be completed by Program Manager or Designee Only

Program Manager or Designee’s Email:

Program Manager or Designee’s Phone:

Program Manager or Designee’s Name:

Program Manager or Designee’s Signature: ___________________________ Date: __________

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CONFIDENTIAL

SERIOUS INCIDENT REPORT (SIR)

County of San Diego Behavioral Health Services (BHS)

FAX: 619-236-1953  Serious Incident Report Line 619-584-3022
Fax LEVEL ONE SIR within 24 hours. Fax Level Two SIR within 72 hours.

SIR INSTRUCTIONS

LEVEL ONE incident shall be reported to the BHS Serious Incident Report Line immediately, upon knowledge of the incident. Level Two incident shall be reported to the BHS Serious Incident Report Line within 24 hours, upon knowledge of the incident.

NOTE: Reporting of a serious incident is based on criteria and determined severity of the serious incident.

A LEVEL ONE Serious Incident is the most severe type of incident. A level one incident must include at least one of the following:

- Any event that has been reported in the media current or recent past regardless of type of incident.
- The event has resulted in a death or serious physical injury on the program’s premises.
- The event is associated with a significant adverse deviation from the usual process for providing behavioral health care.

A LEVEL ONE Serious Incident that occurs on the weekend or holiday shall be reported in accordance with the procedure documented in the Organizational Provider Operations Handbook (OPOH) and the Substance Use Disorder Provider Operations Handbook (SUDPOH).

All other serious incidents are reported as Level Two incidents. For consultation, call QM Program Manager, see below

Privacy Incident Reporting (PIR): Report only to HHSA Compliance Office within one business day via on-line portal.

Report of Findings shall include a thorough review of the serious incident, relevant findings and interventions/recommendations. The Report of Findings shall be submitted within 30 days of the reported serious incident. If a RCA was completed, then complete the RCA section only.

A Root Cause Analysis (RCA) is required for any serious incident that results in 1) a death by suicide, 2) alleged homicide committed by client, or 3) as requested by QM. The RCA and RCA Report of Findings shall be completed and submitted to QM within 30 days of the reported serious incident.

NOTE: The SIR form must be typed. Handwritten reports will be returned to programs for a typed report.

All fields are required and must be completed unless otherwise noted. Incomplete forms may be returned.

NOTIFICATIONS: Certain reports require additional notifications to other parties (i.e. APS and DHCS). Please see specifications on the SIR form.

If you have questions about any serious incident, please contact the QM Behavioral Health Program Coordinator Mental Health Programs: 619-584-5016 Substance Use Disorder Programs: 619-584-3061.

Questions? Call for a Consultation.
CONFIDENTIAL
SERIOUS INCIDENT REPORT (SIR)
County of San Diego Behavioral Health Services (BHS)
QM CONFIDENTIAL FAX: 619-236-1953 Serious Incident Report Line 619-584-3022
Fax LEVEL ONE SIR within 24 hours. Fax Level Two SIR within 72 hours.

Program Name: [ ] Legal Entity: [ ] Type: [ ] LEVEL ONE [ ] Level Two
Client Name: SanWITS Number:
DOB: CCBH Number:
Date of Last Service: DSM-5 Diagnosis:

MediCal: [ ] Yes [ ] No; If yes, MediCal Number:

Staff Involved with incident:

Date/Time/Location of Incident: Date Reported to Provider:

BHS – Mental Health Program
Select Appropriate Option
Other:

BHS - SUD Program
Select Appropriate Option
Other:

Program County Region Location: Select Appropriate Option
Contracting Officer’s Representative (COR):

1. INCIDENT TYPE (You may check more than one if applicable):
   Select Appropriate Option

Media Information:
Other:

2. NOTIFICATIONS:

MH and SUD programs may require additional notifications to other parties (i.e., APS, CWS, Law Enforcement, DHCS, SUD Credentialing Organization, etc.).

* SUD Residential Programs only, report to DHCS SIRs related to: death, injury that requires medical treatment, communicable diseases, poisonings, natural disaster and/or fires or explosions on premises. See DHCS 5079 titled “Unusual Incident/Injury/Death Report” for a copy of the DHCS form and directions.

** The SUD Compliance Division investigates violations of the code of conduct of registered or certified AOD counselors. Alcohol or Drug Abuse Recovery or Treatment Facilities licensed or certified by DHCS are required to report counselor misconduct to DHCS within 24 hours of the violation. See DHCS Substance Use Disorders Services – Complaints, for further details about regulations and how to file a complaint with DHCS (SUD only).

Type: Select Appropriate Option
Entity: Other
Other:

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Appendix G.3
CONFIDENTIAL
SERIOUS INCIDENT REPORT (SIR)
County of San Diego Behavioral Health Services (BHS)
QM CONFIDENTIAL FAX: 619-236-1933 Serious Incident Report Line 619-584-3022
Fax LEVEL ONE SIR within 24 hours. Fax Level Two SIR within 72 hours.

SUD Residential Programs, reported to DHCS (SIR related to: Death, Injury that requires medical treatment, communicable diseases, poisonings, natural disaster and/or fires or explosions on premises): □ Yes □ No

□ Telephonic Report (916) 322-2911 (Within 24 Hours).
Date: ___________ Time: ___________

□ If Applicable, Written (Within 7 days of the Event): DHCS 5079 titled "Unusual Incident/Injury/Death Report".
Date: ___________ Time: ___________

□ If Applicable, death report submitted via fax to the DHCS Complaints and Counselor Certification Division at (916) 445-5084 or by email to DHCSLCBcomp@DHCS.ca.gov.
Date: ___________ Time: ___________

3. DESCRIBE THE SERIOUS INCIDENT: [ADDRESS ALL ITEMS BELOW]
1. Include people involved, precipitating factors, and details of incident; 2. Indicate if client was admitted for medical or psychiatric care; 3. Describe any physical, medical or other concerns.

4. OTHER BEHAVIORAL HEALTH CLIENT SERVICES: (Outpatient, FSP/ACT, WRAP, SBCM, medication management, day treatment, residential, recovery services, etc.)

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CONFIDENTIAL
SERIOUS INCIDENT REPORT (SIR)
County of San Diego Behavioral Health Services (BHS)
QM CONFIDENTIAL FAX: 619-236-1953 Serious Incident Report Line 619-584-3022
Fax LEVEL ONE SIR within 24 hours. Fax Level Two SIR within 72 hours.

5. MEDICAL/PHYSICAL HEALTH:

Current prescribed medication(s):

Name of prescribing physician:

Physical or medical concerns:

6. TARASOFF REPORT OF FINDINGS INDICATED? □ NO □ YES
Program is not required to submit a report of findings for Tarasoff reports unless it is relevant to an identified systemic issue in program operations or to client’s treatment.

7. Date & Time of phone report to QM: Date:_________ Time:_________

Form Completed By:_________

This section to be completed by Program Manger or Designee Only

Program Manager’s Email:_________

Program Manager’s Phone:_________

Program Manager Name:_________

Program Manager Signature:_________ Date:_________

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APPENDIX G.4 – HHSA Privacy Incident Reporting Process

County of San Diego—HHSA

Privacy Incident Reporting Process for Programs

Step 1:
1. Staff becomes aware of suspected or actual privacy incident.
2. Staff notifies manager immediately.
3. If County contractor was involved, notify Contracting Officer’s Representative (COR).

Examples of potential privacy incidents include:
- Giving Client A’s paperwork to Client B
- Sending email with client information to wrong staff
- Sending unencrypted email with client information outside of the County
- Misplacing a client’s chart
- Losing County-issued phone or laptop

Step 2:

If County incident, Program Manager will:
1. If suspected or actual privacy incident involves 500 or more individuals, notify Agency Privacy Officer (APO) immediately by emailing: angie.devoss@sdcounty.ca.gov and frank.larlos@sdcounty.ca.gov
2. For all other suspected or actual privacy incidents follow steps below.
   2.1. Submit an Initial HHSA Privacy Incident Report (PIR) online via the web portal: https://www.sandiegocounty.gov/content/sdc/hhsa/hhsa-privacy-landing.html
   2.2. Complete initial PIR web-form to the best of your ability and submit within 1 business day. The PIR web-form landing page link is also available on the Agency Compliance Office’s website: www.cosdcompliance.org.
   2.3. Submitter will receive an email with the PIR Tracking # and an Access Code. Use this information to access your PIR via the same web link above.
   2.4. Continue to investigate and Update the PIR online within 72 hours, including required information missing from initial report and any additional information requested by APO.
   2.5. Provide any pending or additional information needed to submit Final completed PIR within 7 business days of initial discovery.

If Contractor incident, COR will:
1. Direct Contractor to complete HHSA Privacy Incident Report Web-Form online and updates, as outlined above.
2. Direct Contractor to complete any other steps as directed by APO, including, but not limited to notifications or external reporting.

Step 3:

APO will:
1. Determine whether privacy incident occurred.
2. Recommend level of external reporting to County Counsel and Chief Operating Officer.
3. Assess whether client notifications are needed.

If notifications are required:
1. County Program Manager will draft client notifications using template provided by APO & provide draft to APO within 3 business days.
2. Contractors will submit draft notification to APO compliant with CA Civil Code §1798.29
3. Mail approved notifications to client within 5 business days of receiving APO approval.
4. Provide copy of all notifications as well as date sent to APO.

June/2018 - www.cosdcompliance.org

Appendix G.4
INSTRUCTIONS
Use this form to document participant complaints. Report copies should be kept in an administrative file and not included in the participant’s chart.

For serious allegations or confirmed inappropriate staff behavior (including volunteers/interns) such as sexual relations with a participant, participant/staff boundary issues, financial exploitation of a participant, and/or physical or verbal abuse of a participant, complete the Serious Incident Report (SIR) Form as well. In lieu of completing items 1-2 of this form, attach a copy of the SIR.

Program Name:  
Legal Entity:  

Name of complainant:  
Anonymous complaint:  
Contact number of complainant:  

Date/Time Complaint Received:  
Staff receiving complaint:  

Type of Program:  
□ Outpatient  □ Case Management  □ Residential  

Population Served:  
□ Adult  □ Perinatal  □ Youth  
□ Drug Court  □ Other  

DMC Certified?  
□ Yes  □ No  
Receive SAPT Funding?  
□ Yes  □ No  

Program County Region Location:  
□ Central  □ North Central  □ East  □ South  
□ North Inland  □ North Coastal  □ Out of County  
□ Countywide  
Contracting Officer’s Representative (COR):  

Complaint type:
□ Service not available/inaccessible  
□ Delayed services/referral/appointment  
□ Denied services/referral/appointment  
□ Coverage/enrollment/disenrollment issues (DMC)  
□ Language barriers  
□ Marketing/solicitation issues  
□ Patient rights  
□ Problems with payment to provider/affordability  
□ Quality/appropriateness of care  
□ Confidentiality  
□ Billing  
□ Other  

1. DESCRIPTION OF COMPLAINT:  

2. PROGRAM RESPONSE TO COMPLAINT:  

Program Manager Name:  
Program Manager Email:  

Page 1 of 2  
Rev 8-30-17
Program Manager Phone: 

Report Completed By: 

Program Manager Signature: ___________________________ Date: ___

Appendix G.5
An Adverse Benefit Determination is defined to mean any of the following actions taken by The Plan: 1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit; 2) The reduction, suspension, or termination of a previously authorized service; 3) The denial, in whole or in part, of payment for a service; 4) The failure to provide services in a timely manner; 5) The failure to act within the required timeframes for standard resolution of grievances and appeals; or 6) The denial of a beneficiary’s request to dispute financial liability. Beneficiaries must receive a written NOABD when The Plan takes any actions described above. The Plan must also communicate the decision to the affected provider within 24 hours of making the decision.

<table>
<thead>
<tr>
<th>NOABD</th>
<th>Who Receives Notice?</th>
<th>Criteria for Beneficiary Notice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denial of Authorization Notice</td>
<td>Client or parent/legal guardian</td>
<td>The Plan denies a request for service. Denials include determinations based on type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit. Use this notice for denied residential services requests (both MH and SUD). The Plan must mail the notice within two (2) business days of the decision.</td>
</tr>
<tr>
<td>Modification Notice</td>
<td>Client or parent/legal guardian</td>
<td>The Plan modifies or limits a provider’s request for a service, including reductions in frequency and/or duration of services, and approval of alternative treatments and services. The Plan must mail the notice to the beneficiary within two (2) business days of the decision.</td>
</tr>
<tr>
<td>Termination Notice</td>
<td>Client or parent/legal guardian</td>
<td>The Plan terminates, reduces or suspends a previously authorized service. The Plan must mail the notice to the beneficiary within ten (10) days before the date of the action.</td>
</tr>
<tr>
<td>Timely Access Notice</td>
<td>Client or parent/legal guardian</td>
<td>When there is a delay in providing the beneficiary with timely services, as required by the timely access standards applicable to the delayed service. The Plan must issue this notice if access to services is extended beyond 60 days from the initial request for services. The Plan must mail the notice to the beneficiary at the time of any action regarding the delay.</td>
</tr>
<tr>
<td>Authorization Delay Notice</td>
<td>Client or parent/legal guardian</td>
<td>When there is a delay in processing a provider’s request for authorization of specialty mental health services or substance use disorder residential services. When The Plan extends the timeframes to make an authorization decision, it is a delay in processing a provider’s request. This includes extensions granted at the request of the beneficiary or provider, and/or those granted when there is a need for additional information from the beneficiary or provider when the extension is in the beneficiary’s interest. The Plan must mail the notice to the beneficiary within two (2) business days of the decision.</td>
</tr>
<tr>
<td>Financial Liability Notice</td>
<td>Client or parent/legal guardian</td>
<td>The Plan denies a beneficiary’s request to dispute financial liability, including cost-sharing and other beneficiary financial liabilities. The Plan must mail the notice to the beneficiary at the time of any action regarding the dispute.</td>
</tr>
<tr>
<td>Payment Denial Notice</td>
<td>Client or parent/legal guardian</td>
<td>The Plan denies, in whole or in part, for any reason, a provider’s request for payment for a service that has already been delivered to a beneficiary. The Plan must mail the notice to the beneficiary at the time of any action denying the provider’s claim.</td>
</tr>
</tbody>
</table>
APPENDIX H.1 – BHS CalOMS & Open Admissions Process

BHS CalOMS & Open Admissions Process

REQUIREMENT

• BHS MIS unit submits CalOMS data on the 1st and 15th of each month.
• If either date falls on a weekend or holiday, the data will be submitted the following business day.

CalOMS PROCESS

1. BHS MIS unit will contact providers via email with CalOMS errors generated after each data submission.

2. Providers should read the full email which will include how to resolve some of the common errors.

3. Provider corrections should be made within 2 weeks of the email sent by the MIS unit.

OPEN ADMISSIONS PROCESS

1. BHS MIS unit will contact providers via email with Open Admissions records that are out of compliance or at risk of becoming out of compliance.

2. Providers should read the full email which will include instructions.

3. Providers are expected to update the records as follows:

   a. Records at 10.0 to 10.9 months are at risk of becoming out of compliance and must be updated with an annual update or discharge within 2 weeks of the email sent by the MIS unit.

   b. Records 11.0 months and over are out of compliance and must be updated with an annual update or discharge within 3 days of the email sent by the MIS unit.

June 2018
BHS DATAR Process

REQUIREMENT
- Provider DATAR reporting is due to DHCS by the 7th of each month.

PROCESS

1. Monthly email reminders are sent to each provider on the 1st of each month.

2. Providers have between the 1st of each month and the 7th of each month to submit DATAR data to DHCS. DATAR must be submitted by the close of the business day on the 7th.

3. BHS MIS unit will generate a DHCS Non-Compliance DATAR Report on the 8th of each month to identify any providers not in compliance with the monthly DATAR requirement.

4. Providers identified on the Non-Compliance DATAR list will be notified via email of their non-compliance status and requested to comply immediately.

5. Assigned COR’s and Analysts will be notified after the 8th of each month of providers identified on the Non-Compliance DATA Report.

6. BHS MIS unit will continue to generate additional reports and follow-up with CORs and providers until compliance is 100%.

June 2018
APPENDIX H.3 – BHS DATAR TIP SHEET

What is DATAR?

The Drug and Alcohol Treatment Access Report (DATAR) is the Department of Health Care Services (DHCS) system to collect data on treatment capacity and waiting lists. DATAR assists in identifying specific categories of individuals awaiting treatment.

DEFINITIONS-

Total Treatment Capacity:

The maximum number of clients/participants who could be enrolled for alcohol and other drug treatment at any one time using ALL sources of funds (Public, DMC, 3rd party, client fees...)

Public Treatment Capacity:

Public Treatment Capacity is the maximum number of clients/participants who could be enrolled for Alcohol or Drug Treatment at any one time, using the PUBLIC Funds available.

Public Funds:

Are those that are allocated to the County Drug and Alcohol Programs as well as certain County generated funds (Not limited to-State General, Federal SATP Block Grant, CSAT, County Funds, DMC)

Slot:

Slot is the capacity to provide treatment service to one individual. Total slots reflect the maximum number of individuals a provider can serve at any one time, given its complement of staffing and other resources. “The static capacity that is being reported”

- Methadone slot- Licensed slots
- Outpatient services- the number of clients a provider can accommodate given available resources
- Residential-available beds

Service Type(s):

Service(s) Approved by DHCS to serve clients/participants in a SUD Program

Abbreviations for Service Types:

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>NRT/R</td>
<td>Outpatient Drug Free (ODF)</td>
</tr>
<tr>
<td>MAINT (METH/LAAM)</td>
<td>Outpatient methadone</td>
</tr>
<tr>
<td>NRDX METH</td>
<td>Outpatient methadone detoxification (OMD)</td>
</tr>
<tr>
<td>NRDX</td>
<td>Outpatient detoxification non-methadone ODX</td>
</tr>
<tr>
<td>RDX, NON HOSP</td>
<td>Residential detoxification</td>
</tr>
<tr>
<td>RT/R</td>
<td>Residential drug free (RDF)</td>
</tr>
<tr>
<td>NR DAY INTSV</td>
<td>Day care drug free (DCDF/DCH)</td>
</tr>
<tr>
<td>OTHER</td>
<td>Hospital detoxification, jail settings, etc</td>
</tr>
</tbody>
</table>
## DATAR QUESTIONNAIRE OVERVIEW

| LINE 1-TOTAL TREATMENT CAPACITY | Enter the **Total Treatment Capacity** at this location by type of service. If a program has two or more types of service, then each entry must reflect the number of “slots” per service type at any given time. This number represents the maximum number of clients/participants aka “slots” who could be enrolled for alcohol and other drug treatment at one time using **ALL** sources of funds (Public, DMC, 3rd party, client fees...). Slots:  
- NTP slot- Licensed slots  
- Outpatient services- the number of unique clients a provider can accommodate given available resources  
- Residential-Licensed beds |

| LINE 2A-PUBLIC TREATMENT CAPACITY | Enter the **Total Treatment Capacity funded with PUBLIC funds** at this location by type of service. If a program has two or more types of service, then each entry must reflect the number of slots per service type at any given time. This number represents the maximum number of clients/participants aka “slots” who could be enrolled for alcohol and other drug treatment at any one time using **PUBLIC Funds** available. Slots:  
- NTP slot- Licensed slots  
- Outpatient services- The number of unique clients a provider can accommodate given available resources  
- Residential- Licensed beds |

| LINE 2B- AVAILABLE PUBLIC TREATMENT OPENINGS AT END OF MONTH | Enter for each service type, the unused **PUBLIC** treatment capacity at this location as of the last day of the report month (number of “slots” empty)  
- NTP slot- Licensed slots  
- Outpatient services- The number of unique clients a provider can accommodate given available resources  
- Residential- Licensed beds |

| LINE 3- NUMBER OF DAYS THE PROGRAMS CENSUS/ENROLLMENT EXCEEDED 90% OF PUBLIC TREATMENT CAPACITY DURING THE MONTH | Enter for each service type the number of days during the report month that the programs enrollment exceeded 90% of its **PUBLIC** treatment capacity.  
*I.e.* Facility A has 100 public slots per month and for 12 days they were at 92% capacity. “12” will be entered since for 12 days they were over 90% |
<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Total number of applicants on the waiting list at any time during the entire month.</td>
<td>Enter for each service type, the number of applicants (PUBLIC Funding Slots) that were on the waiting list at any time during the report month.</td>
</tr>
<tr>
<td>5</td>
<td>Number of applicants on waiting list on last day of report month.</td>
<td>Enter for each service type, the number of applicants (PUBLIC Funding Slots) still active on the waiting list as of the last day of the report month.</td>
</tr>
<tr>
<td>6A</td>
<td>Number of applicants admitted to treatment from the waiting list.</td>
<td>Enter for each service type, the number of applicants (PUBLIC Funding Slots) that were removed from the waiting list during the report month because of admission to treatment either at this program or another program.</td>
</tr>
<tr>
<td>6B</td>
<td>Total number of days that applicants admitted to treatment spend on waiting list.</td>
<td>For all applicants (PUBLIC Funding Slots) counted in line 6A, enter the total number of days they were active on the waiting list.</td>
</tr>
<tr>
<td>7</td>
<td>Number of IDU on waiting list.</td>
<td>Enter for each service type, the number of injecting drug user (IDU) applicants (PUBLIC Funding Slots) that were on the waiting list at any time during the report month.</td>
</tr>
<tr>
<td>7B</td>
<td>Number of pregnant women on waiting list.</td>
<td>Enter for each service type, the number of applicants (PUBLIC Funding Slots) on the waiting list that were pregnant during the report month.</td>
</tr>
<tr>
<td>7C</td>
<td>Number of pregnant IDU on waiting list.</td>
<td>Enter for each service type the number of pregnant women in 7B, who were also IDU Users</td>
</tr>
<tr>
<td>7D</td>
<td>Number of Medi-Cal beneficiaries.</td>
<td>Enter for each service type, the number of applicants (PUBLIC Funding Slots) on the waiting list at any time during the report month who were Medi-Cal Beneficiaries, regardless of whether the services requested are covered by Medi-Cal.</td>
</tr>
<tr>
<td>7E</td>
<td>Number of CalWORKS recipients.</td>
<td>Enter the number of CalWORKS recipients (PUBLIC Funding Slots) who were on the waiting list at any time during the report month.</td>
</tr>
<tr>
<td>7F</td>
<td>Number of SACPA Court/Probation referrals.</td>
<td>Enter the number of SACPA Court/Probation referrals (PUBLIC Funding Slots) on the waiting list at any time during the report month.</td>
</tr>
<tr>
<td>7G</td>
<td>Number of SACPA Parole referrals.</td>
<td>Enter the number of SACPA Parole Referrals (PUBLIC Funding Slots) on the waiting list at any time during the report month.</td>
</tr>
</tbody>
</table>
**County TLS Email Encryption**

The County has Transport Layer Security (TLS) available for sending encrypted email through a secured connection. This means that when a TLS connection is established with a vetted County business partner, all email communication sent between the County and the business partner will be automatically encrypted in transit over the Internet through the secured connection.

**County of SD -@showcounty.ca.gov**  **Vetted Business Partners - @xxxxxxx**

County business partners interested in establishing a TLS connection with the County must meet the following requirements:

- Must have TLS-enabled mail servers.
- Must have a server digital certificate issued by a Certificate Authority.

If both items above are met, the business partner may request the County’s TLS Boundary Encryption Form (complete sections 2 -4) and return to HHSA Pilarn.Miranda@showcounty.ca.gov to initiate the process. It takes approximately two weeks to set up.

**Note:** Business partner users are to contact their IT/compliance/security officer if they have any questions regarding TLS email communication.
APPENDIX H.5 – TLS Boundary Encryption Request for Trusts Form

Boundary Encryption

Pre-Qualification Form – Business Partner

This form provides MessageLabs with the technical information required to enable a link between your domains and a Business Partner for the Boundary Encryption service.

MessageLabs clients should complete Section 1 and then email this form to their Business Partner to complete Sections 2 to 4. Please email the completed form to your sales representative.

1. Contact and Domain Details (for the MessageLabs Client)

<table>
<thead>
<tr>
<th>Company Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Company Name</td>
</tr>
<tr>
<td>County of San Diego, HHSA Compliance Office, Information Security</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>1255 Imperial Avenue, Ste730. San Diego, CA 92101</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Messaging Infrastructure Contact</th>
<th>Recurring Technical Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Name</td>
<td>Contact Name</td>
</tr>
<tr>
<td>Pilar Miranda</td>
<td>Joe Coyne</td>
</tr>
<tr>
<td>Phone Number</td>
<td>Phone Number</td>
</tr>
<tr>
<td>619-338-2634</td>
<td>619-767-5068</td>
</tr>
<tr>
<td>Email Address</td>
<td>Email Address</td>
</tr>
<tr>
<td><a href="mailto:Pilar.Miranda@sdocounty.ca.gov">Pilar.Miranda@sdocounty.ca.gov</a></td>
<td><a href="mailto:Joseph.Coyne@sdocounty.ca.gov">Joseph.Coyne@sdocounty.ca.gov</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will all of your domains be included in this Business Partner configuration?</td>
</tr>
<tr>
<td>If No, list the domains to be included below.</td>
</tr>
<tr>
<td>Which of your organization’s domains will be included in this Business Partner configuration?</td>
</tr>
<tr>
<td>sdocounty.ca.gov</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
## 2. Business Partner Details

<table>
<thead>
<tr>
<th>Business Partner Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business Partner Company Name</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>Technical Contact Name(s)</td>
</tr>
<tr>
<td>Telephone Number</td>
</tr>
</tbody>
</table>

### TLS Security Requirements

To authenticate your TLS-enabled mail servers, you must obtain and install X.509v3 digital certificates. Indicate the Certificate Authority (CA) that issues your server digital certificates and the strength of encryption they support. We recommend obtaining 2,048-bit certificates from a recognized public CA. Ask your CA to ensure that the 'SSL-Client' X.509v3 extension is included in your certificate.

| Certificate Authority that issued your digital certificates | Select one: |
| Certificate key size (bits) | |
## Business Partner IP and Domain Information

Please indicate which of the Business Partner’s SMTP domains should be included in this configuration.

<table>
<thead>
<tr>
<th>Domain Name</th>
<th>Email Server Hostname or IP Address</th>
<th>TLS Static Route or MX Record</th>
<th>Mailhost Software</th>
<th>Session Encryption Strength Available</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

The email domain name that MessageLabs will enforce TLS from to.

**Note:** subdomains will be automatically included and inherit the TLS settings of the top level domain. To exclude a subdomain, list it in Section 4 below.

**Example:** yourdomain.com

<table>
<thead>
<tr>
<th>Example: yourdomain.com</th>
<th>Example: ft.s.yourdomain.com</th>
<th>Example: TLS Static Route</th>
<th>Example: Exchange 2003</th>
<th>Example: Normal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select one:</td>
<td>Select one:</td>
<td>Select one:</td>
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</tr>
</tbody>
</table>

Page 3 of 4

Version 1.01

Appendix H.5
4. Exclusions

Please list any of the Business Partner’s subdomains that should be excluded from this configuration.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Subdomain to exclude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: yourdomain.com</td>
<td>Example: ifs.yourdomain.com</td>
</tr>
</tbody>
</table>