Drug Medi-Cal Organized Delivery System

Implementation Plan

For

County of San Luis Obispo

Health Agency

Behavioral Health Department

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PART I
PLAN QUESTIONS

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

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

- ☒ County Behavioral Health Agency
- ☒ County Substance Use Disorder Agency
- ☒ Providers of drug/alcohol treatment services in the community
- ☒ Representatives of drug/alcohol treatment associations in the community (Recovery)
- ☒ Physical Health Care Providers
- ☒ Medi-Cal Managed Care Plans
- ☒ Federally Qualified Health Centers (FQHCs)
- ☒ Clients/Client Advocate Groups
- ☒ County Executive Office (individual meeting)
- ☒ County Public Health
- ☒ County Social Services/Child Welfare Services
- ☒ Foster Care Agencies/Social Workers
- ☒ Law Enforcement
- ☒ Court/District Attorney/Defense Attorneys/Family Attorneys/County Counsel/Judges
- ☒ Probation Department
- ☒ Education
- ☒ Recovery support service providers (including recovery residences)
- ☒ Health Information technology stakeholders (Behavioral Health Department staff)
- ☒ Other (specify): Behavioral Health Board, Members of the general public

2. How was community input collected?

- ☒ Community meetings
- ☒ County advisory groups
- ☐ Focus groups
- ☒ Other method(s) (explain briefly): Individual meetings with stakeholders

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

- ☐ Monthly
- ☐ Bi-monthly
- ☒ Quarterly
- ☐ Other:

Review Note: One box must be checked.

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

☒ SUD, MH, and physical health representatives in our county have been holding regular meetings to discuss other topics prior to waiver discussions.
☐ There were previously some meetings, but they have increased in frequency or intensity as a result of the Waiver.
☐ There were no regular meetings previously. Waiver planning has been the catalyst for new planning meetings.
☐ There were no regular meetings previously, but they will occur during implementation.
☐ There were no regular meetings previously, and none are anticipated.

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

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

How will these required services be provided?

☐ All County operated
☒ Some County and some contracted
☐ All contracted

OPTIONAL
☒ Additional Medication Assisted Treatment
☐ Partial Hospitalization
☒ Recovery Residences
☒ Other (specify): Telehealth

6. Has the county established a toll free 24/7 number with prevalent languages for prospective clients to call to access DMC-ODS services?
☒ Yes (required): 1-800-838-1381

☒ No. Plan to establish by: September 30, 2016. We may choose to contract with another organization for the 24/7 overnight call services.
Review Note: If the county is establishing a number, please note the date it will be established and operational.

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

☒ Yes (required)
☐ No

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

☒ Yes (required)
☐ No

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

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

☒ Yes (required)
☐ No

PART II
PLAN DESCRIPTION (Narrative)

1. Collaborative Process. Describe the collaborative process used to plan DMC-ODS services. Describe how county entities, community parties, and others participated in the development of this plan and how ongoing involvement and effective communication will occur.

The collaborative process utilized to develop this DMC-ODS Implementation Plan by San Luis Obispo County Behavioral Health Department (SLOBH) included interviews with key informants and providers, multiple group meetings, and public input meetings. The table listed below demonstrates the collaborative process by the number of group and public input meetings and target audience. The decision was made to incorporate the planning process for DMC-ODS into existing stakeholder group meetings. In our medium, rural County, many of the stakeholders are the same and it was determined to utilize existing meetings as the public input meetings. Four presenters were used: Star Graber, PhD, LMFT, Division Manager for Drug and Alcohol Services; Anne Robin, LMFT, Behavioral Health Administrator; Clark Guest, MA, Program Supervisor for Drug and Alcohol Services; and Teresa Pemberton, LMFT, Program Supervisor for Behavioral Health Department. Two power point presentations were developed and used in the public information dissemination about the DMC-ODS, see copy in Attachment A. All presentations were approximately one hour.

Table 1. Individuals and Community Groups Engaged for Implementation Plan

Date	Group	Regional Location	Target Audience Members
11/4/2015	Behavioral Health Department Fiscal	San Luis Obispo	Behavioral Health Department Fiscal and Administrative staff
11/20/2015	District Attorney Office	San Luis Obispo	District Attorney's Office staff
1/12/2016	San Luis Obispo DAS Clinic	San Luis Obispo	Treatment providers, clinicians, people in recovery, Health Information Technicians, drug testing staff
1/13/2016	Criminal Defense Attorneys	San Luis Obispo	Public Defender's Office staff and other criminal defense attorneys
1/19/2016	Atascadero DAS Clinic	Atascadero	Treatment providers, clinicians, people in recovery, Health Information Technicians, drug testing staff
2/2/2016	Grover Beach DAS Clinic	Grover Beach	Treatment providers, clinicians, people in recovery, Health Information Technicians, drug testing staff
2/16/2016	ACA Planning Group	San Luis Obispo	County Public Health staff, County Department of Social Services (Medi-Cal) staff, community medical providers, client advocacy groups
2/17/2016	Behavioral Health Board	County-wide	Family members, persons with lived experience, agency representatives, Mental Health providers
3/2/2016	Child Welfare Services	County-wide	Department of Social Services, Child Welfare Services, Foster Care representatives
3/15/2016	Family Treatment Court Steering Committee	County-wide	Court Commissioner, Department of Social Services Social Workers, County Counsel, persons

			with lived experiences, treatment providers
3/29/2016	Paso Robles DAS Clinic	Paso Robles	Treatment providers, clinicians, people in recovery, Health Information Technicians, drug testing staff
4/21/2016	Inter-agency Group Meeting	County-wide	Treatment and social service agencies representatives who work on behalf of families
4/27/2016	Superior Court Judges	County-wide	Superior Court Judges who work in all areas of law, including specialty courts, criminal courts, and dependency/delinquency courts
5/25/2016	Homeless Services Oversight Council	County-wide	Representative of organizations who serve the homeless in San Luis Obispo County
5/27/2016	ARCH Benefits Group	County-wide	Agency representatives and advocates who work on behalf of low income citizens to access appropriate eligibility benefits
6/2/2016	Recovery Provider	Atascadero	Recovery organizations, providers, and individuals who represent the recovery community

After the power point presentation, each group was given the opportunity to answer the following questions in an unstructured manner:

1. What are the benefits of participating in the DMC-ODS for our County?
2. Which of the levels of care that need the most attention?
3. What might be some challenges in developing this system of care?
4. Are services in San Luis Obispo County accessible for the individuals who need the service? Geographically, linguistically, timely?
5. How to best coordinate care with the physical health care providers?
6. What are some of innovative ideas for Recovery Support Services given personal knowledge of the clientele?
7. Feedback about current providers of the treatment services in the County? Other potential providers?

The major themes from these presentations that impacted the development of the plan are summarized below.

Table 2. Major Themes from Community Engagement	
CAT Team embedded in the community, add SUD	Transportation services needed for the clients
More services out in the field. Home visits. Hospital visits.	Provide treatment services at high risk population locations including Syringe Exchange, Homeless Shelter and Resource Centers
Cal Poly treatment location for Young Adult Treatment	Cuesta College treatment location for re-entry DMC students
Trainings and ongoing technical assistance will be needed for the new providers. Need to attract new residential treatment providers to the County	Recovery Residences and Transitional Housing will be needed
12 Step Meetings on-site at DAS treatment clinics	Family member services such as Art Work, Naranon meetings, Celebrating Families, CAM (children services)
Services available in the evenings and seven days a week	Sober community activities like Walk for Recovery and providing community services opportunities for clients
Life Skills needed, such as credit counseling, financial skills and resources	Vocational training and work with employers

Wellness activities such as dental providers, nutrition, and fitness	Co-parents need help too, expand and engage in Family Education and Parenting groups
Bilingual services available to commensurate with the Hispanic population (North County, South County, Cambria)	Integration efforts with physical health, Emergency Departments, and coordinate continuity of care between Primary Care Physicians and specialty Drug and Alcohol Services
Residential treatment program placements and transportation to out of County contracted providers	Change in the County's social norms which center around the wine industry, drinking activities, need awareness campaign of the treatment resources
Provide social and extra-curricular activities that are sobriety based (sports, outdoor activities, hikes, surfing, equestrian therapy)	More individual therapy and family therapy options, including the use of individual network providers. Family education would be really important.
Recovery services should occur at all points in the continuum of care, 1 – 90 days; 91days - 6 months; then after treatment episode for long-term recovery support	Recovery Coaching should be used as an evidence based practice and coaches should be paid or earn a stipend
Expansion of the covered treatment services to include co-occurring disorder individuals who are in pre-contemplation stage.	Use the shelter system to provide services in the community and offer services for a variety of stages of recovery
Community Health Centers and Primary Care offices need linkage to Behavioral Health services and provider training to the Medical Doctors and Medical staff.	In working with local hospitals, consider senior citizens who have fallen may also have SUD as there are lots of retirees in our community. How to reach this population, can use those recovery coaches perhaps.
Monumental increase in services available	Support for opting in for San Luis Obispo County

Opportunities for ongoing involvement by the various stakeholder groups during implementation will occur in a variety of settings, including but not limited to, ongoing and regularly scheduled meetings between Behavioral Health Department and Behavioral Health Board and other ongoing collaborative meetings such as the Community Corrections Partnership and the ACA Planning meeting or updates to regular meetings as listed above. The DMC-ODS is being managed by the Behavioral Health Department's management team which holds meetings on a regular weekly basis and DMC-ODS planning and implementation issues will continue to be addressed throughout the next few years.

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

The mission of the San Luis Obispo County Health Agency is:

> *The Health Agency provides a broad array of services essential to the health and well-being of those living in and visiting San Luis Obispo.*

The mission of the San Luis Obispo County Behavioral Health Department is:

> *San Luis Obispo County Behavioral Health Department works in collaboration with the community to provide services necessary to improve and maintain the health and safety of individuals and families affected by mental illness and/or substance abuse. Services are designed to assist in the recovery process to achieve the highest quality of life by providing culturally competent, strength based and client and family centered strategies utilizing best practices.*

The mission of the Drug and Alcohol Services Treatment Division is:

> *We provide professional, ethical, accessible alcohol and drug treatment that promotes recovery and improves the quality of life of clients, their families, and the community.*

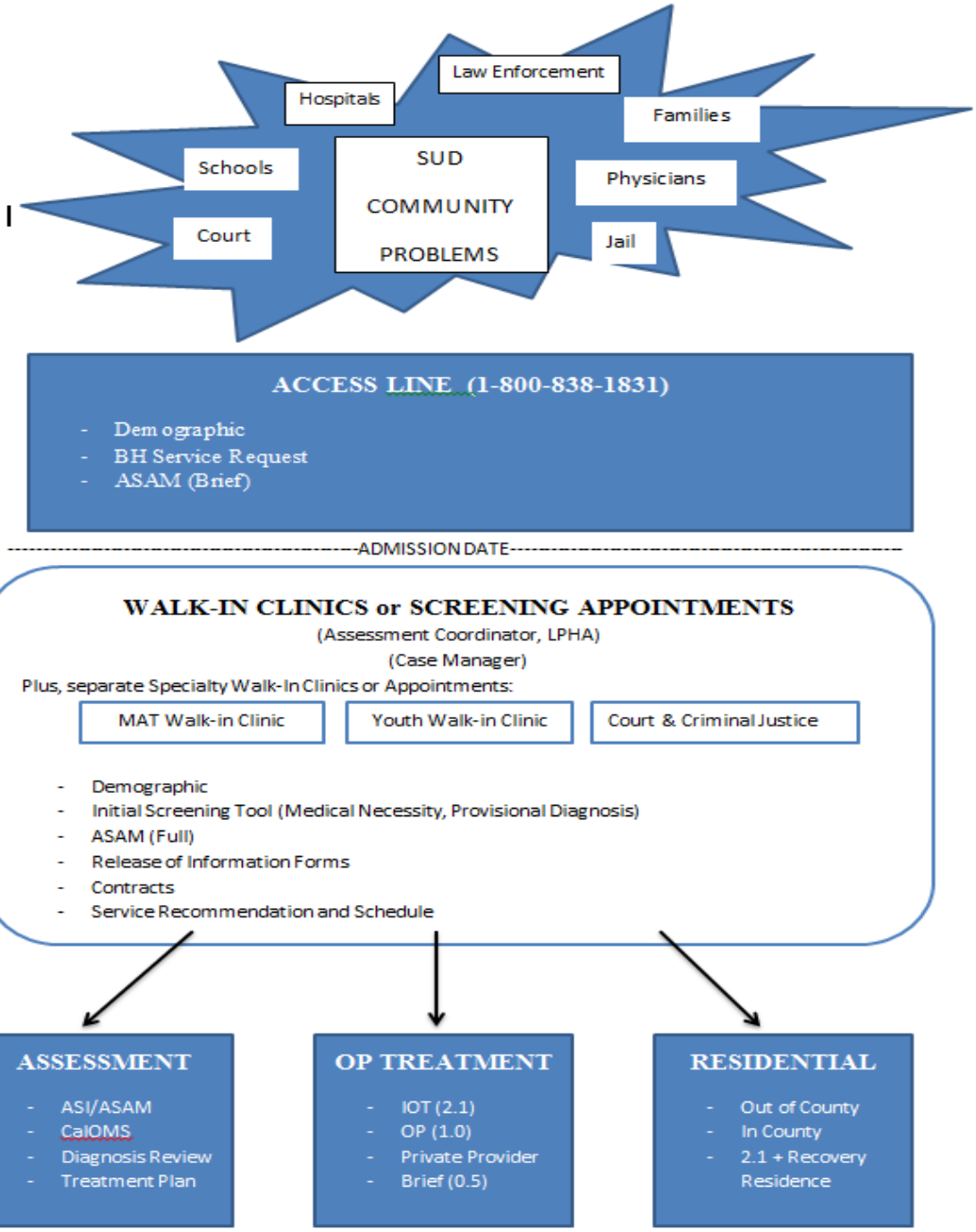
Referrals come from a variety of sources—self-referral, family members, employers, primary care providers, emergency departments at the four local hospitals, schools and colleges, criminal justice systems, and other community based social and human services. Operationally, a value of open no-wrong door, regional walk-in clinics are available on a weekly basis in each County-operated treatment clinic. Once a client comes to the walk-in clinic, they are immediately screened for substance use disorder diagnostic criteria (medical necessity), level of care using ASAM criteria, and given the treatment recommendations by a Licensed Practitioner of the Healing Arts (LPHA) clinician. With some motivational interviewing, the client may accept the treatment recommendation and attend an outpatient treatment group as soon as the same day. Once accepted to the outpatient treatment program, the client is also scheduled for an individual full assessment, given a schedule for their groups, and assigned random color code drug testing as indicated. The Assessment Coordinator (LPHA) facilitates a warm hand-off to the assigned primary treatment Specialist and provides introductions to the staff and tours the clinic.

Streamlined group orientations are held for our agency partners who refer clients for many of the court ordered treatment programs such as Judges, Probation, and Attorneys. Driving Under the Influence programs, Deferred Entry of Judgement diversion program, Proposition 36 Treatment program, AB109 Re-Entry and community based treatment services, and specialty treatment courts. All provide separate registration, orientation and screening processes. Additional treatment requirements may exist for the criminal justice clientele and their questions can be answered and introductions made to the specialized treatment staff. Each of the court ordered treatment programs have a continuum of care built into the criminal justice programming depending upon the client's individual needs. These are not 'cookie cutter' programs, but rather consist of the same screening, assessment, and treatment planning services that all clients attend conducted by the Assessment Coordinator (LPHA). The referrals may be made pre-plea or post-plea, for misdemeanors or felonies, for moderate to high criminal factors, or low criminal factors but with mild to severe substance use disorders.

Co-occurring Disorders (mild to moderate mental health diagnosis in combination with mild to severe substance use disorders) are served by San Luis Obispo County Drug and Alcohol Services division. Drug Medi-Cal will only be billed for the appropriate substance use disorder allowable services under the DMC-ODS waiver.

With the new DMC-ODS allowance to serve clients in any "appropriate community setting", we are currently conducting screening services at the Court House, at the County Jail, at Emergency Rooms in the local hospitals, and at the Homeless Shelter. For youth treatment services, referrals and screening services are conducted at many County high school, continuation and community school sites, as well as regional Family Resource Centers.

Diagram 3. Client Flow Chart



Requesting Services and Referrals: Referrals to DMC-ODS services will come through five primary gates, including 1) calls to the Behavioral Health Department Access Line/Managed Care which may result in an individual screening appointment being scheduled with an Assessment Coordinator in one of the County-operated clinics; 2) individuals walk-in to one of the County-operated clinics as a result of a referral (health care or other community based organizations), seeing information on the County or Program website (www.slodas.org) regarding the walk-in clinics and meet with an Assessment Coordinator; 3) potential clients may request an individual appointment time in lieu of a walk-in clinic access; 4) direct referral from criminal justice entities to the weekly scheduled registration and orientation session for specific programs; and 5) direct contact by members of the public with the Narcotic Treatment Program.

Referrals can be formalized using the Universal Referral Form and Consent for Release of Information which is signed in advance of the referral and then faxed to San Luis Obispo (SLO) Drug and Alcohol Services at (805) 781-1227. These referral forms are entered into the electronic health record system for ease of access to all County-operated clinics. These forms include basic information about the client who is being referred and the reason for the referral. Since the form also contains an Authorization for Release of Information, feedback can be provided to the referring party about the status of the referral. Regardless of the entry point, each individual is registered and screened following the same process and tools described below in the Initial Screening section.

If the phone call comes into the Behavioral Health Department Access Line (1-800-838-1831), the Clinician fills out a Service Request form (see Attachment B) and schedules the individual to attend a walk-in clinic or schedules a screening appointment with the Assessment Coordinator at the desired clinic location. See Client Flow Chart above.

Initial Service Screening, Authorization, and Placement: All individuals are triaged for risk (suicidality, homelessness, emergent physical health needs), insurance coverage/eligibility verification and are advised of the benefits to which they are entitled under the DMC-ODS. A uniform Behavioral Health Department/Substance Use Disorder Screening tool and decision tree based on the American Society of Addiction Medicine (ASAM) dimensions is in use. See Attachment B. The screening also includes: client eligibility and demographics; review of Health Questionnaire, preliminary DSM5 diagnostic impressions, and preliminary SUD ASAM level of care determination. Screenings are all conducted by Licensed Practitioners of the Healing Arts (LPHA) Clinician or Program Supervisors (who may be certified SUD Counselors). The basic referral and screening process is mirrored in the Youth System and Medication Assisted Treatment (MAT)/Withdrawal Management system with some variations required by the specific needs of the target population.

Once screened using the Initial Screening Tool (see Attachment B), the beneficiary will be referred or linked directly to the appropriate ASAM Level of Care treatment. The Assessment Coordinator will introduce the client to the primary outpatient treatment Specialist, set the recommended outpatient treatment group schedule, assign the color code random drug testing

(if needed), tour the outpatient treatment clinic, and schedule the follow-up individual assessment appointment with the Assessment Coordinator. All clients are given the Client Handbook which describes the various documents signed, program rules, and potential referral information. If the client has immediate case management needs, such as housing, recovery residence, residential treatment or other community based needs (primary care), the Assessment Coordinator will introduce the client to the clinic's Case Manager. Placement considerations include findings from the screening, initial drug testing results, geographic accessibility, threshold language needs, age, criminal justice requirements, and beneficiary preference. All staff performing screening and assessment may refer beneficiaries directly to any SUD network provider for the following services:

- Outpatient and Intensive Outpatient Treatment Services (County-operated or individual network providers)
- Narcotic Treatment Program Services (contract provider)
- Outpatient Withdrawal Management Services (County-operated)
- Medication Assisted Treatment Services (County-operated, contract or network providers, or individual community healthcare prescribers)
- Recovery Support Services (County-operated)
- Case Management Services (County-operated)
- Recovery Residences (contract providers). Not paid for with Medi-Cal funding, but is listed here to illustrate the full scope of available services.

Note that if the screening or assessment of the beneficiary determines that the medical necessity criteria has not been met and the beneficiary is not entitled to any substance use disorder treatment services from the County of San Luis Obispo, then a written Notice of Action will be issued in accordance with 42CFR 438.404.

Assessment and final Medical Necessity Determination: Once a beneficiary has completed the initial screening process and it is confirmed that SUD treatment may be appropriate, the client will be offered an individual assessment appointment with the Assessment Coordinator. The use of the Addiction Severity Index (XtraLite), ASAM Criteria, and CalOMS admission data will be administered during the assessment process. Other diagnostic and assessment tools may be used, including a drug screen, and finalization the DSM5 Diagnostic Review tool, all of which are recorded into the EHR. Medical necessity for services must be determined as part of the intake assessment process and will be performed through a face-to-face interview or via telehealth. The Medical Director, a licensed physician, or a Licensed Practitioner of the Healing Arts (LPHA) must diagnose the beneficiary as having at least one DSM5 Substance Use Disorder, excluding Tobacco-Related Disorder and non-substance related disorders. A qualifying diagnosis for beneficiaries under the age 18 includes "an assessed risk" for developing a substance use disorder. The Medical Director, a licensed physician, or a LPHA can also diagnose mental health disorders for access to co-occurring disorder integrated services. Withdrawal Management services, Medication Assisted Treatment, and Psychotropic Medication Evaluations may also be performed by a licensed Nurse Practitioner or other medically licensed staff. All providers must document the diagnoses in the client electronic health record (EHR) and indicate how the client

meets the ASAM Criteria definition for services. Psychotropic medication services are not covered through DMC-ODS, but again are provided for illustration of the one-stop services for co-occurring disorders. Psychotropic medication services are paid for from other funding sources.

In the event that the comprehensive intake assessment yields an ASAM level of care recommendation that does not agree with the preliminary ASAM screening result, the LPHA or Case Manager must work with the client to transition to the appropriate level of care, up to and including transitioning the client to a residential treatment provider. If it is determined residential detoxification or residential treatment is required, the Specialist shall request prior authorization from the Assessment Coordinator, provide evidence of meeting the criteria for Level 3.0+ residential services and request assistance from the clinic Case Manager. The Case Manager is critical to ensure the successful transition of high-risk utilizers and those at risk of drop-out during the transition of level of care. The County of San Luis Obispo has a long history of collaborative working relationships and the majority of the SUD treatment services are operated by the County (which makes the treatment system more seamless).

Transitions to another Level of Care, Authorization, and Case Management: This may include step-up or step-down in SUD treatment services (e.g. transition to intensive outpatient treatment plus recovery residence following completion of residential treatment). For complicated care transitions, Case Managers will provide warm hand-offs and transportation to the new program as needed. If the client is transferring to a residential treatment provider outside of San Luis Obispo County, a Discharge Summary will be prepared for the residential treatment provider and faxed to them (with appropriate Authorization to Release Information) prior to arrival of the client. When the client returns to SLO County, the Access Clinician, the regional Assessment Coordinator and the clinic Case Manager will be the primary contacts. DMC-ODS providers will aim to admit eligible beneficiaries within five (5) business days—but no later than 10 business days—from the assessment. In the unlikely event that admission to treatment will be greater than 10 business days due to non-budget related capacity issues, DMC-ODS providers shall provide interim services and seek to link the beneficiary with another provider offering the appropriate ASAM level of care. In instances where a residential treatment provider submits a prior authorization request to the Access Coordinator, SLO County will respond with an approval or denial within 24 hours of the request. Authorization requests for after hours, County holiday or weekend admissions should be initiated on the morning of the next business day.

In order to prevent delays in admissions to treatment, Access will allow presumptive authorizations for the bed days provided for after hours, County holiday or weekend admissions for San Luis Obispo County residents who are Medi-Cal beneficiaries. Presumptive authorization does not guarantee payment and submission of claims to Medi-Cal are subject to a client's eligibility and services being rendered and documented in accordance with Title 22, the ASAM Criteria, and the DMC-ODS Standard Terms and Conditions.

Upon receipt of request for an Authorization and Assessment summary from a residential provider, Access staff will review the request and based on the review, provide one of the following responses to the requesting agency within 24 hours: Approved as Requested, Approved as Modified, Deferred, or Denied. Beneficiaries participating in a face-to-face assessment with SLO County's Assessment Coordinator that meet the Title 22 and ASAM Criteria definitions of medical necessity for residential treatment will be referred to the appropriate ASAM level of care. The Assessment Coordinator will authorize residential treatment services and sends an authorization approval to the provider in coordination with the Access Team.

The length of residential services range from 1 to 90 days maximum for adults and 30-day maximum for adolescents, unless medical necessity requires a one-time extension of up to 30 days on an annual basis. Only two non-continuous 90-day residential stay episodes will be authorized in a one-year period. Perinatal and criminal justice clients may receive a longer length of stay based on medical necessity. If even longer lengths of stay are needed, other non-Medi-Cal funds may be used. The referrals, authorizations and preliminary payor source will be tracked by the County of San Luis Obispo Access Team. Authorizations and re-authorizations will be required on a monthly basis for residential treatment.

Re-Assessment and Time Frames: All treatment clients will be re-assessed at a maximum of every 90 days, unless there are significant changes warranting more frequent re-assessments. Re-assessments allow the treatment team to review client progress, comparing the most recent client functioning and severity to the initial assessment and to evaluate the client's response to care in treatment services. Changes that could warrant a re-assessment and possibly a transfer to a higher or lower level of care include, but are not limited to:

- Achieving treatment plan goals
- Inability to achieve treatment plan goals despite amendments to the treatment plan
- Identification of intensified or new problems that cannot adequately be addressed in the current level of care
- Lack of beneficiary capacity to resolve his/her problems
- At the request of the beneficiary

Clients who are initially authorized for residential treatment will be re-assessed at a maximum of every 30 days, unless there are significant changes warranting more frequent re-assessments. Re-authorizations will be processed in accordance with the re-assessment results as needed.

Case Management and Recovery Support Services: All SUD providers are expected to individualize treatment and use the full continuum of services available to beneficiaries to ensure clients receive the most appropriate care at the correct time. Case management services will help ensure clients move through the system and access other needed health and ancillary services to support their recovery. As beneficiaries complete primary treatment, they are connected to recovery support services to build connections within the recovery community and to continue to develop self-management strategies to prevent relapse. If an

individual does relapse, Recovery Support Workers can quickly reconnect the beneficiary back to treatment for further care through the Assessment Coordinator in each regional clinic.

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

Access Line:

SLOBH Managed Care program operates a toll free 24/7 Central Access Line (1-800-838-1381)

- The Central Access Line is staffed by Managed Care's Licensed Practitioner of the Healing Arts (LPHA) staff during regular business hours.
- Live assistance is available in English and Spanish (threshold languages) and through Language Line Solutions for all other languages spoken in the community.
- After-hours, callers have the option of obtaining information, leaving a message or interacting with a live person. Services are available 24/7 to treat a beneficiary's urgent conditions such as psychiatric or medical emergencies.
- SLOBH contracts with Transitions Mental Health Association (TMHA), who operates SLO Hotline, an accredited suicide prevention hotline, for after-hours access line coverage. Additional information about SLO Hotline is available at: http://t-mha.org/main/main_hl.html

Screening:

Beneficiaries who request substance use disorder treatment will be screened via telephone to determine the urgency of the request. A more complete face-to-face screening to determine ASAM level of care will be scheduled. For beneficiaries whose phone screening suggests that withdrawal management, medication assisted treatment and/or residential treatment is necessary, the face-to-face screening will be scheduled within 1 business day.

Screening to determine mental health treatment needs will also be completed at agency phone contact and any necessary referrals for assessment and treatment will be completed. Options will range from scheduling a comprehensive assessment at a Mental Health clinic or Integrated Treatment program or referral to the contracted network providers for MH treatment.

Data Collection:

A Behavioral Health Service Request form (see Attachment B for sample form) will be completed to record each call. Information on calls received is tracked separately by MH or SUD primary issue. Every effort will be made to obtain as much of the following information as possible:

Contact Information

- Date and time of call (required)
- Caller's name (required)
- Caller's phone number

- Referral Source
- Legal Status/Responsible Party contact information

Caller Demographics
- Age/DOB/Gender
- Address/Phone
- Contact preferences or restrictions

Caller Insurance/Medi-Cal information

Language Needs and Preferences
- Primary/Preferred language
- Interpretation needs
- Offer of free interpreter services

Risk Factors/Urgency Level
- Risk of danger to self or others
- Special status (hospital discharge, jail release)
- Overview of Functional Impairments
- Call Urgency (Crisis, Urgent, Routine)
- Initial determination of need for residential or withdrawal management treatment

Disposition of Call (required)
- Was a screening offered?
- Date/time/location/provider of offered screening
- Whether client accepted offered screening
- Wait time (in days) to offered screening

Data reporting/outputs:
Call data will be evaluated on a monthly basis and will include (tracked separately for English, Spanish, and Other speaking callers):
- Number of calls requesting substance use disorder treatment
- Number of callers referred for screening
- Wait time for screening at regional clinics
- Number of clients referred for screening who attend screening within 30 days of referral
- Number of grievance, appeal or complaint calls

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

Describe how the county plans to coordinate with surrounding opt-out counties in order to limit disruption of services for beneficiaries who reside in an opt-out county.

All DMC-ODS treatment provider facilities are required to maintain DHCS SUD certifications in addition to the DMC certifications. Perinatal Services Network Guidelines are followed by the County-operated clinics. Youth Treatment Guidelines are followed by the County-operated clinics for adolescent substance use disorder treatment services. County staff are licensed or certified and are in compliance with certification requirements. All providers are required to comply with Federal, State, and local requirements, including County standards and evidence-based practices that meet the DMC-ODS quality requirements. County of San Luis Obispo will provide all opt-in waiver required services for outpatient, withdrawal management, medication assisted treatment, recovery support services, and case management.

Table 4. Drug Medi-Cal Organized Delivery System Required Services			
DMC Services	State Benefit Plan (Non-Waiver)	Opt-in Waiver Required	Opt-in Waiver Optional
Outpatient Services	Required	Outpatient Treatment Intensive Outpatient	Partial Hospitalization
Narcotic Treatment Program	Required	Required	
Residential	Perinatal only	At least one level of service	Additional levels
Withdrawal Management		At least one level of service	Additional levels
Medication Assisted Treatment		Required	Additional medications
Recovery Support Services		Required	
Case Management		Required	
Physician Consultation		Required	

Specifically, below is a list of services that the County of San Luis Obispo will provide as part of the DMC-ODS system of care.

Table 5. Services Available in San Luis Obispo County			
	Service Type	ASAM Level	Required or Optional
A	Early Intervention Services/SBIRT	.50	Provided in partnership with existing primary care providers
B	Outpatient Treatment Services	1.0	Required
C	Intensive Outpatient Treatment Services	2.1	Required
D	Withdrawal Management Services (WM)	1 – WM and 2 – WM	1 Level Required
E	Residential Treatment Services	3.1 (to be determined)	1 Level Required
F	Narcotic Treatment Program (NTP)	1.0 -- NTP	Required
G	Medication Assisted Treatment	1.0 OBOT and 1.0 -- NTP	Optional/Required
H	Recovery Support Services	N/A	Required
I	Case Management	N/A	Required
J	Physician Consultation	N/A	Required
K	Recovery Residence	N/A	Optional
L	Telehealth	N/A	Optional

Service Descriptions:

A. Early Intervention (ASAM Level .50)
County staff provides Screening, Brief Intervention, and Referral to Treatment (SBIRT) for all substance use disorders in collaboration with primary care providers, Emergency Departments at four local hospitals, and the Psychiatric Health Facility (PHF). Beneficiaries at risk of developing a SUD or those with an existing SUD are identified and offered screening for adults, brief treatment as medically necessary, and when indicated a referral to treatment.

B. Outpatient Services (ASAM Level 1.0)
Outpatient services consist of up to 9 hours per week of medically necessary services for adults and less than 6 hours per week of services for adolescents. County-operated services will offer ASAM Level 1.0 including: assessment, treatment planning, individual and group counseling, family therapy, patient education, medication services, collateral services, crisis intervention services, and discharge planning and coordination. Services may be provided in-person, by telephone, or by telehealth, or in any appropriate setting in the community.

C. Intensive Outpatient Treatment (IOT) (ASAM Level 2.1)
Intensive outpatient treatment involves structured programming provided to beneficiaries as medically necessary for a minimum of nine (9) hours and a maximum of 19 hours per week for adult perinatal and non-perinatal. Adolescents are provided a minimum of six (6) and a maximum of 19 hours of services per week. Services include: assessment, treatment planning, individual and/or group counseling, patient education, family therapy, medication services, collateral services, crisis intervention services, treatment planning, and discharge planning and coordination. Services may be provided in-person, by telephone or by telehealth, or in any appropriate setting in the community.

D. Withdrawal Management Services (ASAM Levels 1 – WM and 2 – WM)
Withdrawal Management services are provided as medically necessary to beneficiaries and include: assessment, observation, medication services, and discharge planning and coordination. Beneficiaries receiving a residential withdrawal management shall reside at the facility for monitoring during the detoxification process. San Luis Obispo County Behavioral Health Department will offer ASAM Level 1 – WM: Ambulatory Withdrawal Management without extended on-site monitoring. In addition, working together with specially designated recovery residences, San Luis Obispo County Behavioral Health Department will offer ASAM Level 2 – WM: Ambulatory Withdrawal Management with

extended monitoring and at night the client stays at a recovery residence. This is for those clients who are participating in ASAM Level 1 Ambulatory Withdrawal Management, but do not have a supportive family or living situation.

San Luis Obispo County Behavioral Health Department will work with all four local hospitals (Arroyo Grande Community Hospital, French Hospital, Sierra Vista Hospital, and Twin Cities Community Hospital) and other area service providers to assist beneficiaries to access ASAM Level 3.7 – WM (Medically Monitored Inpatient Withdrawal Management) and ASAM Level 4.0 – WM (Medically Managed Inpatient Withdrawal Management) when medically necessary. Currently, the local hospitals refer clients to out of county facilities. SLOBH will coordinate with these providers to smoothly transition and support beneficiaries to less intensive levels of care as soon as possible within the DMC-ODS.

At this time, SLOBH will not offer ASAM Level 3.2 – WM Clinically managed residential withdrawal management (commonly known as social model detoxification), however, we will review utilization and ASAM data and make a determination by the end of implementation Year 2 whether there is a demonstrated need for this level of care within our continuum. Should a need be substantiated an RFP would be released for ASAM Level 3.2 – WM or we will contract with out of county providers for this level of withdrawal management.

E. Residential Treatment Services (ASAM Level 3.1 – pending DHCS approval)

Residential treatment is a 24-hour, non-institutional, non-medical, short-term service that provides residential rehabilitation services to youth, adult, and perinatal beneficiaries. Residential services are provided in facilities designated by DHCS as capable of delivering care consistent with ASAM Level 3.1: Clinically managed low intensity residential. This level of care provides 24-hour structure with available trained personnel, at least five hours of clinical service per week and prepare for outpatient treatment. Beneficiaries are approved for residential treatment through a prior authorization process based on the results identified by the ASAM assessment. The length of stay for residential services may range from one day to ninety (90) days, unless a re-assessment of medical necessity justifies a one-time extension of up to 30 days. Only two non-continuous 90-day regimens will be authorized in a one-year period. Perinatal and criminal justice involved clients may receive a longer length of stay based on medical necessity. A monthly re-authorization process is implemented to ensure that the client continues to benefit and need the residential treatment services.

Residential treatment services includes assessment, treatment planning, individual and group counseling, client education, family therapy, collateral services, crisis intervention services, transportation to all medically necessary treatments, and discharge planning and coordination. All providers are required to accept and support patients who are receiving medication assisted treatments.

SLOBH is awaiting DHCS to issue DMC licensure and provisional ASAM designations for our currently contracted perinatal residential provider (Bryan's House). This provider may be designated as ASAM Level 3.1 and/or Level 3.5 (Clinically managed high intensity residential services). SLOBH will ensure that all ASAM Levels (3.1, 3.3, and 3.5) are available within three years of final approval of the County's Implementation Plan and will follow the County policy and process for selecting new providers. It is anticipated that some of the residential treatment providers may be out of county and contractual relationships will be developed.

For clients in any residential treatment program, case management services will be provided by County staff to facilitate 'step down' to lower levels of care and support. County staff will also provide the transportation services (if needed) to the medically necessary facility.

F. Opioid (Narcotic) Treatment Program (OTP/NTP, ASAM OTP Level 1)

SLOBH contracts with a licensed Narcotic Treatment Program (Aegis Treatment Centers) to offer services to beneficiaries who meet medical necessity criteria requirements. Services are provided in accordance with an individualized client plan determined by a licensed prescriber.

Services provided as part of an NTP include: assessment, treatment planning, individual and group counseling, patient education, medication services, collateral services, crisis intervention services, medical psychotherapy, and discharge services. Clients receive between 50 and 200 minutes of counseling per calendar month with a therapist or certified counselor, and when medically necessary, additional services may be provided.

- Language Capability is Spanish and English.
- No wait list for new admissions and patients are scheduled the same week or following week on Monday and Wednesday.
- Patients are scheduled for their first face to face service on the same day they are admitted to do their 5 in 5 and intake.

- Medical Doctor Appointments are scheduled 7 day and 14 day follow-up or sooner at the patient's request.
- Atascadero Aegis Treatment Center provides Bus Passes, and utilizes public transportation, and Dial a Ride, when transportation is needed for patients with hardships and/or disabilities.

Aegis currently provides the following services: Detoxification, Extended Detoxification, and Methadone Maintenance. The total current capacity is 256 clients with the distribution as follows:

Table 6. Current Census at Aegis Treatment Centers, Atascadero		
Service	#Patients	Average Days in Treatment
Detoxification	10	17
Extended Detoxification	4	18
Methadone Maintenance	242	1,284
Total	256	---

A review of the zip code data has determined that five (2%) of the clients currently seen in the Atascadero clinic are from Monterey County. A review of the zip code data from the Aegis Treatment Center in Santa Maria (Santa Barbara County) has determined that 75 (20%) of the clients are from San Luis Obispo County. A satellite methadone clinic would be ideally located in the South County of San Luis Obispo to serve the NTP clients within our county for DMC-ODS service. Aegis Treatment Centers will provide the required methadone services for NTP under the DMC-ODS.

G. Additional Medication Assisted Treatment (MAT) Services (Optional, ASAM Level 1)

SLOBH offers medically necessary MAT services through Behavioral Health Department staff and contracted providers, an NTP program, and a provider network licensed as primary care clinics. Services include: assessment, treatment planning, medication assisted treatment, ordering, prescribing, administering, and monitoring of medications for substance use disorders.

MAT will expand the use of medications for beneficiaries with chronic alcohol related disorders and opiate use. Medications may include: naltrexone, both oral (ReVia) and extended release injectable (Vivitrol), topiramate (Topomax), gabapentin (Neurotin), acamprosate (Campral), and disulfiram (Antabuse). Other medications may be prescribed as indicated for substance use disorders (including those that may become available in the future):

- Opiate overdose prevention: naloxone (Narcan). See Attachment D for naloxone policy and procedures for the County of San Luis Obispo.
- Opiate use treatment: buprenorphine-naloxone (Suboxone) and naltrexone (oral and extended release). Note: Methadone will continue to be available through the licensed narcotic treatment program.
- For tobacco cessation and nicotine replacement therapy as indicated.

Additionally, SLOBH is currently coordinating care and expanding the availability of MAT outside the DMC-ODS by building the capacity of the entire local health system to use these treatments for beneficiaries with a substance use disorder. Behavioral Health Department facilitates a grant funded Opiate Safety Coalition that is training physicians, nurse practitioners, and psychiatrists in primary care and specialty mental health clinics on the efficacy of using MAT, practice guidelines, and medication administration. In addition, the Behavioral Health Department is the expert on naloxone distribution in the County, and we are currently training pharmacies to prescribe this overdose antidote to extend the availability of naloxone in the community. Physician consultation is supporting implementation in areas such as: medication selection, dosing, side effect management, adherence, and drug-drug interactions.

H. Recovery Support Services (ASAM Dimension 6, Recovery Environment)

Recovery Support Services are available once a beneficiary has completed the recommended course of treatment. Beneficiaries accessing Recovery Support Services are taught to manage their own health and health care, use effective self-management strategies, and use community resources to provide ongoing long-term lifestyle management.

Recovery Support Services may be provided face-to-face, by telephone, via internet, or elsewhere in the community. Services may include: outpatient individual or group counseling to support the stabilization of the client or reassess the need for further care; recovery monitoring/recovery coaching; peer-to-peer services and relapse prevention; Wellness Recovery Action Plan (WRAP) development; education and job skills; family support and family recovery services (such as Celebrating Families!); self-help and community support groups; socialization; and linkages to various ancillary services (housing, transportation, and case management). County staff will coordinate, monitor and support a cadre of peer recovery support workers and volunteers to provide Substance Abuse Assistance and Relapse Prevention—the “Recovery Network”. This will provide the necessary linkage between the community and the County to ensure smooth transitions in both directions.

I. Case Management Services

Case management services support beneficiaries as they move through the DMC-ODS continuum of care from initial engagement and early intervention, through treatment, to recovery services. Case management is provided for clients who may be pre-contemplative and challenging to engage, and/or those needing assistance connecting to treatment services, and/or those stepping down or up to other levels of care and support. San Luis Obispo will use a comprehensive case management model based on the ASAM bio-psycho-social assessment to identify needs and develop a case plan and follow the SAMHSA CSAT TIP 27 (Treatment Improvement Protocol) Comprehensive Case Management for Substance Abuse Treatment.

Case management services may include: comprehensive assessment of needs and services, client plan development, coordination of care with mental health and physical health, monitoring access, client advocacy and linkages to other supports including but not limited to: mental health, housing, transportation, food, and benefits enrollments. Case Managers will be trained and utilize Motivational Interviewing (MI) and Motivational Enhancement Therapy (MET), harm reduction, and strength-based, trauma informed approaches. Case management services will be provided by County staff. All case management services are consistent with confidentiality requirements identified in 42CFR, Part 2, California law, and the Health Insurance Portability and Accountability Act (HIPAA). See Case Management Specialist Manual in Attachment E.

J. Physician Consultation

Physician consultation services assist physicians and nurse practitioners seeking expert advice on complex client cases and designing the treatment plan in such areas as: medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. SLOBH trains psychiatrists and psychiatric nurse practitioners in integrated settings on medication guidelines and offers the opportunity for them to consult one-on-one with a psychiatrist who has an addiction medicine background. Physician consultation to primary care and behavioral health providers for the use of vivitrol, buprenorphine, other SUD medications, and pain management is made available in an effort to build the capacity of the entire health system to treat beneficiaries with SUD. San Luis Obispo County may use existing physician staff, or contract with addiction medicine physicians, addiction certified psychiatrists, or telehealth providers, or clinical pharmacists to provide consultation services. In the future, expansion of telehealth will continue to increase access for physician consultations.

K. Recovery Residences

Recovery Residences (RR) are available for beneficiaries who require housing assistance in order to support their health, wellness and recovery. There is no formal treatment provided at these facilities, however, residents are required to actively participate in outpatient treatment and/or recovery support services during their stay. The recommended maximum length of stay is six months, with the beneficiary contributing towards the cost of the housing after two-three months. A potential subsidy (not Medi-Cal funding) is available (on a reducing scale) for up to six months, although not all clients need or qualify for the subsidy. See the Self-Sufficiency policy in Attachment F. Authorizations for length of stay are made on a monthly basis to the Recovery Residence provider. Exceptions to the six month maximum length of stay can be made as clinically necessary and approved by the Division Manager of the Behavioral Health Department.

San Luis Obispo County has developed standards for contracted RR providers and has been monitoring to these standards. RRs are not reimbursable through Medi-Cal, but in a community with few residential treatment beds, the RRs are invaluable partners to achieving a lifestyle of recovery for the beneficiaries. When the client concurrently receives outpatient treatment or intensive outpatient treatment in close collaboration with the Recovery Residence, the level of treatment provided surpasses the Level 3.1 ASAM Residential level. We have been successfully using the combination of Recovery Residence (non-Medi-cal funded) and the concurrent outpatient treatment in lieu of residential treatment for many years for SAMHSA funded grant projects. ***The Recovery Residence is County monitored, contracted, and works collaboratively in a close relationship with the County-operated outpatient treatment provider.*** See Attachment F for Recovery Residence sample contract, self-sufficiency policy, and monitoring tools.

L. Optional Services Levels pending ASAM utilization review

SLOBH will consider whether to offer additional optional services available under the waiver once baseline data on beneficiary ASAM service need and utilization has been collected and analyzed. If an unmet need for a service is determined, SLOBH will amend this plan to incorporate the additional service(s) and will initiate a RFP process to identify qualified providers or provide County-operated services. Service levels which SLOBH anticipates for possible expansion include: Withdrawal Management (ASAM-WM Level 3.1) and Partial Hospitalization Services (ASAM Level 2.5) in the future.

M. Service Level Barriers

SLOBH anticipates the following barriers to providing a number of services within the DMC-ODS continuum of care: start-up costs associated with starting new facilities and programming; facility siting challenges including zoning; hiring and retaining qualified staff, particularly those able to meet threshold language needs; DMC certification delays; and geographic location and related beneficiary transportation barriers. Housing and transportation services are the biggest service barriers in our county.

N. Coordination with Surrounding Counties

SLOBH has established relationships with surrounding counties' substance use service divisions through state level associations and local collaborations. We meet quarterly at the CBHDA/SAPT committee meetings to discuss various service challenges and opportunities. SLOBH will provide original DMC modalities to any beneficiary in an opt-out county seeking services within San Luis Obispo County and we will coordinate with other neighboring counties, whether opt-in or opt-out, to ensure beneficiaries can access services easily and quickly. We will also work together as needed, when a regional approach is required to deliver a component of the continuum of care, e.g. youth residential treatment.

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

There is a significant prevalence of individuals with complex conditions, including beneficiaries with co-occurring mental health and substance use disorders. In FY2015-16, 26% of Medi-Cal beneficiaries who received mental health and/or substance use disorder services were identified as having co-occurring disorders. This is higher than the previous fiscal year which was at 18% of Medi-Cal beneficiaries who received mental health and/or substance use disorders were identified as having co-occurring disorders.

<u>County Structure to Deliver Substance Use and Mental Health Services</u>

The current county structure is an integrated Behavioral Health Department under the San Luis Obispo County Health Agency. The Behavioral Health Department is comprised of six different Divisions: Adult Mental Health Services, Youth Mental Health Services, Prevention and Outreach, Quality Support Team, Medical, and Drug and Alcohol Services/Integrated Forensics Services. The co-occurring disorders (COD) treatment is primarily provided through the Integrated Forensics Services. In addition, the Drug and Alcohol Services Division conducts county-operated treatment of those with mild-severe substance use disorders and with mild-

moderate mental health disorders. Thus, meaning that beneficiaries can access both substance use and mental health services from the same provider at the same site.

The Mental Health Services Act (MHSA) provided an opportunity to expand co-occurring disorder services in San Luis Obispo County in accordance with stakeholder input. The Adult Full Service Partnership (FSP) program targets adults 26-59 years of age with serious mental illness. The Adult FSP participants are at risk of institutional care because their needs are greater than behavioral health outpatient services typically provide. The individual may be homeless, a frequent consumer of the Psychiatric Health Facility (PHF) or hospital emergency department services, involved with the justice system, or suffering with a co-occurring substance abuse disorder. The overall goal of Adult FSP is to divert adults with serious and persistent mental illness from acute or long term institutionalization and, instead, maintain recovery in the community as independently as possible.

There were two traditional Adult FSP teams in 2013-2014, serving a combined average of 36 clients per month. The core FSP teams include a County Mental Health Therapist and a Personal Services Specialist (PSS) provided by Transitions-Mental Health Association (TMHA). Also available to the team is a co-occurring disorders specialist, psychiatrist, and program supervisor that serve participants in all of the FSP age group programs. A Spanish speaking therapist is made available to these programs to assist in providing a full range of mental health treatment.

Two Co-occurring Specialists, funded by MHSA, provides an Integrated Dual Disorders Treatment program, developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) which includes intervention, intense treatment, and education. Individualized case plans are specific to each client's needs. In 2013-2014 the Integrated Dual Disorders Treatment program served an average of 36 consumers each month. One of the co-occurring Specialists is located in the Mental Health Division and one of the co-occurring Specialists is located in the Drug and Alcohol Services Division. Co-location of the COD services is important to maintain access to integrated care for the clients with both disorders.

Specialty Mental Health Services, serving adults with serious and persistent mental illness and youth with severe emotional disturbances, are managed by the San Luis Obispo County Mental Health Plan, and are delivered through a combination of County-operated and community – based providers. Mental health services for beneficiaries with mild to moderate mental health issues are provided by the Holman Group (contracted by CenCal Health) through its network of community providers.

Coordination of Care: Co-Occurring Mental Health and Substance Use Disorders

The Behavioral Health Department deliberately set out in the DMC-ODS planning process to avoid the expansion of the silos, and instead we looked for opportunities to continue to propel agency and system integration to the next level. Taking this approach, BHD expanded the support structures already in existence within the BHD quality and administrative arenas. In addition, to coordinate mental health services for beneficiaries with co-occurring disorders in

both integrated and separate structures, San Luis Obispo County BHD currently is utilizing, or plans to utilize within Implementation Year 1, the following strategies:

- Integrated Access Line: The Beneficiary Access Line is a County-operated integrated mental health and substance use disorder toll-free Access Line (1-800-838-1381) available 24/7. Integration of information, screening, and referral services will create a centralized repository of services for the whole behavioral health system of care.
- MOU with Medi-Cal Managed Care (CenCal Health): Implement the screening, referral and care coordination activities outlined in the MOU between SLO Behavioral Health Department and CenCal Health.
- Expand Mental Health Network Providers: For DMC-ODS, mental health providers that are currently in the provider network will be provided technical assistance, if needed, to educate them on the available resources and referral processes for services for co-occurring disorders. The goal is to assist the mental health contractors to explore the feasibility, capacity, and need for pursuing a contract which covers both mental health and substance use disorders services.
- Case Management: For all beneficiaries in the DMC-ODS, case management services will be available to ensure and facilitate, as needed, coordination with mental health services with both Holman Group referrals and Specialty Mental Health services.
- Integrated BHD Screening and Assessment processes: Screening and assessment provides the opportunity to identify co-occurring disorders at a service system entry point and ensure that appropriate releases are signed to begin the care coordination process. The approach is that people with co-occurring disorders are the 'expectations' and not the 'exceptions.' In addition, by walking into a screening and assessment process anywhere within the Behavioral Health Department, the beneficiary is entitled to the whole array of mental health and substance use disorder treatment. Integrated treatment is the best option and ease of access for the complex needs beneficiary. Single screening and assessment procedures and tools to identify co-occurring mental health and substance use disorders have been developed by BHD.
- County-operated Drug and Alcohol Services treatment program: Currently, BHD coordinates services between programs for individuals with co-occurring disorders through a single electronic health record, coordinated treatment and recovery plans, and integrated or coordinated service teams that remain in regular communication with one another since employees belong to the same organization, are often co-located, share the same email, calendaring, and telephone systems. All HIPAA and 42CFR, Page 2 requirements are met. San Luis Obispo County has been operating co-occurring disorder treatment for many years and many of the Drug and Alcohol Services clinics are dual certified by Department of Health Care Services for both drug Medi-Cal and for mental health Medi-Cal. There are currently COD identified programs within adult and youth Drug and Alcohol Services and there are currently identified clinicians who are COD capable.
- Quality Support Team integration: The Quality Support Team will expand its oversight to the DMC-ODS programs and services, as well as to staff and contract providers. The

experience and skills of the quality review staff in cooperation with fiscal, technical, and administrative staff will prove invaluable during performance reviews, audits, reporting, and evaluations, assuring compliance with the DMC-ODS requirements (such as EQRO) which are based upon the mental health regulations. This approach provides the support to conduct regular internal reviews and ongoing internal monitoring to test for compliance and helps to achieve performance standards and benchmarks. Additionally, this creates opportunities for more holistic quality improvement measures that incorporate both SUD and MH practices, which will have greater impact on client outcomes when conducted within an integrated service delivery system.

The Quality Support Team will provide written procedures for linking beneficiaries with mental health services and co-occurring disorder treatment services and including the referral process for Holman Group, from Holman Group, and the referral process with individual contract providers. See Attachment G.

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

San Luis Obispo County has participated in a Behavioral Health Integration Program (BHIP) planning process since 2014. This collaborative has been funded through a grant by the Blue Shield Community Foundation, and includes decision makers from local hospitals, the Federally Qualified Health Center, public health, behavioral health, and several community based organizations. The goals of this collaborative are to bring education to physical health care providers on mental health and substance use disorder identification and treatment, develop interagency coordination protocols (including a universal release of information process), promote the development of Health Information Exchange in San Luis Obispo County, and promote the Triple Aim of Better Care, Improved Health and Lower Costs.

One BHIP's goals for the new grant year will be to provide education and training on SBIRT to a wide variety of physical health care practitioners. By both educating the health care practitioners on an evidenced based brief screening, and providing the system navigators, Promotores, case managers, and peer coaches in all of the County and allied services with information about referral resources and procedures, we intend to increase the number of individuals successfully engaged to SUD services. BHIP recently sponsored Peer Navigator training for 21 individuals. We anticipate a similar training program for peer navigators within the SUD system to enhance access to physical health care and other community services. BHD has contracted with a local CBO to utilize trained Promotores for interpretation services in our mental health clinics. These Promotores will also become available for SUD services, as well as become effective navigators for Spanish speaking clients to BH and primary care services.

Community Health Centers of the Central Coast (CHC) is the primary provider of outpatient physical health care for Medi-Cal eligibles in the County. Currently, the Health Agency Drug and Alcohol (DAS) division staff has informal procedures and connections for referral and care of

clients to CHC. Over the next quarter, plans will be made to formalize referral processes for both assessments and ongoing medical care at CHC. A proposal to bring the mobile medical van to DAS sites was vetted in 2015, but due to changes at CHC the program did not begin. This project will be reviewed again in the next fiscal year as grant funds may become available to support the coordination of this project.

SLOBH has had working relationships with the emergency departments of all four local hospitals for several years. During quarterly meetings with Emergency Department directors and staff, issues of concern related to mental health holds and crisis referrals are dealt with in open, problem solving discussions. Patients with substance use disorder needs are also discussed in this context, and several initiatives have started to better identify and refer these individuals. The new case management and field based services, which are eligible services under the waiver, will allow DAS to respond to both the ED's for urgent responses and to the hospital inpatient settings for initial screening and discharge planning.

The Managed Care Plan, CenCal Health, is an active participant in many of the integration and collaborative planning committees throughout the County. The MCP's involvement has been essential to moving several initiatives forward, including assistance for Medically Fragile individuals into temporary supported housing units, enhanced payments for skilled nursing facilities, and data sharing. Individuals with substance use disorders make up a high percentage of the medically fragile population, especially among the homeless. System navigation, peer support, and transitional housing with supports have all been developed and coordinated within the County through collaborative efforts including County and MCP funds.

The SLO County Health Agency BHD is the primary provider of SUD Medi-Cal services in the County. Policies and procedures for collaboration, referral, and consultation with primary health care are in development and will be finalized during the first quarter of the new fiscal year. In the future, contracted agencies will be required to follow similar protocols for coordination. A new position within the Quality Support Division will be dedicated to quality and utilization review for SUD services. This position will be tasked with monitoring compliance to policies as well as ongoing documentation and quality review. Quality review committees are already in place and will add collaboration and referral to physical health care providers to the review elements.

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

- Comprehensive substance use, physical, and mental health screening: There are areas of increased technical assistance, including SBIRT in physical health care, ensuring that all physical health and mental health partners understand the requirements related to 42CFR, Part 2, and that procedures and forms are updated to effectively enable the communication necessary for effective care coordination, shared plan development and

collaborative treatment planning. With increased medical staffing associated with DMC-ODS (in withdrawal management and in medication assisted treatment (MAT)), the cross communication between primary physical care points of entry will by necessity improve for beneficiaries. We currently have a Blue Shield Community Foundation grant to assist in this collaboration under BHIP (see above section).

- Beneficiary engagement and participation in an integrated care program as needed: We have been using motivational interviewing techniques to offer beneficiaries participation in an integrated care program as needed.
- Shared development of care plans by the beneficiary, caregivers and all providers: San Luis Obispo County is a medium county with a number of collaborative treatment planning meetings, including those for youth and families, those who are in the criminal justice system and for those involved in the child welfare system. We can adapt the joint planning meetings to a broader mission of serving all Medi-Cal beneficiaries.
- Collaborative treatment planning with managed care: This is new to the substance use disorder treatment field, but under our Behavioral Health Department, we will integrate our DMC-ODS with the mental health managed care existing processes and procedures.
- Care coordination and effective communication among providers: With the implementation of the full continuum of care of the DMC-ODS and the emphasis on the levels of care based on ASAM criteria, there will be an increased expectation and need for care coordination among the providers. We anticipate some challenges, of course, during the initial implementation, especially regarding the higher levels of care (3+ residential and 4+ medical services). However, BHD will work closely to identify the obstacles and develop improvements among the providers. BHD will also evaluate any Consumer Grievances due to problems with care coordination. We anticipate being able to resolve these issues locally and get to solutions.
- Navigation support for patients and caregivers: The implementation of case management and recovery support services will be significant improvements in assisting clients in navigating other services. Drug and Alcohol Services has been able to implement case management services in several co-occurring disorder grants and AB109 programs and we have many years of experience in navigation within substance use disorder treatment. San Luis Obispo County has recently provided training for Peer Navigators and we are able to provide more trainings for healthcare system navigators through the BHIP. We are confident in our experience to provide local comprehensive case management, no challenges are anticipated in this arena.
- Facilitation and tracking of referrals between systems: We currently have an electronic health record (EHR) which can incorporate all behavioral health providers and will eventually be able to provide continuity of care summaries to physical healthcare within the County through Health Information Exchange. The Health Information Exchange is a continuing project in San Luis Obispo. The Universal Release form facilitates referrals and tracking of the referrals between systems.

8. Availability of Services. Pursuant to 42 CFR 438.206, the pilot County must ensure availability and accessibility of adequate number and types of providers of medically necessary services. At minimum, the County must maintain and monitor a network of providers that is supported by

written agreements for subcontractors and that is sufficient to provide adequate access to all services covered under this contract

8a. The Anticipated Number of Medi-Cal Clients

It is estimated in the California Mental Health and Substance Use Needs Assessment (2012) that 10.3% of adults and 3% of youth has an alcohol or drug diagnosis. Based on these rates, it is estimated that 1,515 youth ages 0-19 and 23,542 adults may experience a need for substance use treatment as compared to the population in San Luis Obispo County. The Behavioral Health Department is responsible for treatment of individuals who are eligible for Medi-Cal as well as for individuals referred through the criminal justice system.

According to the San Luis Obispo Health Initiative, CenCal Health has 39,693 Medi-Cal beneficiaries (December, 2015) in the county over the age of 12. Prevalence rates vary and very limited historical data is available to use in making the projections for the number of Medi-Cal clients who will utilize the DMC-ODS services. However, we know up to 14.2% of the Medicaid population meets the diagnostic criteria for a substance use disorder according to NSDUH (2008-2010 National Survey of Drug Use and Health, 2013 American Community Survey), while the California Department of Health Care Services (DHCS Behavioral Health Needs Assessment, Vol 2 2013, page 30) estimates 10.3% of the population meets criteria for a SUD. Using these prevalence estimates, BHD projects between 4,088 to 5,636 Medi-Cal youth and adult beneficiaries have a SUD and could benefit from treatment.

Table 7. SUD Prevalence and SUD Medi-Cal Clients in San Luis Obispo County

Beneficiaries	Population of SLO County (2014)	SUD prevalence	CenCal # beneficiaries	DHCS prevalence SUD	Medicaid prevalence SUD
Youth (12-21)	50,514	1,515	9,961	1,026	1,414
Adult (21+)	228,569	23,542	29,732	3,062	4,222
Total	279,083	25,057	39,693	4,088	5,636

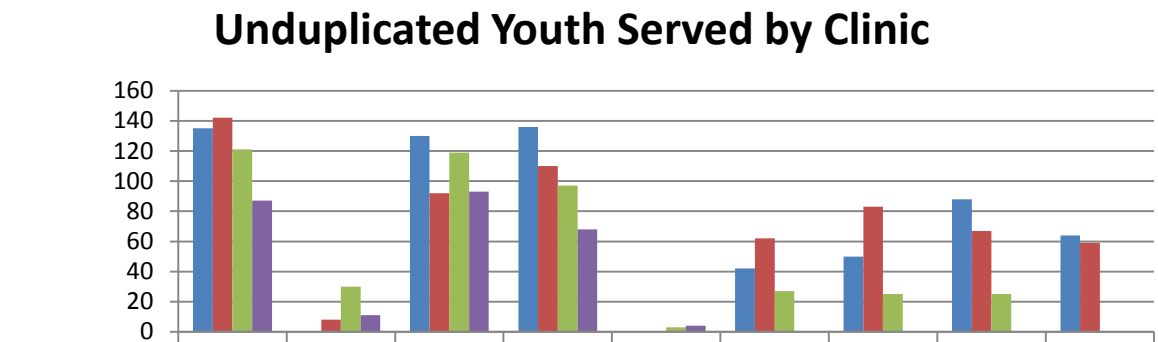
Estimates developed by Mercer (2013) projected a 24% penetration rate for those Medi-Cal beneficiaries with a SUD who would seek treatment. This penetration rate was multiplied by the number of Medi-Cal beneficiaries with a SUD disorder in San Luis Obispo County as of December 2015 (data provided by CenCal Health) to arrive at the projected number of Medi-Cal beneficiaries seeking SUD treatment under the DMC-ODS program.

Table 8. Estimated SUD Medi-Cal Clients Seeking SUD Treatment

Beneficiaries	DHCS prevalence SUD	Penetration rate estimate (24%)	Medicaid prevalence SUD	Penetration rate estimate (24%)
Youth (12-21)	1,026	245	1,414	339
Adult (21+)	3,062	735	4,222	1,013
Total	4,088	980	5,636	1,353

The projection models would demonstrate client counts for youth between 245 and 339 in San Luis Obispo County. For adults, the projection would have between 735 and 1,013 being served in SUD treatment. However, reviewing the last three years of data on unduplicated client counts (below), we can see that in San Luis Obispo County we are reaching a higher penetration rate than expected.

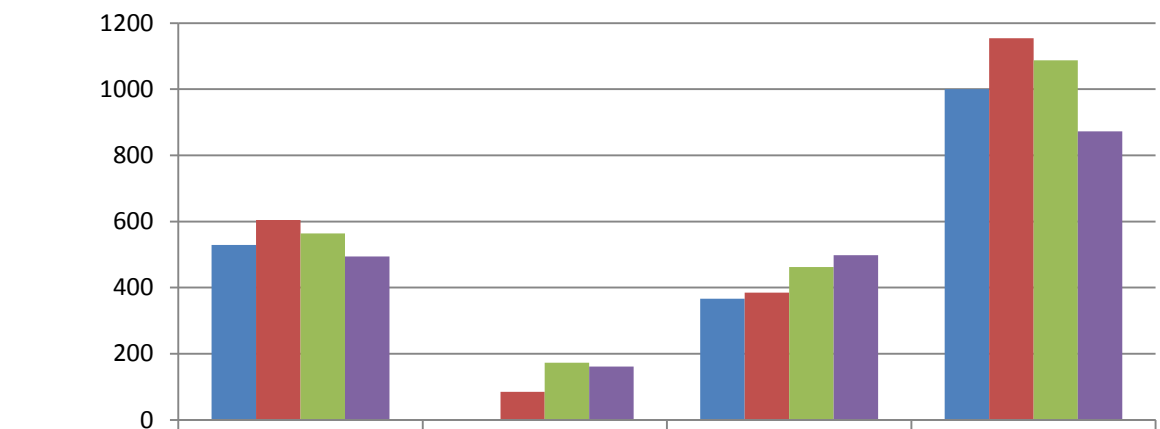
Graph 9. Unduplicated Youth Served by Clinic



	Atascadero	Paso Robles	Grover Beach	SLO	South Street	Sober Schools Loma Vista	Sober Schools Chalk Mountain	Sober Schools Mesa View	Sober Schools Vicente
FY '12-'13	135	0	130	136	0	42	50	88	64
FY '13-'14	142	8	92	110	0	62	83	67	59
FY '14-'15	121	30	119	97	3	27	25	25	0
FYTD '15-'16	87	11	93	68	4	0	0	0	0

Although the unduplicated youth served has gone down over the past three fiscal years, the numbers are currently in the projected range. With our DMC-ODS Implementation Plan for youth treatment, there does appear to be adequate outpatient treatment providers currently. For youth, the addition of intensive outpatient treatment services and case management for the severe substance use disorder adolescent is to be implemented in January, 2017.

Graph 10. Unduplicated Adults Served by Clinic

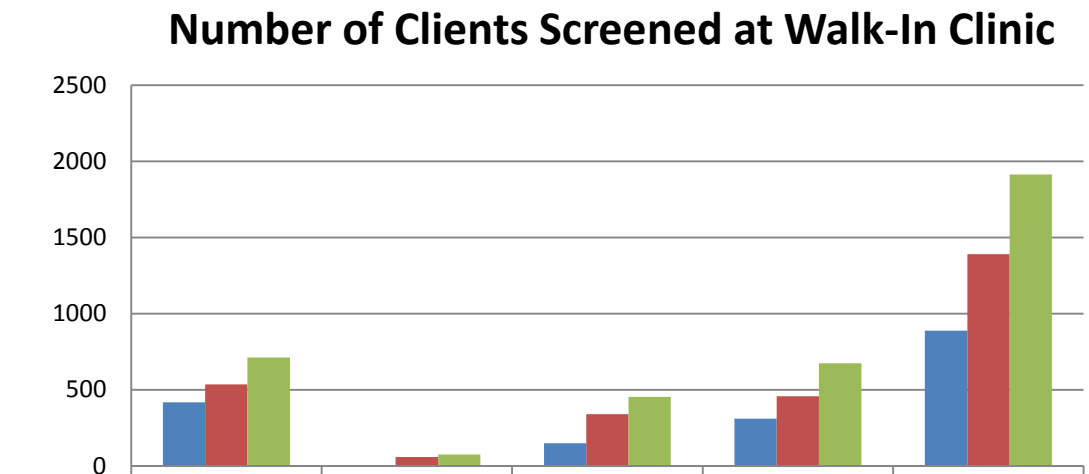


	Atascadero	Paso Robles	Grover Beach	SLO
FY '12-'13	529	0	367	1000
FY '13-'14	605	85	385	1154
FY '14-'15	564	173	462	1087
FYTD '15-'16	494	161	498	873

The unduplicated adults served by clinics is much higher than the projection model would have anticipated, meaning the numbers (FY2014-15 n=2,286) are currently more than the expected range (735 – 1,013). This may be due to the high prevalence of adult criminal justice clients in the unduplicated client counts.

The San Luis Obispo County Implementation Plan is to re-distribute the population between the Atascadero regional clinic and the Paso Robles regional clinic. By increasing the availability of treatment in the Paso Robles region, we would expect at least 5% increase in the overall numbers of unduplicated clients served in the total of North County. We would also expect continual slight increase in the Grover Beach clinic as indicated by the trend line, approximately 2%. The overall numbers for the San Luis Obispo clinic should be projected to remain the same.

Graph 11. Number of clients screened at a walk-in clinic



	Atascadero	Paso Robles	Grover Beach	SLO	All Clinics
FY13-14	418	2	149	310	889
FY14-15	534	58	340	457	1390
FY15-16	712	75	454	673	1914

Reviewing the data from the last three fiscal years to determine the number of unduplicated clients seeking to access SUD treatment services through a regional walk-in clinic, illustrates the tremendous impact that the Affordable Care Act has had on the SUD treatment system. These numbers are limited by the capacity of the staffing in each geographic region. When the DMC-ODS waiver expands the access capacity, the numbers of people seeking treatment services are expected to continue to climb for the next few years. In Paso Robles, we would expect the number of clients screened to be similar to the other geographic regions.

The San Luis Obispo County Implementation Plan will also expand the DMC-ODS services not previously allowed, such as Case Management, Recovery Support Services, and Residential Treatment.

8b. The Expected Utilization of Services by modality

Utilization of services in the DMC-ODS is expected to be similar to service utilization in the current system of care, except where prior funding shortfalls have resulted in restrictions in the level of care or duration of services, and where new services available under the DMC-ODS are being implemented that are not readily available currently. In FY2014-15, there were 447 unduplicated youth and 2,286 unduplicated adult clients within the County outpatient treatment system. Of these, the current rate of Medi-Cal beneficiaries is 85%.

- Withdrawal management (detoxification): Admission to the outpatient withdrawal management program accounted for 7.7% of the total of FY2014-15 treatment admissions (175/2,286). The average length of stay was 79 days and approximately 7%

of them were repeats. With the implementation of the DMC-ODS, the number of clients admitted to the outpatient withdrawal services is expected to increase, but we also plan to increase the length of stay, and increase the number of successful completions. Of the 175 detoxification admissions, fourteen (14), or 8%, were assigned to a Recovery Residence simultaneously, meaning they could have benefitted from a residential withdrawal management facility.

- Residential treatment: Currently there are limited funding resources for residential treatment. The clients who may need residential treatment have been admitted to outpatient or intensive outpatient treatment plus a Recovery Residence. It is estimated that authorization of residential treatment services that is based upon the ASAM Criteria will increase residential treatment utilization; it could be up to 25% of the admissions who may need residential treatment services. Currently, for example, 54% of the AB109 referrals in the County receive outpatient treatment services plus Recovery Residence stay up to six months. The monthly average number of the County's clients that are in a Recovery Residence is 115. The average length of stay in the recovery residence is 79 days. These high numbers of clients who are in Recovery Residence, however, is more due to the shortage of housing in the area, rather than the true need for residential treatment. Therefore, San Luis Obispo County will continue to utilize this model of Recovery Residence plus outpatient SUD/COD treatment as first step prior to residential treatment assignment. Only those clients who have not shown significant progress in outpatient treatment (through the use of the ASAM Criteria) will be authorized for residential treatment. This is in line with the ASAM Criteria of 'least restrictive environment' for treatment and in addition, will provide cost savings.

- Outpatient treatment: This level of care currently amounts to 90% of the total treatment admissions in FY2014-15 and the average length of stay for outpatient services was 95 days. The average length of stay is anticipated to be the same for DMC-ODS planning purposes.

- Narcotic Treatment Program (methadone maintenance): Methadone maintenance and detoxification services currently account for approximately 10% of the FY2014-15 treatment admissions in San Luis Obispo County with an average length of stay of 1,284 days. Aegis Treatment Centers has determined that they will not be significantly expanding methadone treatment services in the next year. The focus will be to serve the clients that are currently going to Santa Barbara County for their methadone services (75 clients).

- Case management: Access to case management has not been a covered benefit prior to DMC-ODS. However, the County of San Luis Obispo has experience over the past four years in providing case management services to clients with AB109 funding. The AB109 clients receive assessment and active support to enter treatment, but also receive ongoing case management services over the course of their treatment (lasting months). For the clients who receive ongoing case management, the intensity of the case

management is increased or decreased depending on the client's level of need over time. In the current year, 50 – 60% of the AB109 clients received case management services. The average case manager to client ratio was 1.0 full-time equivalent (FTE) Case Manager to 30 clients.

Approximately 2,256/12 months is 188 new clients per month, approximately 60% of the clients will need case management which is 112 clients needing case management per month. With a ratio of 1:30 clients, San Luis Obispo County proposes to hire 4.0 FTE total new Case Managers to provide case management services for the County. We will place 1.0 FTE in each of the four regional clinics to handle the case management needs for each clinic working together with the designated Assessment Coordinator with a focus on the transitions between level of care.

- Recovery support services: Recovery support services are currently not available and there is little data available from SUD systems of care outside of the County to support estimates of utilization of recovery support services. Recovery support services will be needed by clients who complete outpatient and intensive outpatient treatment services. If we anticipate that 45% of the clients will finish their program successfully, then 1,015 adult clients will need recovery support services. The County Implementation Plan is to hire 1.0 FTE of a Recovery Support Specialist (who is a person with lived experience) to act as a Recovery Coordinator, including the solicitation of a cadre of peer volunteers to conduct the Substance Abuse Assistance and Relapse Prevention services. In addition, County staff will conduct Medi-Cal Recovery Support Services (such as Recovery Coaching, Monitoring, Group Counseling, Family Support Services, Celebrating Families!, Peer-to-Peer Substance Abuse Assistance).

8c. The number and types of providers required to furnish the contracted Medi-Cal Services

All providers in the DMC-ODS must be Medi-Cal certified and DHCS certified to provide the services to eligible beneficiaries. A more detailed list of number and types of providers including current patient load, capacity, and population served is in the Attachment J.

Table 12. Numbers and Types of Providers

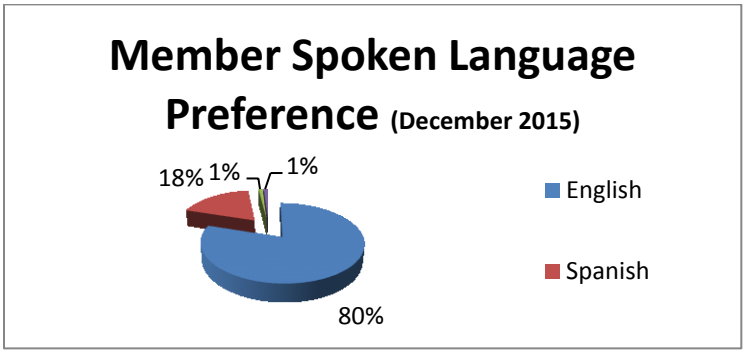
Type of Provider	Current Providers	Needed Providers
Narcotic Treatment Program	Aegis Treatment Centers	Adequate
Outpatient Treatment Program	County-operated (5) clinics (youth & adult)	Private individual network providers
Intensive Outpatient Treatment	County-operated (5) clinics (youth & adult)	Expansion requested
Withdrawal Management	County-operated	Expansion requested
Medication Assisted Treatment	County-operated	Expansion requested Private network prescribers Primary care providers
Residential Treatment	Bryan's House (5 beds for women and 10 children)	Approximately 60 residential treatment placements are

		anticipated
Youth Residential Treatment	None	Approximately 20 residential treatment placements are anticipated
Case Management	County-operated (5) clinics (youth & adult)	Expansion requested

8d. Language capability for the county threshold languages

The threshold languages for San Luis Obispo County are English and Spanish, which accounts for the primary language reported by 98% of the Medi-Cal beneficiaries. Based on an analysis of current (December 2015) San Luis Obispo County Medi-Cal beneficiaries, 81% report English as their primary language and 18% report Spanish as their primary language. As such, all Behavioral Health Department clinics will offer services in Spanish, either through hiring bilingual staff or having access to oral interpreter services, including: screening, assessment, outpatient and intensive outpatient treatment services for adults and youth, who are either monolingual Spanish-speaking or bi/multilingual, with a preference for services to be provided in their primary language. For County-operated services, we would strive to have a minimum of 18% of the treatment staff who are bilingual in each regional clinic.

Diagram 13. Threshold Language of Medi-Cal Beneficiaries



8e. Timeliness of first face-to-face visit, timeliness of services for urgent conditions and access after-hours care

Table 14. Timelines for Services

Code	Type of Care	Time Frame (days are calendar days)
D	Emergency/Crisis	Immediately, 24 hours per day, 7 days per week
U	Urgent: Within 7 days	Appointment given within 7 days
V	Urgent: Within 8 – 14 days	Appointment given within 8 – 14 days
R	Routine/Non-Urgent	Appointment offered with 15 calendar days

These timelines for DMC-ODS services will be reflected in the Quality Improvement Plan and all providers are committed to timely access to services. The current standard is for each beneficiary to be offered a first appointment within ten days for non-urgent services. A first appointment may be provided in any appropriate community setting, in-person (group or individual session), by telephone, or by telehealth.

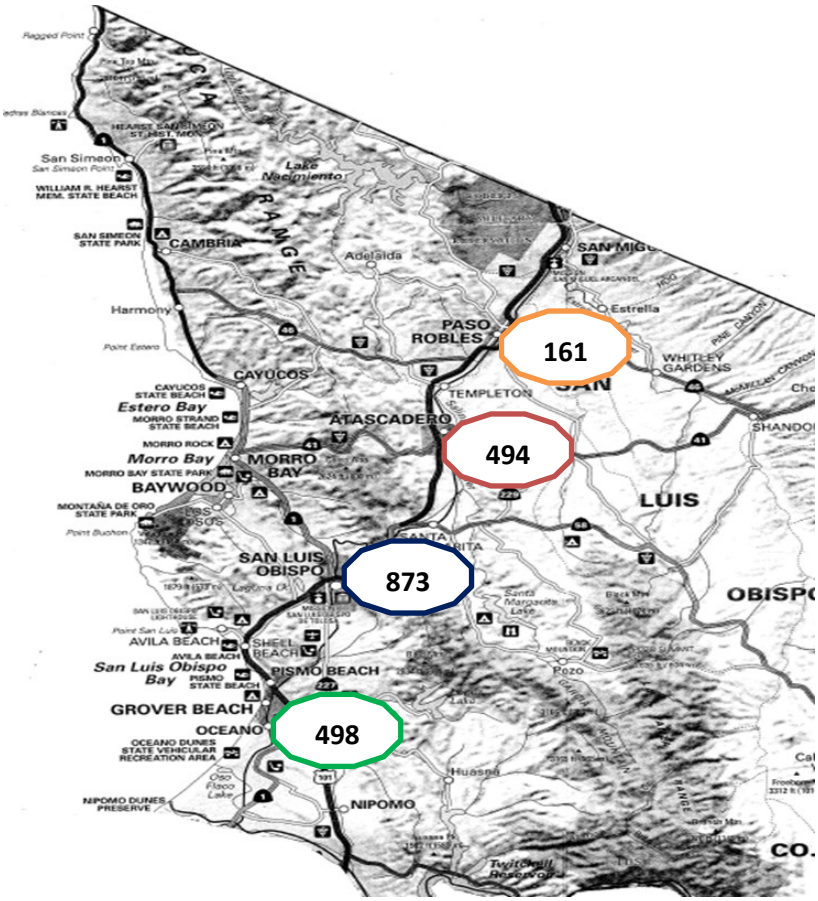
Emergency or Crisis conditions will be responded to immediately and may include calling emergency transportation to an emergency department at the local hospital for medical issues or calling the Mental Health Evaluation Team (MHET) for psychiatric emergencies. All beneficiaries experiencing a medical or psychiatric emergency will be directed to the nearest hospital for services. Urgent conditions require immediate attention but do not require inpatient hospitalization. Post-hospitalization follow-up is an urgent service that occurs within seven (7) calendar days of discharge from acute care (either medical or psychiatric hospitalization). Another urgent service within 7 days is upon discharge from County Jail or Prison or State Hospital. At the time of first contact, each beneficiary will be triaged to identify the presence of an emergency or urgent condition. After hours care can be accessed by calling the 24-hour Access Line, where callers are screened and triaged for risk and appropriate referrals are made. Each regional Drug and Alcohol Services clinic will provide urgent appointments on the next business day following the weekend or holiday.

8f. The geographic location of providers and Medi-Cal beneficiaries, considering distance, travel time, transportation, and access for beneficiaries with disabilities

Based on an analysis of current San Luis Obispo County CenCal Health report (December, 2015), the county's distribution of Medi-Cal beneficiaries is divided into three regional access points: South County (32% of the total beneficiaries), Mid-County/San Luis Obispo (25% of the total beneficiaries), and North County (44% of the total beneficiaries). In our DMC-ODS implementation plan, we are proposing to divide up the North County where the largest number of Medi-Cal recipients is located, into two geographic areas—those associated with Paso Robles and those associated with Atascadero. In addition, the Mid-County/San Luis Obispo area has cities associated with the Atascadero region. Using a re-distribution by cities, we have the following breakdown of Medi-Cal beneficiaries: South County (30%), Mid-County/San Luis Obispo (21%), Atascadero (20%) and Paso Robles (29%). San Luis Obispo County's DMC-ODS Implementation Plan includes four functioning regional clinics associated with this regional distribution. All four regional clinics are aligned along the Highway 101 corridor (see Map) with an average of 20 minutes travel between each regional clinic. The county's regional transit does cover the route up and down the county using Highway 101. Other county health and social services are also aligned in these four regional areas.

The numbers on Diagram 16 of the map distribution indicates the client caseload in the adult treatment clinics. In addition to the adult clinics, the youth treatment services are located on school sites (High School, Continuation School, and Community School) and Family Resource Centers throughout the County.

Diagram 15. San Luis Obispo County Map of Medi-Cal beneficiary SUD Adult caseload distribution



For persons with disabilities, SLOBH county-operated and county contractors will adhere to the following policies and regulations to serve all clients.

- Americans with Disabilities Act of 1990;
- Section 540 of 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 Section 51 through 51.3 and all applicable laws related to services and access to services for persons with disabilities.

All providers are required to make accommodations to serve persons with physical disabilities, including vision and hearing impairments. In addition, services must be made available to all individuals with mobility, communication or cognitive impairments as required by federal and state laws and regulations. If a provider is unable to meet the needs of a person with a specific

physical disability, they must expedite the person's transition to ensure the individual is successful in accessing needed support and services. Beneficiaries are advised of their right to receive services and any complaints and grievances are investigated and appropriate and timely action is taken to ensure access.

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

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

The following Quality Support Team Work Plan has been drafted in accordance with 42CFR 438.206 for Fiscal Year 2016-2017 to ensure timely access to services.

QST Work Plan:
The annual QST Work Plan identifies key areas that will be a focus of the Department's quality improvement efforts for the year. The goal is data-driven, continuous quality improvement with measurable outcome benefits for plan members.

Goal # 1: Maintain a responsive toll free 24/7 Central Access line

Goal # 2: Monitor Service Delivery Capacity

Goal # 3: Increase system capacity to serve Latino beneficiaries

Goal # 4: Provide timely access to services

Goal # 5: Monitor attendance rates for key services

Goal # 6: Maximize consumer satisfaction responses

Goal # 7: Monitor and respond to beneficiary requests

Goal # 8: Monitor and respond to provider requests

Goal # 9: Implement interventions when better care was more appropriate

Goal # 10: Improve clinical documentation

Goal # 11: Conduct effective clinical records reviews

Goal # 12: Develop improved Site Certification procedures

San Luis Obispo County Behavioral Health/Drug & Alcohol Services
Quality Support Team Work Plan Fiscal Year 2016-2017

Goal # 1: Maintain a responsive toll free 24/7 Central Access line	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person/Group**
Monitor the performance of the toll free Central Access line during and after regular business hours <u>Measurable Objectives</u>: All calls will be logged as required (100% success rate) Staff who answer phones will utilize the scripted responses (90% success rate)	1. Implement scripted responses at all clinic locations and in Central Access (1st quarter) 2. Conduct monthly test calls (English and Spanish) to evaluate performance in the following areas: • Language capacity • Informing beneficiaries about how to access mental health services • Informing beneficiaries about how to access urgent services • Informing beneficiaries about how to access the problem resolution and fair hearing process • Log of calls that includes name of beneficiary, date of call, initial disposition 3. Complete quarterly reporting to DHCS (quarterly)	Managed Care Program Supervisor QST staff TMHA Hotline Coordinator

Goal # 2: Monitor Service Delivery Capacity	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person/Group**
Establish goals for the number, type, and geographic distribution of SUD services <u>Measurable Objective</u>: Maintain a network of providers that is sufficient to provide adequate access to services	1. Continue to measure and track access and attendance at each clinic site as a measure of capacity (see Goals 3- 5 for detail) 2. Track wait time from request to screening and from screening to assessment at all sites 3. Track requests for service by beneficiary zip code; analyze for gaps (quarterly)	QST staff Managed Care staff and Program Supervisor

within 14 days of referral or request		

Goal # 3: Assess ability to serve Latino beneficiaries	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person(s)**
Establish a baseline for the number and percentage of clients served who are Latino Measurable Objective: 5% increase in utilization by Latino clients	1. Measure penetration rate (annually) 2. Measure number and percentage of clients served who are Latino (quarterly) 3. Track number of clients receiving three or more services by ethnicity to allow examination of our ability to retain consumers (quarterly) 4. Maintain bilingual staff capacity at all key points of contact, including at the toll free Central Access line	QST staff BH Administration

Goal # 4: Provide timely access to services	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person/Group**
Wait time for screening (routine) Measurable Objective: Screening offered within 14 days of request (80% success rate)	1. Monitor and report wait time for screening for English and Spanish speaking consumers (monthly) 2. Allocate clinic staff so that sufficient screening appointments are available to meet the demand. 3. Recommend corrective action if a site is unable to meet the standard (monthly) 4. Make data-driven staffing recommendations to Behavioral Health Administrator	Managed Care Program Supervisor QST staff BH Administration Clinic Program Supervisors

Goal # 5: Monitor attendance rates for key services	Planned Steps/Activities to Reach the Goal (Reporting Frequency)	Responsible Person/Group
Assessment appointments Measurable Objectives: 85% attendance rate (youth) 80% attendance rate (adults)	1. Monitor and report attendance rate at scheduled intake appointments by site (monthly) to develop a baseline 2. Develop and implement a survey to determine reasons for missed intake appointments	QST staff Clinic Program Supervisors

Goal # 6: Maximize consumer satisfaction	Planned Steps/Activities to Reach the Goal (Reporting Frequency)	Responsible Person/Group
Consumer Satisfaction Survey Objective: 85% of the responses on the survey will be rated "Strongly Agree" or "Agree" when asked about overall satisfaction with services	1. Develop and implement a consumer satisfaction survey 2. Encourage a representative sample of beneficiaries to complete the survey 3. Report promptly to staff at all sites.	QST staff Clinic Support Staff

Goal # 7: Monitor and respond to beneficiary requests	Planned Steps/Activities to Reach the Goal (Reporting Frequency)	Responsible Person/Group
Resolve beneficiary requests at the lowest possible level Measurable Objective: Successfully resolve all beneficiary concerns within	1. Track all consumer requests (second opinion and change-of-provider requests, grievances, appeals, fair hearings) 2. Monitor and report outcome and timeliness of resolution (quarterly)	Patient's Rights Advocate

legal time frame (100% compliance)		

Goal # 8: Monitor and respond to provider requests	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person/Group**
A. Resolve provider appeals at the lowest possible level <u>Measurable Objective</u>: Successfully resolve provider appeals within legal time frame (100% compliance)	1. Track provider appeals and requests 2. Monitor and report outcome and timeliness of resolution (quarterly)	Managed Care Program Supervisor QST staff
B. Make timely authorization decisions <u>Measurable Objective</u>: Provide referrals to Residential Treatment within 24 hours of the request (100% compliance)	1. Track and report the number and percentage of Residential Treatment referrals which are completed within 24 hours of the request 2. Monitor and report outcome and timeliness of resolution (quarterly)	Managed Care Program Supervisor QST staff

Goal # 9: Implement interventions when better care was more appropriate	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person/Group**
Conduct regular review of Incident Reports	1. Review Incident Reports; monitor and report (monthly) 2. Refer Incident Report to Morbidity & Mortality Committee in event of	QST Staff Medical Director

Measurable Objective: Review and respond to Incident Reports within two weeks of report submission (within one day for suspected privacy incidents)	death or serious injury 3. Make recommendations regarding follow-up when better care was more appropriate	Privacy Officer

Goal # 10: Improve clinical documentation	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person/Group**
Provide regular training to improve documentation Measurable Objective: 100% of MHP staff will attend documentation training at least annually	1. Revise and distribute Documentation Guideline update (twice yearly; more often if needed) 2. Establish training schedule to include all clinic and contractor sites 3. Track attendance at face-to-face and completion of E Learning documentation training (annually)	QST staff

Goal # 11: Conduct effective clinical records reviews	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person/Group**
Establish a consistent audit protocol and schedule as part of Utilization Management Program Objective: Identify areas of strength and deficiency in documentation to help guide training and to ensure appropriate access and billing for	1. Establish a monthly audit schedule to include all sites with a focus on high utilizers of services or areas of specific need 2. Analyze and report results (monthly)	QST staff Health Information Technology (HIT) staff

services		

Goal # 12: Develop improved Site Certification procedures	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person/Group**
Identify DHCS site certification standards and incorporate into MHP procedures Objective: Create a standardized set of procedures for certification and tracking of all county operated, contract provider, and out of county provider sites	1. Develop a review and monitoring process that ensures that each site requiring certification remains in compliance with standards 2. Develop a common tool and strategy for identifying out of county providers that need to be certified in order to serve SLO beneficiaries 3. Report progress (quarterly)	QST staff Program Supervisors Contract providers

10. Training Provided. What training will be offered to providers chosen to participate in the waiver? How often will training be provided? Are there training topics that the county wants to provide but needs assistance?
Review Note: Include the frequency of training and whether it is required or optional.

On a quarterly basis, the County provides Drug Medi-Cal training to all of its staff and providers, including the interface between Drug Medi-Cal and the Electronic Health Record (EHR). The Drug Medi-Cal training includes the following elements:

- Screening (Screening Tool, ASAM)
- Assessment (ASI, Diagnostic Review)
- Treatment Plans
- CalOMS
- Progress Notes
- Justification for Continuing Treatment
- Discharge Plan or Discharge Summary
- Sub-units training

The Drug Medi-Cal training is a Live training, with hands-on access to the EHR while sitting in a computer lab with up to 12 other clinicians or staff. The opportunity to ask questions, work through vignettes and examples, and learn-by-doing is provided. An annual refresher course in Drug Medi-Cal regulations is required for each staff person. All new staff are required to attend a week-long training on Medi-Cal documentation standards and demonstrate competency in documentation as well as the operation of the EHR in order to receive a certificate of competency before conducting treatment services on their own.

The County of San Luis Obispo also provides mandatory annual training on: Harassment Prevention, Compliance and Code of Ethics, Fraud, Waste, and Abuse, Privacy and HIPAA Training, Law and Ethics, and 42CFR Training. This is a combination of customized video training and Live training options.

Using the online training software, Relias, the County of San Luis Obispo provides required online training for at least two pertinent clinical issues per year as designated by the SLOBH Cultural Competency Committee. Recent topics have included Veteran's issues, Homelessness, Trauma Informed Care, Bullying, and Cultural Diversity issues.

Lastly, in-person or Live Trainings are also available on an annual basis as we provide training on the evidence based practices which are in use in our County (see section below). In June, 2015, Dr. David Mee-Lee came to San Luis Obispo County to train on ASAM Criteria. These trainings are optional for those who do not directly need the material, but staff can also be designated as required to attend due to their role.

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

Although the County of San Luis Obispo brought in Dr. David Mee-Lee in June 2015 to train on the ASAM Criteria, County staff have changed and due to the integration in several areas (such as Managed Care and Quality Support Team), more training on ASAM Criteria is needed and SLO County staff have been attending training through CIBHS. A train-the-trainer model would be preferred to build internal capacity and meet ongoing training needs to accommodate new staff and providers, to ensure inter-rater reliability for placement decisions, and for utilization management. In addition, we anticipate working together with DHCS and UCLA to come up with a standard reporting mechanism for the ASAM Criteria data elements. This will help to ensure that the inter-rater reliability is consistent.

We have implemented many evidence based practices and they are consistently applied and available in our County (see section below). However, we would benefit from DHCS support and training to provide fidelity assessments for monitoring the evidence based practices.

Currently, Drug and Alcohol Services provides buprenorphine in the detoxification program. Naloxone (an opiate overdose prevention medication) and Antabuse (for alcohol use reduction) are also available on a limited basis. Long-term administration of the newer medications (buprenorphine, acamprosate, and naltrexone) has not been used at Drug and Alcohol Services. We would request technical assistance to implement these new medication protocols. There are currently no other providers in the community utilizing the newer medications. The long-term goal would be to establish physicians in the community who are willing to continue to prescribe these medications when the patient finishes treatment services. Thus ensuring long-term recovery continues as needed.

Financial rate setting, cost reporting, invoicing, financial audits of providers, and other administrative supports training by DHCS would be appreciated by our County.

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

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

- Telephone access line and services in the prevalent non-English languages.

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

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

Monitoring Process:

SLOBH Quality Support Team (QST) will expand to become an integrated Behavioral Health division.

Quality Support Team Program Structure and Description:

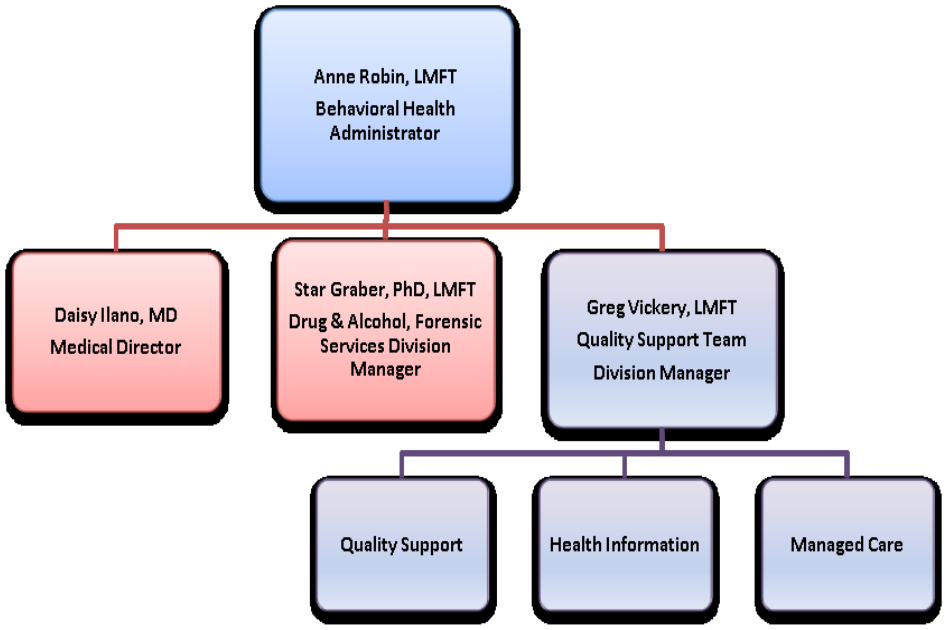
Purpose:

- To define the Quality Support Team's structure and elements
- To assign responsibility for QST activities to team members
- To provide a framework for understanding the Quality Support Team Work Plan, which establishes quantitative measures to assess performance and identifies and prioritizes areas for improvement
- To clarify processes for identifying and implementing improvements to better meet the needs of the MHP's beneficiaries

Organizational Overview:

The chart below shows a very simplified view of the part of SLOBH's Management Team and where QST fits in the structure. The QST Division Manager, Greg Vickery, LMFT, reports directly to the Behavioral Health Administrator and participates on the Behavioral Health Management Team.

Diagram 16. Quality Support Team Overview



QST staff report directly to the QST Division Manager. The following SUD Quality Support Team staff will be added to the existing Mental Health QST. QST staff executes key Quality Management, Quality Improvement, Utilization Review and Utilization Management duties including:

1. Staff: 1.0 FTE ASO I/II (TBA)

- QST Committee: Collect, report and present access, appeal and other data elements tracked by the QST Committee
- QST subcommittees: Organize, monitor and track QST subcommittees, maintain minutes, agendas and records
- Site Certification: conduct site reviews, coordinate with DHCS site reviewers, monitor, track and maintain certification records, maintain ITWS/BHIS files
- Quality of Care concerns: track and record Incident Reports, coordinate follow up requests
- Policy & Procedure: review, draft, coordinate input and approval
- Committee membership: QST Committee, Incident Report Review

2. Staff: 1.0 FTE LPHA Clinician (Julianne Schmidt, LMFT)

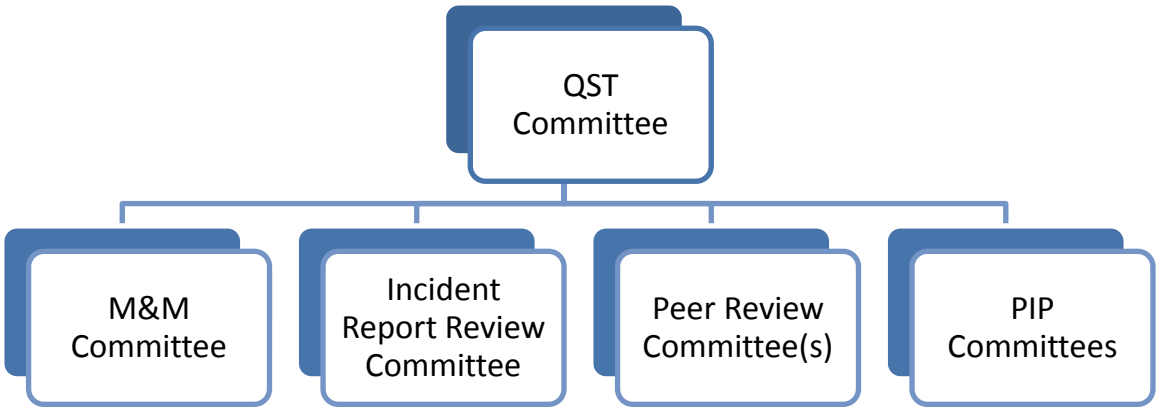
- Outpatient utilization management: review medical records to ensure consistent application of medical necessity criteria, adherence to documentation requirements, proper coding and claiming of services, identification of over or under utilization of services
- Provide staff training to improve documentation and coding

- Acts as the Clinical PIP coordinator and staff representative or coordinator of the following: QST Committee, Morbidity & Mortality, Incident Report Review, PIP, and Peer Review.

QST Committee Structure:

Within FY 2016-2017, SLOBH will integrate the SUD QST Committee with the MHP's Outpatient QST Committee. Initially, however, the two will be separate to allow focus on establishing detailed performance objectives and measures. The QST sub-committee structure is illustrated below.

Diagram 17. Quality Support Team Committee Structure



QST Committee (Outpatient) Membership:

- QST Division Manager (chair): Greg Vickery, LMFT
- BHD Administrator: Anne Robin, LMFT
- Medical Director: Daisy Ilano, MD
- Drug & Alcohol Services Division Manager: Star Graber, PhD, LMFT
- QST staff
- Managed Care Program Supervisor: Amanda Getten, LMFT
- Behavioral Health Advisory Board member
- SLOBH Patient's Rights Advocate: Leah DeRose, LMFT
- SLOBH Ethnic Services Manager: Juan Munoz-Morris
- Compliance Officer: Ken Tasseff
- Contractor/Provider staff
- Consumer/Family members
- Peer/Advocate members:
  - TMHA Peer Advocacy Program Manager
  - Family Advocate
  - Health Navigator

QST Committee Activities:

1. Quality Improvement Plan goals initially will focus on establishing baseline measures and performance standards that will result in a complete QST Work Plan.
2. Approve, and monitor the goals and objectives of the QST Work Plan. When the QST includes the SUD staff, the work plan will be adjusted to ensure substance use disorder activities are incorporated.
3. Monitor key quality indicators (monthly), including:
    - Wait time for assessment and acute care follow up (English and Spanish)
    - Wait time for appointments
    - Attendance at key appointments, including screening and assessment
    - Utilization of MAT and Withdrawal Management services
    - Coordination with physical health care services
    - Responsiveness of Central Access line
4. Monitor key quality indicators (quarterly), including:
    - Notices of Action
    - Grievances, Appeals (beneficiary and/or provider), Fair Hearing requests
    - Change of Provider and Second Opinion requests
    - Peer Review Results (medical services provided by prescribers and nursing staff in Withdrawal Management and Medication Assisted Treatment)
5. Periodic monitoring of beneficiary satisfaction.
6. Review and evaluate results of other quality improvement activities, including the clinical and nonclinical PIPs.
7. Receive reports from sub-committees and recommend necessary actions, including corrective actions when opportunities for more appropriate care are identified.
    a. Morbidity & Mortality Committee is chaired by the Medical Director. This subcommittee meets monthly to review instances of death or serious injury.
    b. Peer Review Committee is chaired by the Medical Director. This sub-committee meets monthly to review the clinical documentation of medical staff to ensure the safety and effectiveness of prescribing practices. A specific SUD Peer Review Committee will be added and chaired by each of the regional Program Supervisors for the SUD clinics. This sub-committee will meet quarterly at a minimum to review the clinical documentation of SUD staff to ensure the implementation of evidence-based practices, correct SUD treatment processes, level of care decisions, and continuity of care are consistent and appropriate for each client.
    c. Incident Review Committee is chaired by the QST Division Manager. Outpatient Incident Reports from Behavioral Health staff and contractors are reviewed to ensure improved care and appropriate follow up.
8. Receive reports from Cultural Competence committee.
9. Review and recommend policy changes and additions.
10. Other quality improvement activities as identified, including making recommendations for training and program development that improve beneficiary care.

Patients' Right Advocate, Beneficiary Complaints, Grievances, and Appeals

San Luis Obispo County Behavioral Health has implemented a problem resolution process that enables each beneficiary to resolve problems or concerns about any issue related to SLOBH's performance of its duties. The PRA will ensure that beneficiary rights are promoted and protected and that the problem resolution process works effectively for SLOBH beneficiaries. The Drug and Alcohol Services Patients' Rights Advocate will be the same as for the Mental Health Services within the Behavioral Health Department. The PRA reports directly to the Behavioral Health Administrator and receives additional support from the QST Division Manager.

The PRA will:

- Ensure beneficiaries are informed of their rights
- Advocate for beneficiaries
- Receive and investigate complaints
- Monitor behavioral health facilities, services, and programs for compliance with patient's rights provisions
- Provide training and education for providers and beneficiaries
- Exchange information with the State Patient's Rights Program

The PRA will ensure that beneficiaries are informed of their rights and have access to the problem resolution processes. Informing materials will be provided to clients at the beginning of services and upon request thereafter. Informing materials will be available in English, Spanish, and alternative formats. The PRA will ensure that the Beneficiary Handbook, Guide to Behavioral Health Services, which contains detailed information about the problem resolution and rights, will be available at all certified sites and through the 24/7 Access Line at 800-838-1831. The PRA will ensure that SLOBH's Client Information Centers contain notices explaining grievance, appeal, and expedited appeal procedures and patient's rights so that the information will be readily available to both beneficiaries and staff. The Consumer Request Forms and postage paid, self-addressed envelopes will be available in each Client Information Center. Clients will be able to obtain, complete and return a Consumer Request Form without having to make a verbal or written request to anyone. The contact information for the PRA and the State Office of Patients' Rights will be posted in all Behavioral Health facilities.

Problem Resolution: The PRA will receive, investigate and resolve complaints received from providers or beneficiaries about violations of patient's rights. The Consumer Request Forms will be tracked, logged, and responded to advocates to beneficiaries and/or representatives regarding requests for Second Opinions, Change of Provider, Grievances, Appeals, and Expedited Appeals. Assistance will be provided to the beneficiary (at their request) with the problem resolution process and will include, but not be limited to, help writing the grievance, appeal, expedited appeal on a Consumer Request Form. The PRA will coordinate prompt resolution of grievances and appeals and will notify beneficiaries of the disposition of the problem. See Attachment H for Patients' Rights Advocate forms and policy and procedures.

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

San Luis Obispo County Behavioral Health will ensure that all providers (including County-operations) are implementing at least two of the identified evidence based practices (EBP's) through the following:

- Incorporating the requirement to implement at least two of the EBP's listed in the Standard Terms and Conditions in all Requests for Proposals and awarded Contracts for the DMC-ODS services.
- Including provisions in all contracts for DMC-ODS services requiring providers to implement at least two specific EBP's in the contract, we well as information on how they will be implementing the EBP's with fidelity to the model.
- Similar to all quality and compliance monitoring, SLOBH will monitor adherence to implementing at least two of the identified EBP's through review and approval of the contract language, mid-year monitoring, which includes a written provider self-audit and on-site monitoring visit and review of progress reports.
- If a provider is found to be out of compliance, SLOBH will offer technical assistance to adhere to requirements, as well as issue a written report documenting the compliance and requiring a Corrective Action Plan be submitted to the County.

For many years, SLOBH has provided a number of evidence based practices in its treatment programs as listed below. This listing does not preclude other EBP's from being added or changed from the listing.

Table 18. Evidence Based Practices for San Luis Obispo County

Name	Purpose
Matrix Model	Substance use disorder treatment, a cognitive behavioral therapy (Adults and Youth)
Seeking Safety	Trauma based treatment, offered for women and men, appropriate for both group and individual settings
Helping Men/Women Recover	Gender specific services for substance use disorder treatment used in group counseling
Moral Reconation Therapy (MRT)	Appropriate for criminogenic factors that often accompany substance use disorders (Adults and Youth)
Motivational Interviewing	A practice of using motivational interviewing for client engagement
Illness Management and Recovery (IMR) and Integrated Dual Disorder Treatment (IDDT)	Co-occurring Disorder treatment services offered in an integrated manner
Recovery Support Services	Recovery Support Services are important to beneficiaries in the recovery and wellness process

Seeking Safety: Seeking Safety combines a present-focused therapy to treat post-traumatic stress disorder (PTSD) with a cognitive behavioral therapy substance abuse treatment approach. Seeking Safety is designed for flexible use in both group and individual format as well as for women, men, and mixed-gender groups and in a variety of settings (e.g., outpatient, inpatient, residential). Key principles include:

- Safety as a goal (assisting clients to find safety in their relationships, thinking, behavior, and emotions);
- Integrated treatment plans that treat both PTSD and substance abuse simultaneously;
- A focus on replacing or rebuilding ideals lost as a result of both PTSD and substance abuse; and
- A focus on cognitive, behavioral, interpersonal, and case management issues.

Seeking Safety has shown positive results in a variety of settings, reducing both trauma-related symptoms and substance use (Najavits, 2002). Two of these studies were randomized controlled trials (Hien, 2004, Najavits, under review). Findings from a not yet published study, funded by SAMHSA, "Women with Co-Occurring Disorders Violence Study," also found positive results for trauma informed treatment. This four-site study saw reductions in mental health symptoms and substance use indicators. Designed by Dr. Lisa Najavits under a National Institute of Drug Abuse grant, the program was developed to treat both substance abuse disorders and PTSD.

Helping Women/Men Recover: At the core of San Luis Obispo's treatment program are the gender responsive addiction treatment Helping Women/Men Recover frameworks. The materials can be used in a variety of settings and the exercises can be adapted for work with individuals. These evidence-based models have been modified to meet the special needs of the target population by lengthening its content, intensifying selected components, and incorporating trauma treatment.

The program is organized into four modules: self, relationships, sexuality, and spirituality. These reflect the four areas that represent triggers for relapse and the areas of greatest change in recovery. The topics take into account the physical, psychological, emotional, spiritual, and sociopolitical aspects of the holistic health model of addiction. It is a comprehensive integrated theoretical that not only incorporates cognitive behavioral techniques, but also affective-dynamic and systems perspectives. It will provide specific gender responsive services for both mothers and fathers in treatment.

Helping Women Recover has demonstrated reduced substance use with criminal justice involved women. In a randomized clinical trial, female inmates who had substantial substance use history were placed into Helping Women Recover or standardized treatment. From baseline to the 12 month follow-up women in the intervention group had a larger decrease in drug use composite scores on the ASI than their counterparts (NREPP, 2010). In addition, a smaller percentage of the intervention group than the comparison group women were re-

incarcerated during the 12 months follow-up period—67% less likely to recidivate. Less substance use and less recidivism are outcomes that we want to achieve in our treatment programs.

Both the Helping Men/Women Recover and Seeking Safety have been found to be effective in low-income and minority populations, and additionally, have already been culturally modified successfully. Both Helping Women/Men Recover and Seeking Safety are long-term group and individual counseling formats. These evidence based practices are available in Spanish language formats should they be needed and are effective with criminal justice populations.

We have selected the Helping Women/Men Recover over other evidence based practices for multiple reasons:

- It uses a cognitive behavioral therapy approach to substance abuse management, which has demonstrated to be gender responsive setting working with both mothers and fathers;
- It has fully developed fidelity measure that will assist us in its implementation;
- Because our County providers currently have received training in the Helping Women/Men Recover, we anticipate expedited enhancement; and
- Its core characteristic—development of individualized treatment—promotes sensitivity to cultural, physical, linguistic, and other needs.

Moral Reconation Therapy (MRT): Moral Reconation Therapy is a systematic treatment strategy that seeks to decrease recidivism by increasing moral reasoning. Its cognitive behavioral approach combines elements from a variety of psychological traditions to progressively address ego, social, moral, and positive behavioral growth. MRT takes the form of group and individual counseling using structured exercises and prescribed homework assignments. The MRT Workbook is structured around sixteen objectively defined steps focusing on seven basic treatment issues: confrontation of beliefs, attitudes, and behaviors; assessment of current relationships; reinforcement of positive behavior and habits; positive identity formation; enhancement of self-concept; decrease in hedonism and development of frustration tolerance; and development of high stage moral reasoning. MRT is an open-ended group format that may meet once a month or up to five times per week. Group size can vary from 5 to more than 20. Homework tasks and exercises are completed outside of group and then presented to group members during meetings. The most important aspect of the treatment is when the participant shares work with the group. The facilitator is trained to ask appropriate questions concerning the exercises and to maintain focus on the participants' completion of MRT's 16 steps.

MRT does not require high reading skills or high mental functioning levels, as participants' homework includes making drawings or writing short answers. The format seems especially appropriate for a drug court treatment program in a self-contained clinical setting.

In one study of the use of MRT, after one year of release from custody, adult male felony inmates who participated in MRT showed a re-incarceration rate that was two-thirds lower

than that of a control group of inmates who had volunteered for the MRT program, but did not receive it due to limited treatment funding. In another study, male and female clients who participated in MRT were rearrested for any offense at a rate of 20% compared with 45.3% for a matched control group. In several other studies, the authors (Little, 2001, 1999) maintain that MRT cuts the expected 1-year recidivism rate in half. Studies show that well-implemented cognitive behavioral interventions can reduce recidivism by as much as 30 percent on average, particularly with moderate to high-risk offenders.

In 2012, "A Meta-Analysis of Moral Reconation Therapy" was published for the International Journal of Offender Therapy and Comparative Criminology. The study considered criminal offending subsequent to treatment as the outcome variable. The overall effect size measured by correlation across 33 studies and 30,259 offenders was significant (r=.16), indicating that MRT has a small but important effect on recidivism. Of all, 20 (62%) of the studies were conducted on incarcerated offenders with the balance on community-based offenders. Only 6% of the studies involved female offenders. However, more research is needed and the impacts would be important not only to proponents of MRT, but also to proponents of gender-responsive interventions.

The Moral Reconation Therapy program was chosen because:

- The target population of this project is medium to high-risk offenders;
- It has been proven to be effective in substance abuse treatment;
- It has been shown to reduce recidivism—a goal of our programs;
- Some SLOBH staff have been trained in MRT treatment protocols; and
- It is based in cognitive behavioral therapy and fits well with the other selected evidence based practices used in the County.

Illness Management and Recovery (IMR): The purpose of this practice is to help people to develop personalized strategies for managing their mental illness and moving forward with their lives. The focus of IMR is to provide people with the information and skills they need in order to make informed decisions about their own treatment. The educational materials in the toolkit are written for schizophrenics, bipolar, and major depression (which are consistent with the population of focus for this project). IMR is used on a weekly basis with consumers either individually or as a group for 3 to 10 months. The interventions include: psycho-education; behavioral tailoring (for consumers who choose to take medication); relapse prevention; and coping skills training. Some of the topics presented are: recovery strategies, practical facts on mental illness, building social support, drug and alcohol use, and copying with stress and problems. These strategies will help the BHTC participants establish a clean and sober lifestyle and to improve the quality of their lives with medication compliance (if applicable).

Most of the research on IMR has focused on persons with schizophrenia which is the top disorder being treated in our Co-occurring Disorders Program (Psychiatric Services, 2002). There is research literature on the efficacy of the various interventions of IMR on other diagnostic populations, particularly Bipolar disorder (CIMH, website).

Integrated Dual Disorders Treatment (IDDT):

Stage of the Individual Consumer	Appropriate Interventions
Pre-contemplation & Engagement	Outreach, practical help, crisis intervention, develop alliance, assessment
Contemplation & Preparation Persuasion	Education, set goals, build awareness of problem, family support, peer support
Action – Active Treatment	Substance abuse counseling, medication treatments, skills training, family support, self-help groups
Maintenance – Relapse Prevention	Relapse prevention plan, continue skills building in active treatment, expand recovery to other areas of life

The program is for all adult consumers (both male and female) with both substance abuse or dependence disorders and mental illness, such as schizophrenia, bipolar disorder, or depression. Issued as a SAMHSA Toolkit in 2003, IDDT features include: assertive outreach; stage-wise comprehensive treatment; treatment goals setting with person-centered interventions for each stage; and flexibility to work within each stage of treatment. Examples of interventions that are linked to the stage of the individual are highlighted above:

Integrated Dual Disorders Treatment will address the goals of treatment in its recovery model. IDDT is consumer driven providing unconditional respect and compassion. The clinician is responsible for helping clients with motivation for treatment and the focus is on the client goals and function, not on adherence to treatment.

Most evidence for this practice is found for adults, with a wide range of ages studied primarily ages 18 – 55, both male and female. IDDT has most evidence with Caucasians, with some evidence for African Americans, and more evidence needed for Latinos. Furthermore, the research for this practice has been focused on patients with dual disorders—mental illness (schizophrenia, bipolar, or depression) and substance abuse or dependence.

Recovery Support Services: Recovery Support Services (RSSs) are non-clinical services that assist individuals and families to recovery from alcohol or drug problems. They include social support, linkage to and coordination among allied service providers, and a full range of human services that facilitate recovery and wellness contributing to an improved quality of life. We will focus on SAMHSA's definition of four major dimensions that support a life in recovery:

- Health—overcoming or managing one's disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and, for everyone in recovery, making informed, healthy choices that support physical and emotional well-being.
- Home—having a stable and safe place to live.

- Purpose—conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society.
- Community—having relationships and social networks that provide support, friendship, love, and hope.

First, recovery support needs span the periods of pre-recovery engagement, recovery initiation, recovery stabilization, and recovery maintenance. As such, these service relationships last far longer than counseling relationships that are the core of addiction treatment, are far more likely to be delivered in the client's natural environment, and often involve a larger cluster of family and community relationships.

Second, recovery support relationships are less hierarchical (less differential of power and vulnerability) than the counselor-client relationship, involve different core functions, and are governed by different accountabilities. As such, the ethical guidelines that govern the addiction counselor are often not applicable to the recovery coach.

Third, individual consumers of peer-based recovery support services differ in the kind of non-clinical support services needed, and it is not uncommon for the same person to need different types of support services at different stages of his or her addiction and recovery careers. This requires considerable care in evaluating support service needs, delivering those services within the boundaries of one's knowledge and experience, and knowing how and when to involve other service roles.

Studies find that when an individual's full array of needs (e.g. food, clothing, housing, transportation) is met, short- and long-term outcomes, including retention in treatment and reduction in substance use are improved. Further, Finney, Noyes, Coutts, & Moos (1998) found that recovery oriented support may foster greater self-efficacy and longer abstinence.

Recovery Support Services was chosen as the evidence based practice because:

- It has been shown to be effective with clients with substance use disorders
- Comprehensive medical and social care will be enhanced through RSSs, especially in working with the new population of heroin addicted individuals
- San Luis Obispo is a rural medium sized County and we do not have access to resources and large nonprofits that other urban areas have, so it can be difficult for our clients to navigate the County's resources. Furthermore, being in a rural medium County, public transportation is not as well-designed as larger Counties, and so providing transportation with Recovery Support Services will be paramount.
- Recovery Support Services will be conducted by peers who can pass their strength, hope and experience to others
- Recovery Support Services are individually based and will provide necessary supports to overcome ethnic and gender disparities.

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

Although SLOBH intends to coordinate with neighboring counties, SLOBH is not proposing to implement a formalized regional model at this time. Youth residential treatment and possibly adult residential treatment services will require a regional model through contracts with providers in neighboring counties.

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

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

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

San Luis Obispo County has one managed care health plan which is combined with Santa Barbara County, known as CenCal Health. We are in the process of amending the current MOU between the San Luis Obispo County Mental Health Plan and CenCal Health, to incorporate related provisions from the DMC-ODS STCs, which was originally executed on October 28, 2008 and revised on September 24, 2015. SLOBH is working on developing the proposed language for the amended MOU and is in the process of meeting together with CenCal Health for discussions. It is expected that the MOU will be signed by the end of September, 2016. A copy of the MOU will be sent to DHCS when approved.

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

San Luis Obispo County Behavioral Health has implemented a telehealth pilot project based out of the Mental Health Youth Treatment Services. Based upon the initial success of the pilot, the plan is to expand the services throughout the county. This provides behavioral health services for the rural and hard to reach populations in our County. In addition, the county has a dearth of medical professionals and our plan is to expand telehealth services to provide physician, psychiatrist, and nursing accessibility to the clients in the regional mental health and SUD clinics. Services will include consultative and 'direct' client care including medication screening, assessment, evaluation, monitoring, and management. Consultation and 'direct' client care services for the co-occurring disorder mental health and substance use clients, medication assisted treatment, physical health co-morbidities, and other categories may be conducted using telehealth services.

In lieu of a SUD client coming to a Drug and Alcohol Services clinic or a psychiatrist or nurse providing on-site services at multiple clinic locations, telehealth would be used to centralize the services thus improving client access, minimizing travel time, and maximizing the use of the medical professional's time. The medical professional would operate out of one central site, meet with clients and staff over the telehealth network providing direct client care and consultation to the staff. A Drug and Alcohol Services staff member (LPHA or Licensed Psychiatric Technician or Drug and Alcohol Worker) will be with the client, while the medical professional is on the other end of the camera.

The benefits of video-based telehealth include (Maheu, et al, 2004):

- Increased client satisfaction
- Decreased travel time
- Decreased travel, child and elder care costs for the clients
- Increased access to underserved populations
- Improved accessibility to specialists
- Reduced emergency care costs
- Faster decision-making time
- Increased productivity/decreased lost wages for the clients
- Improved operational efficiency
- Efficacy is on par with in-person care for many groups
- Decreased hospital utilization

We propose using telehealth services through mobile devices (tablets, mobile phones, and laptops) using a secure connection such as U-SEE, which would allow provision of services regardless of the location of the client. Staff could have complex case discussions while each member of the team is in a different location and view presentations together. Equipping

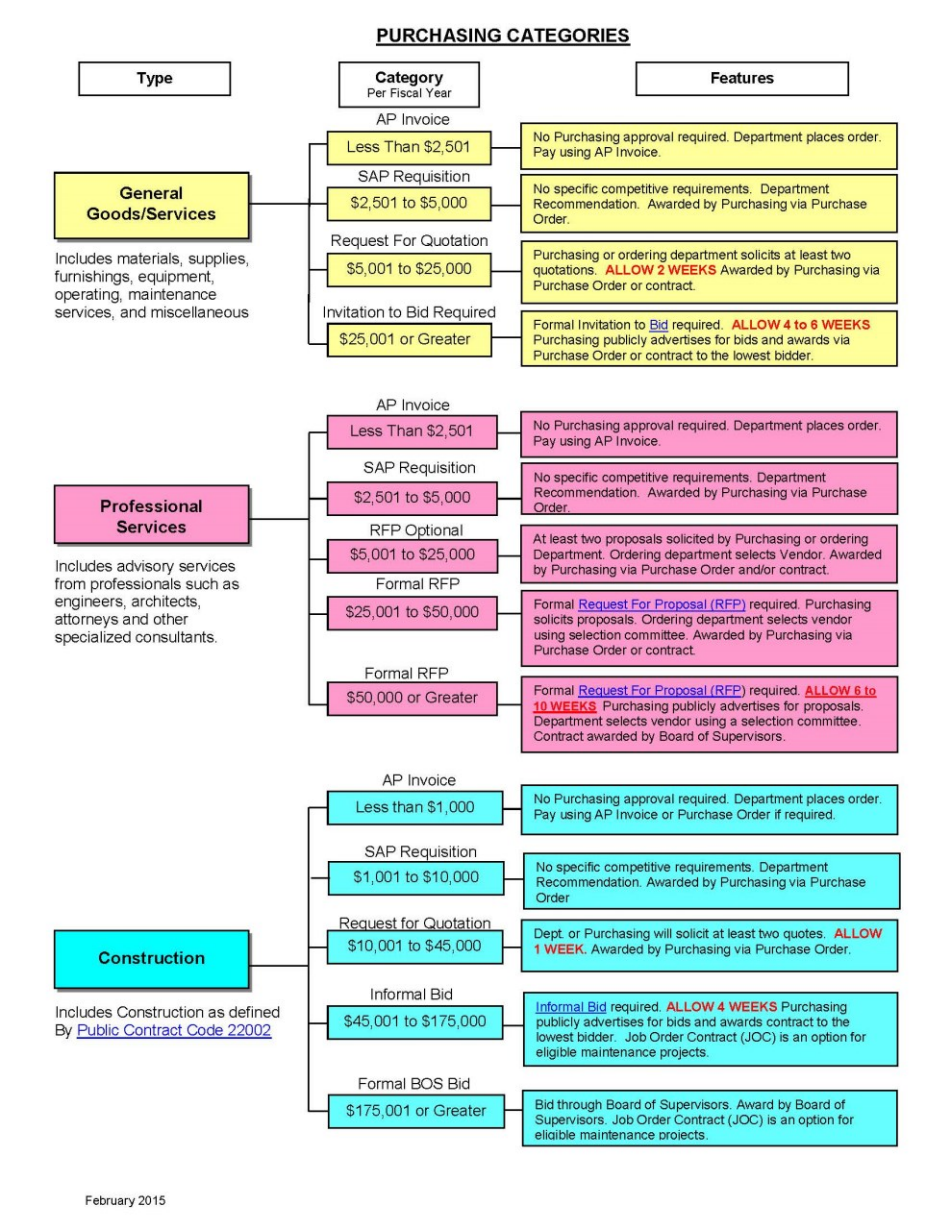
clients with self-care apps on their own mobile devices that could connect them with their case managers beyond 'office hours' and locations or with appropriate recovery support services will also be considered. Technology can offer value for individuals and their families along the entire spectrum of behavioral health services. This may include screening, assessment, prevention, treatment, recovery management, and continuing care (SAMHSA TIP 60, 2015). Additionally, by offering technology assisted care to clients (e.g. encouraging clients to complete online skills training modules), clinicians may increase their time availability for clients with multiple challenges; focus more of their time on the delivery of services that require their clinical expertise and interaction with clients; and enable clients to review repetitive but clinically important content, such as psychoeducational materials, without having to devote extensive time to such activities themselves.

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

Contracting:

San Luis Obispo County Behavioral Health complies with the San Luis Obispo County policies and procedures for the selection and retention of service providers as described in the County contract manual. These policies and procedures apply equally to all providers regardless of public, private, for-profit or non-profit status. Services contracted under DMC ODS are considered the "Professional Services" category as outlined in the County contracting manual.

Diagram 19. Purchasing Categories



Services under $25,000 can be acquired by a solicitation process that includes a minimum of two firm quotes and a description of how services will be delivered. A formal Request for Proposals (RFP) process may be used but is not required. The provider that best demonstrates

the capacity and capability to deliver quality services, has a strong financial portfolio, and has a realistic implementation plan will be chosen.

For services greater than $25,000 a formal Request for Proposal (RFP) process is required. This process includes the publishing of the project or program scope of work, the requisite provider organizational characteristics, a description of how services will be delivered that aligns with the terms and conditions of the RFP, and a budget that is sufficient to deliver the services and achieve the desired outcomes. All RFPs include a sample contract containing all the required terms and conditions.

Once proposals are received San Luis Obispo County Behavioral Health convenes a review panel that may include content experts, other Mental Health and Substance Use Disorder providers, another departmental stakeholder (eg: social services), consumers and or family members. The panel is given criterion to evaluate each proposal and make recommendations to the Behavioral Health Administrator for funding. If necessary in order to make a final recommendation, the panel may choose to interview one of more of the applicants.

Once approved by the Behavioral Health Administrator, a formal recommendation for approval is recommended to either the San Luis Obispo County Purchasing department (contracts under$50,000) or the San Luis Obispo County Board of Supervisors (contracts over $50,000). Once approved by the Board the contract is officially executed. Per County policy the RFP process for contracts above $25,000 may be waived by a justification signed by the Purchasing Department. Situations in which an RFP may be waived include, but are not limited to, emergency situations or those in which an independent contractor is the “sole source” of a particular service in the County.

Contract Term: The County has a 3-year contract term limit. A standard renewal process is in place to request the extension of a contract beyond the 3-year limit. The request requires the review and approval of the Behavioral Health Administrator, the Health Agency Compliance Officer, County Counsel, and, if over $50,000, the by the Board of Supervisors.

Appeals Process: The County has a formal appeals process. This is documented in the contracts manual and in San Luis Obispo County’s standard RFP form that the proposer completes and submits to the County via Public Purchase when proposing to perform services. If a proposer desires to protest the selection decision, the proposer must submit by facsimile or email a written protest within five (5) business days after delivery of the notice about the decision. The written protest should be submitted to the Behavioral Health Administrator in writing, must include the name and address of the Proposer and the Request for Proposals numbers, and must state all the specific ground(s) for the protest.

A successful protest will include sufficient evidence and analysis to support a conclusion that the selected proposal, taken as a whole, is an inferior proposal. The Behavioral Health Administrator will respond to a protest within five (5) business days of receiving it, and the

Department may, at its election, set up a meeting with the proposer to discuss the concerns raised by the protest. The decision of the Behavioral Health Administrator will be final.

Service Continuity: If a current DMC provider is not selected, the County will take responsibility for ensuring the continuity of care for the beneficiary, including working with the beneficiary to secure another alternative service provider, transfer to the newly selected service provider, or appropriate increase or decrease in level of care and transition to that service provider.

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

SLOBH offers or contracts for medically necessary MAT services through Behavioral Health Department staff and contracted office based opiate treatment (OBOT) providers, a NTP program, and a provider network licensed as primary care clinics. Services include: assessment, treatment planning, medication assisted treatment, ordering, prescribing, administering, and monitoring of medications for substance use disorders. Physicians and licensed prescribers in DMC programs will be reimbursed for the ordering, prescribing, administering, and monitoring of medication assisted treatment.

MAT will expand the use of medications for beneficiaries with chronic alcohol related disorders and opiate use. Medications may include: naltrexone, both oral (ReVia) and extended release injectable (Vivitrol), topiramate (Topomax), gabapentin (Neurotin), acamprosate (Campral), and disulfiram (Antabuse). Other medications may be prescribed as indicated for substance use disorders (including FDA approved medications that may become available in the future):

- Opiate overdose prevention: naloxone (Narcan). See Attachment D for naloxone policy and procedures for the County of San Luis Obispo.
- Opiate use treatment: buprenorphine-naloxone (Suboxone) and naltrexone (oral and extended release). Note: Methadone will continue to be available through the licensed narcotic treatment program.
- For tobacco cessation and nicotine replacement therapy as indicated.

An increase in physician time and 1.0 FTE licensed psychiatric technician (LVN/LPT) each for North County and for South County will be needed to increase the availability of MAT to all areas of the county. Patients receiving drug Medi-Cal outpatient treatment services through Drug and Alcohol Services would also be prescribed MAT through the physician (MD) working at the program as need is determined. The patient would then fill the prescription at the pharmacy of their choice. The LVN/LPT would be available at each of the DAS clinics in North County and in South County to monitor side effects, order laboratory testing, provide medication education groups, and document client progress to the medication in the electronic health record, working closely with the program physician to make medication adjustments as needed.

Additionally, SLOBH is currently coordinating care and expanding the availability of MAT outside the DMC-ODS by building the capacity of the entire health system to use these treatments for beneficiaries with a substance use disorder. Behavioral Health Department has a grant funded Opiate Safety Coalition that is training physicians, nurse practitioners, and psychiatrists in primary care and specialty mental health clinics on the efficacy of using MAT, practice guidelines, and medication administration. In addition, the Behavioral Health Department is the expert on naloxone distribution in the County, and we are currently training pharmacies to prescribe this overdose antidote to extend the availability of naloxone into the community. Physician consultation is supporting implementation in areas such as: medication selection, dosing, side effect management, adherence, and drug-drug interactions.

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

All providers shall obtain authorization for residential services prior to referring or admitting a beneficiary. Residential authorization processes are completed to assure beneficiaries access medically necessary services in a timely manner. All authorization and reauthorization are tracked through the EHR on the Behavioral Health Referral Form (see sample in Attachment I). There are four primary pathways that will support beneficiaries in accessing and receiving timely authorization for residential services.

Path 1: Access Line

Beneficiaries are advised to contact the Access Line to inquire about services. When the Access Line screening yields a residential need, an authorization and a BH Service Request for Level 3+ services is created. An appointment is made by the Access Line with the Assessment Coordinator, provided the caller is open to exploring a residential placement. A beneficiary shall be offered an evaluation appointment within 24 hours of the initial call with the Access Line or on Monday morning following a weekend call. Evaluation appointments may be provided face-to-face, by telephone, or by telehealth, and may be provided anywhere in the community.

Path 2: Walk-in Screening

Prospective clients often are referred by family members, friends, clergy, social services and other health providers, already knowing that the beneficiary needs residential placement for treatment or withdrawal management. The Assessment Coordinator will conduct the Screening Tool with the ASAM Criteria. If the results from the screening indicate the likely need for residential treatment the Assessment Coordinator will submit a Behavioral Health Referral Form to the Behavioral Health Managed Care Team for tracking. The Assessment Coordinator will introduce the beneficiary to the Behavioral Health Case Manager who will work to provide the smooth transition to a residential placement. If the client is not eligible for residential level of care, the Assessment Coordinator will facilitate a ‘warm hand-off’ to the provider that best matches the client’s needs (outpatient, intensive outpatient, or ambulatory withdrawal management). If housing is an issue, the Assessment Coordinator and Case Manager will work

to ensure the client is safe, working with Shelter Care providers and Recovery Residences and other temporary housing options.

Path 3: Outpatient Provider Initiated Authorization

Outpatient provider initiated residential authorization requests are made to the regional Assessment Coordinator who will schedule a face-to-face, telephone, or telehealth interview, conducting the ASAM Criteria to determine level of care placement. The Assessment Coordinator will review the client's progress in outpatient treatment, consult with the primary outpatient Specialist, and conduct any other assessment instruments needed. Upon determination that residential treatment is indicated, the regional Case Manager will work with the client to determine the best residential facility available within the timelines. When the outpatient provider makes a residential referral on weekends or holidays or after-hours for evaluation and residential authorization, the client will be referred to the Access Line. The Access Line staff will conduct an ASAM Criteria over the phone and review the client's lack of progress in outpatient treatment. When indicated, the beneficiary shall be granted a preliminary 7-day authorization for residential treatment. The Behavioral Health Referral Form is filled out by the Assessment Coordinator, Case Manager, and/or Access Line and submitted to the Managed Care Team for tracking. Once admitted to care, the residential provider shall request a re-authorization for treatment for continued care at a residential level.

Path 4: Residential Treatment Re-Authorizations

Residential providers shall request a re-authorization, based on the results of the ASAM assessment at least seven (7) days prior to the end of the initial authorization expiration date. This will allow time for the residential provider to transition the client if the request is denied. Upon receipt of a re-authorization request with a treatment summary (including a new ASAM Criteria), Access staff will review the request and based on the review, provide one of the following responses to the requesting residential agency within 24 hours: Approved as Requested; Approved as Modified; Deferred; or Denied.

Maximum Residential Treatment Duration:

Presumptive authorization does not guarantee payment and submission of claims to Medi-Cal are subject to a client's eligibility, services being rendered, and documentation in accordance with Title 22, the ASAM Criteria, and the DMC-ODS STCs. The maximum duration of residential treatment for adolescents is 30 days on an annual basis. For adults, the annual residential services maximum is 90 days per client. A one-time extension of up to 30 additional days on an annual basis may be authorized, when medically necessary. Only two non-continuous 90 day residential episodes may be authorized in a one-year period for adults. Perinatal and criminal justice involved adults may be considered for a longer stay based on medical necessity and with advanced authorization from the Managed Care Team, Access Line, or Assessment Coordinator. The residential treatment authorizations are from 1 day – 30 days, and shall be re-authorized every 30 days maximum. Re-authorizations shall be documented on a client specific Behavioral Health Referral Form, located in the EHR, with appropriate authorization signatures. A copy of the Behavioral Health Referral Form shall be forwarded to the Behavioral Health Managed Care

Team who will work with the Finance Team for appropriate invoice, DMC billing and pay source monitoring. Other non-Medi-Cal funds can be used for extended lengths of stay.

Denials of Services – Appeals Process:
If medical necessity is not demonstrated during the authorizations or re-authorizations process, the residential authorization shall be denied. The provider shall be notified of the denial in writing with the denial reason. The client will be notified of the denial in writing on a standard Notice of Action form. Clients or providers advocating on the client's behalf may appeal the service denial. The client or provider must send a written letter describing why the client/provider disagrees with the service denial, and why the client meets medical necessity for the requested service modality. The letter shall be faxed to the Access Line. A Review Committee will be convened and must make a final determination within seven (7) days of the initial authorization request. The Review Committee's decision will be final.

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

Residential treatment is biggest barrier to the implementation of the DMC-ODS in the County of San Luis Obispo. Although we currently have a perinatal (women with children) residential treatment provider, contracts with neighboring residential treatment providers or other out of county residential treatment providers will need to be secured and are not currently available upon implementation of the pilot. Outpatient treatment services are currently available in Paso Robles in accordance with the DMC-ODS requirement, however, not to the level of accessibility that we expect. In addition, due to the need to secure a larger clinic in the Paso Robles area and requirements of the existing lease, the full operation of the outpatient treatment clinic in Paso Robles will be implemented in a phase-in plan. Youth outpatient treatment services will be expanded onto school campuses as a priority in September, 2016. The intensive outpatient treatment program for youth and their families is scheduled to commence in January, 2017. See the implementation timeline with deliverables below:

Table 20. Year One Implementation Timeline

Requirement	Deliverable Tasks	Timeline
MOU with CenCal Health	Finalized, signed and approved MOU document sent to DHCS	September 30, 2016
24/7 Access Line	This service is currently available, however, the County is in process of determining other options for providing the overnight call handling	September 30, 2016

Paso Robles expanded outpatient treatment services	New clinic site certified, staff hired, and expansion complete	January 1, 2017
Youth Intensive Outpatient Tx	Staff hired and program implemented	January 1, 2017
Youth Residential Treatment	RFP for in-County or out-of-County youth residential treatment providers	January 1, 2017
Adult Residential Treatment	RFP for in-County or out-of-County residential treatment providers for a variety of adult services	January 1, 2017

County Authorization

The County Behavioral Health Administrator must review and approve the Implementation Plan. The signature below verifies this approval.

Anne Robin, LMFT
County Behavioral Health Administrator
County of San Luis Obispo

San Luis Obispo County

7/5/16
Date

Attachment K. Citations and References

ACTION for Healthy Communities. *Comprehensive Report for San Luis Obispo County, 2010.* San Luis Obispo Community Foundation, San Luis Obispo, CA.

American Association of Community Psychiatrists. (February, 2000). *Principles for the Care and Treatment of Persons with Co-occurring Psychiatric and Substance Disorders.*

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders DSM-IV-TR (4th ed., Text Revision)*. Washington, D.C.: American Psychiatric Association.

Brown, V.B.; Najavits, L.M.; Cadiz, S.; Finkelstein, N.; Heckman, J.; and E. Rechberger (2007). Implementing an Evidence-Based Practice: Seeking Safety Group. *Journal of Psychoactive Drugs,* 39 (3) 231-40.

California Department of Alcohol and Drug Programs and the California Department of Mental Health (2004). *Co-occurring Disorders Workgroup: Final Report.* March 2, 2004.

California Department of Alcohol and Drug Programs. *Co-occurring Disorders: Fact Sheet.* January, 2008. Sacramento, CA.

California Institute for Mental Health (2011). *Implementing SAMHSA Evidence-Based Practice Toolkits: Illness Management and Recovery.* www.cimh.org

California Office of the Attorney General. *Crime Data Report, Statistics by City andCounty: San Luis Obispo County. http://stats.doj.ca.gov/cjsc_stats/prof09/40/3A.htm*

Case Western Reserve University (2008). *Integrated Dual Disorder Treatment: An overview of the evidence-based practice.* www.ohiosamiccoe.case.edu

CenCalHealth, Member Demographic Data All Programs, 2015. Prepared by CenCal Health's Member Services Department. San Luis Obispo Health Initiative (SLOHI).

Census Bureau, United States. (2013). *Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2013 2013 Population Estimates.* United States Census Bureau.

Census Bureau, United States. (2013). *State & County QuickFacts. San Luis Obispo County, California.* United States Census Bureau.

Center for Applied Research Solutions, Inc. (2007). *Indicators of Alcohol and other Drug Risk and Consequences for California Counties: San Luis Obispo County.*

Center for Court Innovation, Drug Courts the Second Decade

Center for Court Innovation (2014). "Evidence-Based Strategies for Working with Offenders."

Center for Mental Health Services (1996a). *The MHSIP consumer-oriented mental health report card*. Washington DC: Center for Mental Health Services.

Center for Mental Health Services (1996b), MHSIP Task Force. (n.d.). The consumer survey. Retrieved September 15, 2005, from www.mhsip.org/reportcard/conssat.pdf.

Center for Substance Abuse Treatment (2005). *Substance abuse treatment for persons with co-occurring disorders.* Treatment Improvement Protocol (TIP) series no. 42 (DHHS Publication No. (SMA) 05-3992). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment. *Definitions and Terms Relating to Co-occurring Disorders.* COCE Overview Paper 1. DHHS Publication No. (SMA) 07-4163. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2007.

Center for Substance Abuse Treatment. *Enhancing Motivation for Change in Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series, Number 35. DHHS Publication No. (SMA) 05-4081. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999.

Center for Substance Abuse Treatment. *Overarching Principles to Address the Needs of Persons with Co-occurring Disorders.* COCE Overview Paper 3. DHHS Publication No. (SMA) 06-4165. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.

Center for Substance Abuse Treatment. *Services Integration.* COCE Overview Paper 6. DHHS Publication No. (SMA) 07-4294. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2007.

Center for Substance Abuse Treatment. *Systems Integration.* COCE Overview Paper 7. DHHS Publication No. (SMA) 07-4295. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2007.

Center for Substance Abuse Treatment. *The Epidemiology of Co-occurring Substance Use and Mental Disorders.* COCE Overview Paper 8. DHHS Publication No. (SMA) 07-4308. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2007.

Center for Substance Abuse Treatment. *Understanding Evidence-Based Practices for Co-occurring Disorders.* COCE Overview Paper 5. DHHS Publication No. (SMA) 07*4278. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2007.

Center for Substance Abuse Treatment. *Addressing Co-Occurring Disorders in Non-Traditional Service Settings*. COCE Overview Paper 4. DHHS Publication No. (SMA) 07-4277. Rockville, MD: Substance Abuse and Mental Health Services Administration and Center for Mental Health Services, 2007.

Center for Substance Abuse Treatment. *Screening, Assessment, and Treatment Planning for Persons with Co-occurring Disorders.*. COCE Overview Paper 2. DHHS Publication No. (SMA) 07-4164. Rockville, MD: Substance Abuse and Mental Health Services Administration and Center for Mental Health Services, 2007.

Chasnoff, I. *Presentation to the San Luis Obispo County Obstetricians.* San Luis Obispo, December 10, 2008.

Chestnut Health Systems. (2006). *Brief Introduction to the GAIN-SS and Assessments.com.* www.assessments.com.

Cissner, A.B. and Rempel, M. *The State of Drug Court Research: Moving Beyond 'Do they Work'.* New York: Center for Court Innovation (2005).

Cognitive-behavioral therapy of schizophrenia. Kingdon, David G.; Turkington, Douglas New York, NY, US: Guilford Press. (1994). xii 212 pp.

Cormac I, Jones C, Campbell C, Silveira DMNJ. Cognitive behaviour therapy for schizophrenia. The Cochrane Database of Systematic Reviews 2002, Issue 1. Art. No.: CD000524. DOI: 10.1002/14651858.CD000524.

Cosden, M. (2008). *Santa Barbara County Alcohol, Drug and Mental Health Services: MARS Program.*

County Alcohol and Drug Program Administrators Association of California. (2005 June). *Advancing California's Continuum of Care for Persons with Co-occurring Substance Use and Mental Health Disorders.* Sacramento, CA.

Covington, S. (2008). *Helping women recover: A program for treating addiction. Revised edition.* San Francisco, CA: Jossey-Bass.

Covington, S. (2008). *Helping women recover: A program for treating addiction. Special edition for use in the criminal justice system.* San Francisco, CA: Jossey-Bass.

Covington, S., Griffin, D., & Dauer, R. (2011). *Helping men recover: A program for treating addiction.* San Francisco, CA: Jossey-Bass.

Covington, S., Griffin, D., & Dauer, R. (2011). *Helping men recover: A program for treating addiction. Special edition for use in the criminal justice system.* San Francisco, CA: Jossey-Bass.

Croton, G. (2007). *Screening for and assessment of co-occurring substance use and mental health disorders by Alcohol and other Drug and Mental Health Services,* Victorian Dual Diagnosis Initiative Advisory Group, Victoria.

DASIS Report: Geographic Differences in Substance Abuse Treatment Admissions for Methamphetamine / Amphetamine and Marijuana.Retrieved March 24, 2008 from http://www.oas.samhsa.gov/2k8/stateMethamphetamineTX/methamphetamines.htm

DAWN Report: Amphetamine and Methamphetamine Emergency Department Visits, 1995-2002. Retrieved March 24, 2008 from http://www.oas.samhsa.gov/2k4amphetamines.pdf

Deci, E.L., R. Koestner, and R.M. Ryan. (1999). A Meta-Analytic Review of Experiments Examining the Effects of Extrinsic Rewards on Intrinsic Motivation. *Psychological Bulletin* 125(6): 627–668.

Dennis, M.L., Feeney, T., Stevens, L.H., Bedoya, L. (2008). *Global Appraisal of Individual Needs—Short Screener (GAIN-SS): Administration and Scoring Manual Version 2.0.3.*

Department of Health and Human Services, SAMHSA Office of Applied Studies, *Treatment Episode Data Sets 2005,* downloaded from http://wwwdasis.samhsa.gov/teds05/TEDSAd2k5Index.htm on March 25, 2008.

Drake, R.F., Essock, S.M., Shaner, A., Carey, K., Minkoff, K., Kola, L., Lynde, D., Osher, F.C., Clark, R.E., Rickards, L. (2001). *Implementing Dual Diagnosis Services for Clients with Severe Mental Illness,* Psychiatric Services, vol 52(4).

Drug Medi-Cal Organized Delivery System (DMC-ODS) Implementation Plan for County of Santa Cruz.. County of Santa Cruz Health Services Agency. December 2015.

Drug Medi-Cal Organized Delivery System Implementation Plan. San Mateo County Behavioral Health and Recovery Services. November 2015. Authored by Stephen Kaplan.

Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver County Implementation Plan. Marin County Department of Health and Human Services Division of Mental Health and Substance Use Services. February 2016.

Ferguson, L.M. & Wormith, J.S. (2012). "A Meta-Analysis of Moral Reconation Therapy." International Journal of Offender Therapy and Comparative Criminology.

Fox, A. and R.V. Wolf. *The Future of Drug Courts: How States are Mainstreaming the Drug Court Model.* New York: Center for Court Innovation (2004).

GAO. *Adult Drug Courts: Evidence Indicates Recidivism Reductions and Mixed Results for Other Outcomes,* February 2005.

Gertson, L. (2008). *The Integrated Dual Diagnosis Treatment Program of Ventural County Behavioral Health.* Presentation to San Luis Obispo County Co-occurring Disorders Workgroup of the Behavioral Health Department, December 11, 2008.

Hein, D.A.; Cohen, L.R.,; Miele, G.M.; Litt, L.C.; and Capstick, C. (2004). Promising Treatments for Women with Comorbid PTSD and Substance Use Disorders. Am*erican Journal of Psychiatry*, 161 (8): 1426-32. http://ajp.psychiatryonline.org

Hubbard, R.L., M.E. Marsden, J.V. Rachal, J.H. Harwood, E.R. Cavanaugh, and H.M. Ginsburg. 1989. *Drug Abuse Treatment: A National Study of Effectiveness.* Chapel Hill, NC: University of North Carolina Press.

Laura & John Arnold Foundation. (2014). "Pre-Trial Criminal Justice Research." www.arnoldfoundation.org.

Lovern, J. (2006). *Co-occurring Disorders: a Brief Introduction.* Presentation to San Luis Obispo County Behavioral Health Services, December 8, 2006

Maheu, Pulier, Wilhelm, McMenamin & Brown-Connolly. (2004). The mental health professional and the new technologies. Erlbaum, New York.

Marks, M. (2003). *For our health and safety: Joining forces to beat addiction* (Report #169). Sacramento, CA: "Little Hoover" Commission on California State Government Organization and Economy.

Mathiesen, S. (2008). *Co-occurring Disorders Module.* The Mental Health Curriculum Modules disseminated by Loma Linda University on behalf of California Social Work Education Center.

McGovern, M. *Dual Diagnosis Capability in Addiction Treatment (DDCAT).* www.adp.ca.gov/COD/pdf/DDCAT_Manual.pdf

McGovern, M.P., Matzkin, A.L., Giard, J. (2007). *Assessing the Dual Diagnosis Capability of Addiction Treatment Services: The Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index.* Journal of Dual Diagnosis, vol. 3(2).

Mental Health America of Los Angeles. (2009). *MHA Village.* www.mahala.org/mha-village.htm.

Mental Health Services Oversight and Accountability Commission. (2008). *Mental Health Services Oversight and Accountability Commission Report on Co-occurring Disorders, Transforming the Mental Health System through Integration.* Revision 5.0.

Minkoff, K, Cline, C. (2004). Changing the World: The Design and Implementation of Comprehensive Continuous Integrated Systems of Care for Individuals with Co-occurring Disorders, Psychiatric Clinics of North America, 27(4):727-43 © 2004.

Minkoff, K. (2007). *Dual Diagnosis: An Integrated Model for the Treatment of people with co-occurring psychiatric and substance disorders.* Presentation to San Luis Obispo County Behavioral Health Services, September 28, 2007.

Mock, M. (1999). *Cultural Competency: Acts of justice in community mental health.* Berkeley, CA.

Mueser, K. & MacKain, S. (2005). *Illness Management and Recovery,* The National GAINS Center for Systemic Change for Justice Involved People with Mental Illness.

Mueser, K.T. & Noordsy, D.L. (1996). *Group Treatment for Dually Diagnosed Clients.* In Drake, R.E. & Mueser, K.T. Dual Diagnosis of Major Mental Illness and Substance Disorder, Part 2. Jossey-Bass: San Francisco.

Mueser, K.T., Corrigan, P.W., Hilton, D.W., Tanzman, B., Schaub, A., Singerich, S., Essock, S.M., Tarrier, N., Morey, B., Vogel-Scibila, S., & Herz, M.L. (2003). *Illness Management and Recovery: A Review of the Research.* Psychiatric Services, vol. 53(10).

Mueser, K.T., Meyer, P.S., Penn, D.L., Clancy, R., Clancy, D.M., & Salyers, M.P. (2006). *The Illness Management and Recovery Program: Rationale, Development, and Preliminary Findings,* Schizophrenic Bulletin, vol. 32, pps. S32-S43.

Najavits, L.M. 2002. *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*. New York: Guilford Press, 2002.

National Institute of Corrections (2014). "Dosage Probation: Rethinking the Structure of Probation Sentences."

National Institute on Drug Abuse, Principles of Drug Abuse Treatment for Criminal Justice Populations, NIH Publication No. 06-53106, July 2006, p. 25.

National Institute on Drug Abuse. (1999). NIDA Community Drug Alert Bulletin – Methamphet-amine. NIH. (http://165.112.78.61/MethAlert/MethAlert.html).

National Institute on Drug Abuse. (2008). *Comorbidity: Addiction and other Mental Illnesses.* NIH Publication No. 08-5771.

North Carolina Practice Improvement Collaborative. *Integrated Dual Disorders Treatment (IDDT).* Mental Health Bulletin #2, www.ncpic.net

O'Brien, J. (2005). *Financing Options for Co-occurring Services.* Presentation to COSIG Leadership Workgroup, January 6, 2005.

O'Donnell, E. (2008). *Cops and the Mentally Ill.* Newsweek, July 31, 2008.

Office of National Drug Control Policy, *National Drug Control Strategy, 2010, Data Supplement, Table 1,* Washington, D.C.

Pierce-Danford, K. & Guervara, M. (2013). "Creating an Effective Pre-Trial Program: A Toolkit for Practitioners." Crime and Justice Institute.

Rawson, R.A.; P. Marinelli-Casey, M.D. Anglin, A.Dickow, Y. Frazier, C. Gallagher, G.P. Galloway, J. Herrell,A. Huber, M.J. McCann, J. Obert, S. Pennell, C. Reiber,D. Vandersloot, J. Zweben, and the Methamphetamine Treatment Project corporate authors. (2004). A Multi-Site Comparison of Psychosocial Approaches for the Treatment of Methamphetamine Dependence. *Addiction* 99: 708–717.

Sensky, T., Turkington, D., Kingdon, D., & Scott., J. A Randomized Controlled Trail of Cognitive-Behavioral Therapy for Persistent Symptoms in Schizophrenia Resistant to Medication. JAMA Psychiatry. February 1, 2000, Vol 57, No.2.

Smith, L., Nathan, P., Juniper, U., Kinsep, P., & Lim, L. (2003) *Cognitive Behavioural Therapy for Psychotic Symptoms: A Therapist's Manual.* Perth, Australia: Centre for Clinical Interventions

Substance Abuse and Mental Health Services Administration (2015). Using Technology-Based Therapeutic Tools in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 60. HHS Publication No. (SMA) 15-4924. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

Substance Abuse and Mental Health Services Administration (2009), Office of Applied Studies, Treatment Episode Data Set, California, 2009, http://wwwdasis.samhsa.gov/webt/quicklink/CA09.htm

Substance Abuse and Mental Health Services Administration (2009). *Illness Management and Recovery: Getting Started with Evidence Based Practices.* HHS Pub. No. SMA-09-4462. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Substance Abuse and Mental Health Services Administration (2010). *The N-SSATS Report: Mental Health Screenings and Trauma-related Counseling in Substance Abuse Treatment Facilities.* Rockville, MD.

Substance Abuse and Mental Health Services Administration. (2002). *Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders*. Rockville, MD: SAMHSA, U.S. Department of Health and Human Services.

Substance Abuse and Mental Health Services Administration. (1998). *CSAT government performance and results act client outcomes measure*. Rockville, MD: SAMHSA.

Substance Abuse and Mental Health Services Administration. (2003). *Co-occurring Disorders: Integrated Dual Disorders Treatment Implementation Resource Kit.*

Substance Abuse and Mental Health Services Administration. (2008). *California: States in Brief.* Rockville, MD: SAMHSA, U.S. Department of Health and Human Services.

The Addiction Technology Transfer Network, Southern Coast Addiction Technology Center/Florida, Compendium of Evidence-based practices for Substance Abuse Treatment, SAMHSA, February 2008.

U.S. Department of Health and Human Services (2001). *Mental health: culture, race, and ethnicity: A report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

U.S. Department of Health and Human Services (2003). *Co-occurring disorders: Integrated dual disorders treatment.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

Veterans Affairs. (2014). *Veteran Population: Population Tables: Counties.* United States Department of Veterans Affairs. http://www.va.gov/vetdata/Veteran_Population.asp.

"Veterans Health Administration, Funding Availability Under Supportive Services for Veteran Families Program." 76 Fed. Reg. 9 (January 14, 2014), pp. 2535-2543.

Volkow, N., & Li, T. K. (in press). Pharmacological therapy. *Neuroscience.*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