Los Angeles County

DMC-ODS

Drug Medi-Cal Organized Delivery System

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Version 10.0

Substance Use Disorder Treatment Services

PROVIDER MANUAL

SAPC | Substance Abuse Prevention and Control

County of Los Angeles Public Health

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Note: Given the continual evolution of the field of addiction treatment, the Provider Manual is a living document that will evolve with the availability of new information and research, changes in policy, regulatory mandates, and/or contractual agreements. As a result, this document is subject to ongoing review and revision at the discretion of the County.

Section 1. MODERNIZING SUBSTANCE USE DISORDER TREATMENT

Transforming the Treatment System of Care

California's Drug Medi-Cal Organized Delivery System (DMC-ODS) transformation, coupled with further system advancements for physical health, mental health, and substance use disorder (SUD) services under California Advancing and Innovating Medi-Cal (CalAIM), provides for a more robust and effective system of care for individuals enrolled or eligible for Medi-Cal, select County-funded programs, as well as other eligible safety net populations.

Additionally, it offers an opportunity for the County to achieve the following:

- Establishing a single benefit package for publicly funded SUD services regardless of referral source or insurance plan;
- Providing the right service, at the right time, in the right setting, for the right duration;
- Raising SUD quality standards to improve health outcomes;
- Integrating physical and mental health service needs with SUD services; and
- Emphasizing SUD's status as a chronic health condition rather than as an acute condition.

These enhancements enable SUD clients to receive quality services tailored to their individualized needs and preferences, thereby improving health and social outcomes.

The Los Angeles (LA) County Department of Public Health (DPH), Substance Abuse and Prevention Control Bureau's (SAPC) Substance Use Disorder Treatment Services Provider Manual, along with other Federal, State, and local regulations[1], govern the delivery of SUD treatment services in LA County. The Provider Manual is specifically designed for use by all administrative and direct service staff to ensure an understanding of the SUD system of care's core values. Additionally, it outlines the clinical and business expectations to ensure quality and outcome-based service delivery.

SUDs as a Chronic Disease

SUDs are often chronic, relapsing brain conditions that cause compulsive substance seeking and use, despite harmful consequences to individuals and their social network[2]. A chronic disease, such as cancer, diabetes, or heart disease, cannot be easily or simply cured, but instead need to be treated, managed, and monitored over time. For example, while an ear infection is considered an acute or episodic condition that requires a fixed period of treatment to obtain a cure, SUDs generally require treatment and management over a much longer period and, at times, throughout a lifetime. While some individuals may develop an SUD and achieve recovery after minimal intervention over a brief period, most will exhibit a more chronic and relapsing course.

[1] 42 CFR Part 2 - Confidentiality of SUD Client Records; 42 CFR Part 438 - Managed Care; Health Insurance Portability and Accountability Act (HIPAA); Title 9 CCR Chapter 8 - Certification of Alcohol and Other Drug Counselors; Title 22 CCR § 51341.1 - DMC SUD Services; DMC-ODS Special Terms and Conditions (STCs); State-County Intergovernmental Agreement; DHCS Behavioral Health Information Notices (BHINs); DHCS's Substance Use Disorder Perinatal Practice Guidelines (August 2024); DHCS's Adolescent Substance Use Disorder Best Practices Guide (October 2020); START-ODS Implementation Plan and Finance and Rates Plan; and the DPH SAPC Contract including but not limited to the Specific Services to be Provided, Information Notices (INs) and Bulletins.

[2] American Psychiatric Association. (2022). Diagnostic and Statistical Manual of Mental Disorders (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787.

The chronic nature of SUDs frames the approach necessary to treat these conditions effectively. Chronic conditions need to be managed via a model of care that offers a continuum of services tailored to an individual's needs at that point in time. As an individual advances along their recovery journey, the type and intensity of treatment services they receive should change and reflect the severity and nature of the client's SUD. This approach highlights the importance of care coordination and access to a full continuum of care that is best tailored to meet client needs. As a result, a key goal of SUD treatment is to provide the right service, at the right time, in the right setting, for the right duration.

Wagner's "Chronic Care Model" identifies a healthcare system's essential elements that encourage high-quality chronic disease care. Effective care of chronic conditions, such as SUDs, is characterized by collaboration with engaged clients, their families and caregivers, and a skilled team of service providers, including counselors and other health professionals. Chronic care systems:

- Create a culture of and mechanisms for providing safe, high-quality care.
- Deliver effective, efficient clinical care and self-management support.
- Promote clinical care that is consistent with scientific evidence and client preferences.
- Organize client and population data to facilitate efficient and effective care.
- Empower and prepare clients to manage their health and healthcare.
- Mobilize community resources to meet the needs of clients.

Defining Client-Centered Care

Treatment retention is crucial for success in SUD care, given that an individual cannot benefit from treatment if they do not participate in it. Furthermore, one critical component of engaging SUD clients in treatment is the ability to deliver client-centered care that eliminates unneeded barriers to enrolling and retaining clients.

Client-centered care is a collaborative approach to SUD service delivery that emphasizes respect for the client and is responsive to an individual's preferences, needs, well-being, and values. Client-centered care does not mean always doing exactly what the client wants. There will be instances when clinical judgment is in the client's best interest yet does not align with every client's asks. However, providers should consider client preferences and values throughout the decision-making process.

Client-centered care requires flexibility from both the providers and the program delivering the services. By cultivating an environment in which clients' individualized needs are prioritized in all aspects of care delivery, SUD programs are better able to engage their clients and better positioned to deliver high-quality care.

Ensuring a Standard Quality of Service

The specialty SUD system is a core component of the more extensive healthcare system. As such, it needs to maintain minimum standards and expectations to ensure high-quality services for the client population served. Similar to managing other chronic conditions, these minimum standards for SUDs ensure a reasonable degree of consistency across provider agencies, while allowing for sufficient flexibility to deliver services tailored to the client's individualized needs. For example, an individual with diabetes may receive slightly different services depending on the provider (i.e., recommendations about dietary/lifestyle changes). Still, certain best practices and clinical standards guide the treatment and management approach.

Similarly, SUD services need to be guided by best practices and clinical standards, including Evidence-Based Practices (EBPs) such as Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT). Standards-based care and individualized care are not mutually exclusive. Provider agencies can offer individualized, client-centered care that meets certain minimum best practices and clinical standards.

Integration and Coordination of Care

A key goal of the specialty SUD system is to better integrate SUD care into healthcare and social service systems and vice versa to better serve the comprehensive needs of its client population. In addition, the specialty SUD system needs to be better organized and coordinated so that clients can effectively access the entire continuum of SUD services and the Level of Care (LOC) available to them.

Integrated care is the routine and systematic coordination of health services to comprehensively and cohesively address clients' various needs. An example of care integration is an SUD program that combines primary care and mental health services, all housed within the SUD treatment facility, to address clients with multiple healthcare needs in one location. Integrating social services, such as housing assistance, is also important. Integrated care should make it easier for clients to receive the care they need by positioning health services in a way that makes them more accessible.

Care Coordination is the deliberate organization of client care activities and the sharing of information among care providers to ensure the needs of clients are addressed comprehensively and across all their areas of need. Care Coordination needs to be client-centered and driven by a combination of client needs and preferences. It should also be based on clinical judgment, so the information being shared and the care being coordinated are in the client's best interests. The primary goal of Care Coordination is to ensure that while multiple health and social service providers may be involved in an individual's care, the services (as listed in Table 1) are organized and coordinated to collectively provide timely, comprehensive, appropriate, and effective care to the client.

Table 1: Examples of Care Coordination Activities

Assessing client needs and goals
Creating a proactive care plan
Monitoring and follow-up, including responding to changes in client needs
Helping with transitions of care
Supporting client self-management goals
Linking to community resources
Working to align resources with client and population needs
Communicating/sharing knowledge
Establishing accountability and agreeing on responsibility

In summary, both integrated and coordinated care can improve client and provider outcomes.

Section 2. CLIENT SERVICE STANDARDS

Substance Use Disorder Benefit Package

LA County's SUD Benefit Package includes:

- Early Intervention
- Outpatient (OP)
- Residential
- Withdrawal Management (WM)
- Addiction Medication Services (also known as Medications for Addiction Treatment [MAT] Services)
- Opioid Treatment Program (OTP)
- Recovery Services (RS)
- Recovery Bridge Housing (RBH)
- Recovery Housing (RH)

Services are free of charge to fully covered members and eligible individuals. This comprehensive continuum of care effectively addresses each unique individual's treatment and recovery needs. Further, provider agencies assist clients in transitioning between LOCs as medically necessary to provide care in the least restrictive environment.

Eligibility Determination and Establishing Benefits

Covered Members and Eligible Individuals

The LA County specialty SUD system is available to the safety net population, specifically individuals who are:

- Residents of LA County; **and**
- Medi-Cal enrolled or in the process of enrollment due to presumed eligibility, including those transferring benefits from another County; **or**
- Uninsured individuals who are ineligible for Medi-Cal but meet its income requirements; or
- Individuals eligible for other State and County programs, specifically:
    - Assembly Bill (AB) 109 (including Proposition 47 and Proposition 57)
    - Drug Court
    - Recovery Support Court (RSC, formerly Family Dependency Drug Court or FDDC)
    - General Relief (GR)
    - California Work Opportunity and Responsibility to Kids (CalWORKs)
    - Juvenile Justice Crime Prevention Act (JJCPA) program
    - California Department of Health Care Services (DHCS) Women and Children's Residential Treatment Services (WCRTS) – for pregnant and/or parenting women (PPW) residential service providers and clients only

Note: Clients need to be eligible for or enrolled in Medi-Cal, or be covered under other county funding noted above, to receive SUD services in LA County. On January 1, 2024, the State of California expanded Medi-Cal to all ages regardless of immigration status. Provider agencies need to enroll all eligible individuals in Medi-Cal to ensure continued coverage for health services.

County of Responsibility and Residence

Services are only eligible for reimbursement if they are delivered to individuals whose County of Residence or County of Responsibility is LA County, and who are treated at a contracted provider agency site.

In accordance with State policy, LA County's SUD Benefit Package follows a County of Residence model of service delivery. This means that individuals need to reside in LA County, and the DHCS Medi-Cal Eligibility Data System (MEDS) file, which is sent to SAPC by DHCS and updated monthly, needs to show LA County as either the County of Residence or County of Responsibility to receive services. This includes individuals who currently live in LA County and are able to transfer their Medi-Cal benefits from another county.

There are instances where a member may have LA County listed as the County of Responsibility (County 19), but another county as County of Residence. As outlined in BHIN 24-001 and BHIN 24-008, claims will be approved as long as either the County of Residence or the County of Responsibility is LA County. This provides greater flexibility in situations such as inter-county transfers (ICTs) and other specific exceptions, including temporary moves.

If a new referral or existing member does not reside in LA County and does not intend to move, they need to be referred to a provider in their County of Residence, unless the member is an out-of-county foster youth referred for treatment or being released from jail, prison, or youth correctional facility. In all other instances, the Provider Agency needs to share the appropriate county's contact information, see www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx.

Provider Agencies should follow the eligibility determination procedures listed in **Table 2** or the ICT process shown in **Figure 1** to identify the County of Residence and/or Responsibility.

Note: The County of Residency / County of Responsibility rule does not apply to Narcotic Treatment Program (NTP) dosing, individual and group counseling services (H0004, H0005, H0020, S5000, and S5001) if these service codes are claimed with modifiers UA (ASAM OTP/NTP) and HG (OTP) (DMC-ODS-Billing-Manual-v-2-0.pdf (ca.gov).

Provider agencies that intend to deliver services to non-County residents need to contract with the County where those members reside to be reimbursed.

Out-of-County Treatment Facilities

Provider agencies that operate a DMC-certified site in an adjacent county (e.g., Kern, Orange, San Bernardino, Ventura) may apply to add those location(s) to their SAPC contract. In most cases, locations in non-adjacent counties will not be approved unless there are significant service gaps that cannot be filled within the county. This Provider Manual and other contract requirements still apply to out-of-county contracted sites.

Opioid Treatment Programs Courtesy Dosing

SAPC allows reimbursement for courtesy dosing of methadone and buprenorphine for up to 30 days for Medi-Cal members who are temporarily in LA County for business or leisure travel. This applies when individuals do not qualify for, or are unable to bring, enough take-home doses to cover the entire duration of their trip. To provide courtesy dosing, Provider agencies need to obtain a courtesy dosing order from the individual's home OTP clinic. This order need to be:

- Signed by the medical director or program physician
- Include the dose, duration, and any special instructions (such as take-home doses)

To receive reimbursement, provider agencies need to complete the Courtesy Dosing Reimbursement Form and submit it securely to SAPC at SAPC-Finance@ph.lacounty.gov with the subject line "Courtesy Dosing". This form needs to include the individual's full name, date of birth, Social Security Number (SSN), Medi-Cal Client Index Number (CIN), County/State of residence, home clinic, dates of service, medication type, Healthcare Common Procedure Coding System (HCPCS), amount billed, and the reason for courtesy dosing. Individuals who receive courtesy doses are not entered in Sage and no additional data collection is required. Claims need to be submitted after the final dose is administered or dispensed to the individual.

Eligibility Determination Process

Before providing services, provider agencies need to verify that the individual is eligible for LA County's SUD Benefit Package and should follow the steps outlined in **Table 2**.

Table 2: Eligibility Requirements for Specialty SUD Services in LA County

	Eligibility Requirement	Source of Verification
Step 1	**Resident of LA County**	**Proof of residence** (e.g., identification card, utility bill, etc.)
Step 2	**Medi-Cal or County Program Eligibility** Need to meet at least one (1) of the following: • Medi-Cal enrolled or in the process of enrollment due to presumed eligibility, including those transferring benefits from another county; **or** • Medi-Cal ineligible but meets income requirements; **or** • Clients in programs listed under the *Covered Members and Eligible Individuals* section.	• Utilize the 270/271 real-time Medi-Cal Eligibility Verification process in Sage, to verify Medi-Cal status through the State system. This process automatically updates the Financial Eligibility status in Sage if the member is enrolled in Medi-Cal. • Medi-Cal application submitted or Medi-Cal verification via Automated Eligibility Verification System (AEVS) file or MEDSLITE. • Once Medi-Cal is active, update the Financial Eligibility Form in Sage with the client's Medi-Cal Eligibility Data System Identification Number (MEDS ID), policy number, and coverage effective date. • Participation in other qualified County-funded programs/projects.
Step 3	**Meet medical necessity criteria to initiate specialty non-residential SUD services** (see *Determining Medical Necessity* section).	• Services are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain (California WIC § 14059.5(a)). • For OTPs, a history and physical exam conducted by a Licensed Practitioner of the Healing Arts (LPHA) at admission, pursuant to Federal and State regulations, qualify for the determination of medical necessity.

	Eligibility Requirement	Source of Verification
Step 4	**Meets medical necessity access criteria for specialty SUD services** (see *Determining Medical Necessity* section).	**ADULTS (AGE 21 AND OVER)** • Complete an American Society of Addiction Medicine (ASAM) CONTINUUM™ assessment* for non-WM, non-recovery service LOCs within the timeframes outlined in **Table 4**; **and** • Document clinical justification for WM through the ASAM CONTINUUM™ Assessment or through directly documenting the client's withdrawal features, during the WM episode. • Need to meet criteria for at least one (1) diagnosis from the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, except for Tobacco-Related Disorders and Non-Substance-Related Disorders; **or** • Meet criteria for at least one (1) diagnosis from the current DSM for Substance-Related Disorders and Non-Substance-Related Disorders prior to being incarcerated or during incarceration, as determined by substance use history. **YOUTH (AGE 17 AND UNDER) AND YOUNG ADULTS (AGE 18-20)** • Youth (age 17 and under): Complete the Assessment Tool - Youth (Paper Version) found on the SAPC website, which serves as the youth ASAM assessment*, is required; Parental consent is not required for services delivered to youth age 12 and over, but is required for services delivered to youth age 11 and under. • Young Adults (age 18-20): Complete the ASAM CONTINUUM™ Assessment* within the timeframes outlined in **Table 4**; and Meet criteria for the DSM criteria specified for Adults (age 21 and over). • For Youth and Young Adults being admitted to early intervention services, meet Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) criteria to ameliorate or correct a substance misuse-related condition and submit a completed ASAM screener for Youth and Young Adults within the specified timeframes. Services need not be curative or completely restorative to ameliorate a substance use condition, including substance misuse and SUDs. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services. For additional information, see *Definition of Early Intervention Services for Youth and Young Adults* section.

*Admission to WM services does not require a full ASAM assessment. RS requires the completion of ASAM CO-Triage® Tool for Adults (age 21 and over) or ASAM Screener for Youth (age 17 and under) and Young Adults (age 18-20).

Note: Provider agencies need to use the 270/271 process to determine a client's Medi-Cal eligibility before admission or authorization for services. Failure to do so may result in non-payment for claims submitted or services rendered to clients under the 30-day policy.

The Real-Time Inquiry (270) Request Form in Sage allows provider agencies to request Medi-Cal eligibility directly from DHCS in real-time. Once submitted, provider agencies will receive an immediate response via the 271 file to determine a client's current or previous Medi-Cal eligibility status.

The 271 results will display the County of Responsibility code, gender, date of birth, and Primary Aid Code that is updated as of the date the 270 is run. However, the 271 does not contain the County of Residence code. If the County of Responsibility shown is not LA County (19), this may result in needing to file for an ICT and provider agencies will need to determine if the client's County of Residence is LA County (19) by using BenefitsCal. If there are additional questions after using BenefitsCal, provider agencies may also contact SAPC to verify the information using the MEDS/MEDSLITE systems. For assistance, email SAPC-EST@ph.lacounty.gov and ensure that Protected Health Information (PHI) is not included in the email message.

After the 271 results are posted in Sage, the aid code and eligibility information will be updated in the MEDS file and the Financial Eligibility forms to reflect the most current data. provider agencies need to run the Real-Time Inquiry (270) Request on a monthly basis to ensure Medi-Cal eligibility remains current in SAPC's system. For guidance on how to interpret the 271 eligibility results, visit the Sage - Other Training Resources webpage on SAPC's website.

It is the provider agencies responsibility to assist clients in maintaining their Medi-Cal benefits if they remain eligible by using the Care Coordination benefit. If a client becomes no longer eligible for Medi-Cal while in treatment, and the treatment duration extends beyond the end of the month in which the termination occurred (as services would continue to be reimbursable by DMC during this period), the following should occur:

1. Determine if the client is eligible for programs listed under the *Covered Members and Eligible Individuals* section:

2. If YES – client's treatment would be moved to the secondary funding source; this would apply to any LOC listed in the most current version of the SAPC IN for the Rates and Standards Matrix.

    a. If NO – continued SAPC payment will depend on the LOC:

        i. Residential (ASAM 3.1, 3.3, 3.5) – If the Provider Agency elects to continue providing services to the client beyond the service authorization period, it needs to be on a sliding-scale basis with no financial participation by SAPC.

        ii. Outpatient (ASAM 0.5 Early Intervention Services, 1.0, 2.1) – SAPC ceases payment for services. In instances where the Provider Agency elects to continue providing services to the client, it needs to be on a sliding-scale basis. Medi-Cal eligible members may NOT be charged sliding-scale fees or flat fees.

        iii. Withdrawal Management (ASAM 1-WM, 2-WM, 3.2-WM, 3.7-WM, 4-WM) – Contact SAPC's Utilization Management Section (SAPC-UM), as this situation is very rare since the maximum duration is 14 days.

3. If the client remains in treatment, modify the Financial Eligibility and California Outcomes Measurement System (CalOMS)/Los Angeles County Participant Reporting System (LACPRS) data to reflect the funding source change.

Establishing and Transferring Benefits

Provider agencies must use the Care Coordination benefits to:

- Assist individuals to obtain Medi-Cal if qualified, if benefits are not active at the time of first contact. Provider agencies need to initiate the process on or before the date of the treatment service to better ensure reimbursement for delivered services.
- Assist LA County residents in transferring Medi-Cal benefits to LA County if assigned to another County on or before the date of the first treatment service. Reimbursement is denied for service claims for non-County residents.

Eligible clients cannot be denied services while their Medi-Cal enrollment is being established. Provider agencies may not charge sliding scale or flat fees for individuals eligible for Medi-Cal or other County-funded programs. For additional information, see *Applying for Medi-Cal* section.

Provider agencies also need to meet access to care requirements, which necessitates that the date of the first service or intake appointment occurs no later than ten (10) business days from the date of referral or screening for all LOCs except OTPs, which needs to occur no later than three (3) business days from the date of referral or screening for these individuals as well.

Medi-Cal Inter-County Transfers

When an individual resides in LA County, but their Medi-Cal benefits are assigned to another county, Provider agencies need to conduct the screening/assessment, and admit the member for medically necessary services while the ICT process is underway. **Members cannot be delayed or denied admission for eligible (i.e., Medi-Cal, AB 109) SUD treatment services due to an incomplete or pending application, or because their Medi-Cal benefits are assigned to another County.** As long as the individual has active Medi-Cal coverage, they are considered a Medi-Cal member, and the Sage Financial Eligibility form needs to list DMC as the primary guarantor at the time of admission.

When Medi-Cal members move to LA County and is seek treatment, the receiving Provider Agency needs to initiate care and concurrently begin the ICT process, as demonstrated in **Figure 1**:

Figure 1: Key Inter-County Transfer Steps

Option 1: Using BenefitsCal Website	Assist the client in creating a new account or signing into an existing account on the BenefitsCal website.
	Complete the MC382/383 form to allow the provider to become an authorized representative on behalf of the client, helping to facilitate further updates. Once completed, upload it into the client's BenefitsCal account and the client chart.
	Link the client's case from the originating county to LA County. Medi-Cal benefits will show as pending in LA County. It will become active once the County of Responsibility has transferred.
	After completing the updated residence in BenefitsCal, download or print the resulting Change Report Summary (CRS) and upload it to the client's chart in Sage. SAPC-UM will honor the CRS effective date as meeting funding requirements when approving the Member Service Authorization Request (SAR).
Option 2: Working with DPSS	Contact the local LA County Department of Public Social Services (DPSS) office and report the change of residence.
	Call the DPSS Customer Service ICT Hotline at (866) 613-3777. Press 1 for English; after the recording, press 5 for Disability Accommodation and Other Hotlines; then press 3 for Benefits Transfer Request.
	Notify the DPSS Eligibility Worker (EW) that your client needs to transfer their existing DPSS case from the originating county to LA County.
	A Notice of Action (NOA) confirming the county transfer and effective date will be mailed to the client.
	Upload the NOA to the client's chart, as SAPC-UM will use the effective date to authorize treatment.
	While not recommended, the client may also contact DPSS in person via phone. Please note that this method may initiate a transfer of both County Responsibility and Residence, which can take one (1) to three (3) months to transfer to LA County and will not be retroactive to the request date.
Provider Agency	Complete a Care Coordination Progress Note in the client's chart for all actions taken to support the ICT process.
	After one (1) to three (3) weeks, contact DPH-SAPC-EST@ph.lacounty.gov to confirm the transfer of residence or wait until AEVS provides confirmation that the County of Responsibility is LA County.
	Submit SAR using the effective date on the NOA or CRS or with confirmation of County of Residence 19 in MEDS or MEDSLITE.
	Select DMC as Guarantor in the Financial Eligibility form to reflect the effective date found on the NOA/CRS, the date found on the client's Medi-Cal card, or the Issue Date indicated in MEDSLITE.
	During the time the transfer of residence is being processed, the provider may utilize any non-DMC funding found in the Other Funding Programs in the CalOMS that the client qualifies for. In that case, select non-DMC as the guarantor and bill accordingly. Once the County of Residence is transferred to County 19 and all claims to the non-DMC funding source have been submitted, change the guarantor to DMC.If not other funding sources, continue with DMC as guarantor.
	To access the AEVS, submit the following forms and register for the provider portal: • Form: Medi-Cal Eligibility Verification Enrollment Form (point frms) • Form: Medi-Cal Point of Service (POS) Network/Internet Agreement (point frm 1 net)

Disclaimer: SAPC is not responsible for, nor does it have control over, changes to eligibility within the DPSS system or any discrepancies between DPSS and the SAPC MEDS file, including the effective dates listed on an NOA or the CRS. These inconsistencies may result in billing denials. If you receive an eligibility-related denial, submit a Sage Help Desk ticket for troubleshooting and support, and/or contact DPSS directly to verify eligibility status. Medi-Cal eligibility verification is only valid on the date it is viewed in AEVS or when eligibility information is confirmed through MEDS or MEDSLITE. If a Member SAR is submitted in the following month, eligibility data in these systems may not align due to system inconsistencies.

In some cases, Medi-Cal members may become incarcerated while their benefits are active. Per DHCS Letter No. 22-26, Medi-Cal benefits are placed in suspension after 28 consecutive days of incarceration. Upon release, the member's release date may not be automatically updated in the DPSS electronic system. As a result, AEVS may continue to indicate that the member is incarcerated. To restore benefits, the member needs to contact DPSS to ensure their release date and suspend end date are accurately entered into the system. Once this information is updated, Medi-Cal benefits will be reinstated effective the date of release, allowing the member to receive Medi-Cal billable services upon admission to a provider agency.

For additional information, see DHCS's Definitions of Incarceration Date, Release Date, Suspend Date, and Suspend End Dates Table.

Applying for Medi-Cal

As outlined in SAPC IN 23-01, the Applying for a Medi-Cal benefit allows provider agencies to receive reimbursement in advance for eligible clients who are in the process of applying for Medi-Cal. This supports the requirement that provider agencies do not deny admission or services to individuals who are presumed to meet the Medi-Cal eligibility criteria.

To support timely access to care, **SAPC reimburses provider agencies for up to 30 calendar days of treatment services** after admission, assessment, submission of the 270 Eligibility Form, authorization, and CalOMS/LACPRS completion for clients who appear to meet Medi-Cal eligibility criteria and have submitted the Medi-Cal application with a CIN assigned, **but** whose application was not processed by the 30th day or was ultimately denied by the State. Only one (1) 30-day reimbursement is available per client (regardless of agency or LOC) per Fiscal Year (FY) system-wide. This does not apply to clients who lose Medi-Cal during a treatment episode and submit a new application.

When using this benefit, provider agencies need to enter "Applying for Medi-Cal" as the primary guarantor in Sage on the Financial Eligibility form. This designation can only be used when the client does not have active Medi-Cal at the time of admission and cannot be used to indicate an ICT.

If Medi-Cal benefits are approved, SUD treatment services are reimbursable starting from the first day of the month in which the Medi-Cal benefit is activated. In some cases, eligibility may be granted retroactively and cover several prior months of service. To avoid delays in coverage and reimbursement, it is important to begin the Medi-Cal application process as close to the first date of service as possible. It is also critical that:

- Clients may step up or step down to a different LOC whenever clinically appropriate, with documentation of medical necessity (e.g., from WM to OP). This not only supports sustained recovery but also allows more time to secure Medi-Cal benefits; **and**
- When there is a change in LOC, the initial care coordinator communicates the status of the client's benefits application to the new care coordinator. The initial Provider Agency will rely on the subsequent provider agency to help the client complete any remaining paperwork to ensure both parties can be reimbursed once the application is approved.

Table 3: Financial Eligibility Form Process for Medi-Cal Eligible

Status	Financial Eligibility	Financial Eligibility Form	Authorization Process	Claiming Information
Medi-Cal Eligible or Enrolled:	When applying for Medi-Cal (i.e., Medi-Cal is pending).	Select: 1. **"Applying for Medi-Cal"** as primary guarantor; and 2. **"LA County - Non-DMC"** as secondary guarantor.	Authorizations will be granted for no more than 30 days.	Submit claims for services provided up to the 30th day of treatment.
	Once approved for Medi-Cal	1. Update **"Applying for Medi-Cal"** to **"California Department of Alcohol and Drug"** for the primary guarantor. 2. Make sure **"LA County - Non-DMC"** is selected as a secondary guarantor.	Once a client is approved for Medi-Cal, the provider should submit a new Authorization with a start date of the 31st day of treatment through the end of the regular authorization period for the requested service type.	Once Medi-Cal has been approved and the Financial Eligibility Form has been updated, submit claims following the usual process.
	If a client has been denied Medi-Cal but is eligible for programs listed under *Covered Members and Eligible Individuals* section.	1. Delete **"Applying for Medi-Cal"** as the primary guarantor. 2. Update the primary guarantor to **"LA County - Non-DMC"**. *Ensure that all payor sources a client qualifies for are identified and updated on their CalOMS.*	Authorizations will be granted for the full period of time for the type of service being requested within the eligibility period.	Once Medi-Cal has been denied, and the Financial Eligibility Form has been updated, submit claims following the usual process.

Definitions of Eligible Plans

Medi-Cal Managed Care

Medi-Cal Managed Care Plans (MCPs) in LA County include LA Care Health Plan (and its delegated partners: Anthem Blue Cross and Blue Shield Promise), Health Net Community Solutions (and its delegated partner: Molina Healthcare), and Kaiser Foundation Health Plan. Other Medi-Cal specialty health plans serve specific populations, such as Positive Health Care California (for individuals with Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome [HIV/AIDS]) and SCAN Health Plan (a Medicare Advantage plan for seniors).

Most Medi-Cal members are required to enroll in an MCP. A complete list of LA County Medi-Cal Managed Care Health Plans is available on the DHCS Health Plan Directory website. Medi-Cal members who present a member card from any of these plans are entitled to receive LA County's SUD Benefit Package. Treating Provider Agencies are responsible for coordinating care, as appropriate, with the member's Health Plan and/or primary care physician.

Note: Some MCPs, such as Kaiser and Anthem Blue Cross, offer both private commercial and Medi-Cal plans. Clients cannot be turned away based solely on the name of their health plan. Staff need to always verify Medi-Cal eligibility before determining coverage.

Medi-Cal and Medicare: "Medi-Medi"

Individuals who are dually eligible for Medi-Cal and Medicare, often referred to as "Medi-Medi" members, are entitled to the full DMC benefit package, including any County-specific supplemental services such as RBH.

Medicare generally does not cover most SUD services, and in most cases, providers are not required to bill Medicare first. However, there are specific exceptions:

- **OTP:** As of January 1, 2020, OTP provider agencies need to be enrolled in Medicare, as Medicare will be the payor of first resort for OTP services. For additional information, see SAPC Bulletin 20-01.
- **Intensive Outpatient (IOP):** As of January 1, 2024, Medicare Part B covers IOP services. Medicare is the payor of first resort for IOP services for Medi-Medi clients. For additional information regarding the final rule expanding Medicare to include IOP services, see Federal Register, Vol. 88.
- **All Other LOCs:** Medicare Part C (Medicare Advantage) needs to be billed as Other Health Coverage (OHC) prior to billing Medi-Cal. Provider Agencies may not collect any Medicare-related share-of-cost from the client prior to delivering services.

Medi-Cal and Private Insurance

If an individual has private insurance (e.g., employer-sponsored, small group, or individual commercial insurance) and is enrolled in Medi-Cal, the private insurance (OHC) coverage needs to be fully utilized before Medi-Cal coverage can be accessed. Medi-Cal is the payor of last resort.

Medi-Cal and Share-of-Cost

Some Medi-Cal members are required to contribute to the cost of their treatment through a share-of-cost. These individuals need to pay out of pocket until their monthly share-of-cost (deductible) is met. This "spend down" clears the client's share-of-cost liability. Once the share-of-cost is met, the client becomes eligible to receive Medi-Cal-covered services for the remainder of that month.

As a reminder, health plans often have commercial and Medi-Cal lines of business. It is possible that a well-known commercial plan (e.g., Kaiser, Anthem) covers members who are also eligible or enrolled in Medi-Cal. provider agencies need to serve all eligible or enrolled clients in Medi-Cal, including those enrolled in Medi-Cal through the health plans in LA County, including LA Care, Health Net, Kaiser, Anthem, Blue Shield, and Molina.

Non-Medi-Cal Eligible Clients

The specialty SUD system in LA County also serves individuals enrolled in County- and State-funded safety net programs. As a result, there may be instances where individuals who are not eligible for Medi-Cal, often due to income above Medi-Cal limits, seek treatment services through the SUD system.

Admission is permitted for individuals who participate in any of the programs listed under the *Covered Members and Eligible Individuals* section, even if they are not Medi-Cal eligible. These individuals are eligible to receive the full SUD benefit package at no cost, as long as their CalOMS admission data reflects participation in one (1) of the eligible programs.

SAPC does not provide reimbursement for services for individuals who have commercial insurance, are not eligible for Medi-Cal, and are not enrolled in one (1) of the programs listed under the *Covered Members and Eligible Individuals* section. In these cases, SUD providers may choose to serve the individual and may collect payment directly from the client using the Client Fee Determination Scale (sliding scale).

Note: Sliding scale fees or flat fees are not permitted for individuals with Medi-Cal or those enrolled in permitted County-funded programs.

Access to Care

Access to care includes both biopsychosocial and physical access to the locations where treatment services are provided. Barriers to access may prevent or delay individuals from receiving care. Common access barriers include:

- **Timely Access:** Delays in conducting the initial screening and assessment or placing prospective clients on unofficial waitlists instead of assisting with connections to another appropriate and available Provider Agency.
- **Physical:** Facilities that are not accessible to individuals with mobility limitations, such as buildings with stairs but no ramp or elevator.
- **Communication:** Lack of capabilities to engage with non-English monolinguals or those with Limited English Proficiency (LEP), hearing, or visually impaired people, or those who do not answer the phone lines during business hours as listed on the Service & Bed Availability Tool (SBAT).
- **Privacy:** Lack of soundproofing in counseling areas or insufficient privacy in assessment rooms.
- **Business Operation:** Staff attitudes that reflect stigma or bias, limited cultural or linguistic diversity among staff, restricted operating hours, or lack of opportunities for client feedback in treatment planning or program design.
- **Geographic:** Program locations that are inaccessible by public transportation, distant from where clients live or situated in areas where clients do not feel safe.

Provider agencies are expected to implement practices that address and reduce the barriers outlined above, including minimizing geographic limitations, to improve access to care. These efforts must align with all applicable Federal, State, and local regulations. Importantly, access to medically necessary services, including all United States Food and Drug Administration (FDA) approved medications for opioid use disorder (OUD), cannot be denied for members who meet criteria for DMC-ODS services. Placing members on waitlists is strictly prohibited.

Access to care begins at the first point of contact. There are four (4) main ways individuals can enter LA County's specialty SUD system, with various resources to facilitate service access:

- Substance Abuse Service Helpline (SASH): Toll-free line at (844) 804-7500
- Connecting to Opportunities for Recovery and Engagement (CORE) Centers
- Client Engagement and Navigation Services (CENS)
- Direct-to-provider self-referrals

Resources to support referrals into the specialty SUD system include:

- **SBAT:** Web-based, filterable provider directory of specialty SUD services and bed availabilty contracted through SAPC. Visit SUDhelpLA.org.
- **RecoverLA:** Mobile-friendly platform offering information on available SUD services throughout LA County, including a mobile version of SBAT. Visit www.RecoverLA.org using a mobile browser for best performance.

Ensuring timely access and reducing barriers to care are fundamental priorities for the specialty SUD system. Provider agencies need to make every effort to reduce the time between the initial eligibility verification, clinical need determination, referral, and the first clinical encounter.

Service Connection Portals

LA County operates three (3) service connection portals to facilitate efficient entry into the SUD system of care:

1. **SASH:** SUD Counselors are available 24/7, 365 days a year to provide screening, assessment, and referrals for youth, adults, and collateral callers.
    a. Conduct the ASAM Screener for Youth (age 17 and under) and Young Adults (age 18-20), or the ASAM CO-Triage® Tool for Adults (age 21 and over), to determine an appropriate provisional LOC.
    b. Facilitate a successful referral and linkage to treatment.
    c. Language assistance and Teletype (TTY) services are available to callers at no cost.

    Note: SASH is now part of a centralized behavioral health call center that includes the Los Angeles County Department of Mental Health' (DMH) ACCESS Helpline. Callers can access either mental health or substance use service assistance by dialing (800) 854-7771. For substance use services, select option 2 after the language prompt. To ensure uninterrupted access to substance use services, the dedicated SASH phone number – (844) 804-7500 – will continue to be active and will automatically route to the centralized call center.

2. **CENS:** SUD Counselors are co-located at various County facilities, Permanent Supportive Housing (PSH), and area office sites during varying hours.
    a. Conduct the ASAM Screener for Youth (age 17 and under) and Young Adults (age 18-20), or the ASAM CO-Triage® Tool for Adults (age 21 and over), to determine an appropriate provisional LOC.
    b. Facilitate a successful referral and linkage to treatment.
    c. Additional services include outreach and engagement, eligibility determination and benefits enrollment, SUD educational sessions, service navigation, and referrals to ancillary supports.

3. **CORE Centers:** SUD Counselors are co-located within DPH Wellness Communities during varying hours (including evenings and weekends).
    a. Conduct the ASAM Screener for Youth (age 17 and under) and Young Adults (age 18-20), or the ASAM CO-Triage® Tool for Adults (age 21 and over), to determine an appropriate provisional LOC.
    b. Facilitate a successful referral and linkage to treatment.

c. Provide SUD prevention education, wellness support, and harm reduction services such as naloxone training and distribution for individuals, youth, families, and those impacted by loved ones' use of alcohol and drugs.
d. For additional information, visit www.publichealth.lacounty.gov/sapc/public/corecenter/?lang=en.

Each of these portals follows standardized procedures for screening, referrals, and follow-up. Provider agencies are held to consistent expectations regardless of which portal the referral originated from.

Summary of Service Connection Portals Referral Process

Individuals may seek referrals by phone (SASH) or in-person (CENS/CORE). The following describes the key steps that occur during the service connection process:

1. Respond to the initial contact based on the type of service connection portal:
    a. For SASH and CORE, individuals initiate the call or visit; therefore, the process can begin immediately.
    b. For CENS, an external department/entity often requests the referral; therefore, an individual may be asked to report to the CENS location, or a phone/paper referral precedes the initial contact. The CENS staff make every attempt to contact the individual on the date of the referral. When this does not happen, staff notify the referring entity and provide the date of the screening and referral appointment. Individuals can also initiate a call or in-person visit with the CENS, and the process can also begin immediately.
2. Connect individuals to interpretation services during the call/interview, and verify accommodations upon referral, including those with sensory impairment.
3. Call 911 when an individual is having a medical, psychiatric, or other emergency and remain on the line or with the individual until emergency personnel have assumed responsibility for the call or arrive at the location.
4. Conduct eligibility and income verification to determine Medi-Cal eligibility and enrollment.
    a. If the individual is ineligible for Medi-Cal, determine whether they are financially eligible for treatment services through their participation in programs listed under the *Covered Members and Eligible Individuals* section; see **Table 2**.
5. Conduct the ASAM CO-Triage® Tool for Adults (age 21 and over) or the ASAM Screener for Youth (age 17 and under) and Young Adults (age 18-20).
    a. When an individual refuses referral, advise the prospective client about risk reduction measures such as needle exchange, overdose prevention, and other harm reduction strategies that may reduce negative consequences.
    b. If the screening results do not indicate a provisional LOC ("negative results") but there is reasonable suspicion that an individual might meet medical necessity for treatment services, SASH, CENS, and CORE can refer to a non-residential LOC setting that can initiate care and conduct an assessment during the engagement period prior to establishing medical necessity, as described in **Table 4**.
    c. For individuals who decline referral to treatment, alternative options (e.g., prevention, CENS Adult At-Risk [AAR] Services) need to be provided in the community or offered by the Medi-Cal MCP, if applicable.

6. Identify appropriate provider agencies using the online Provider Directory, known as the SBAT, and determine available beds/intake appointments. For Youth (age 17 and under), refer the individual to the most appropriate OP Youth SUD Treatment Provider. Individuals reporting opioid use within the past 30 days are also offered referrals to OTP/Addiction Medications (also known as MAT) sites in addition to any other LOC.
7. Assist with scheduling an appointment and/or providing contact information to comply with timely access standards as follows:
    a. Identify up to three (3) provider agencies based on individual preference or time and distance standards; see **Table 4**.
    b. Contact provider agencies with the individual on the phone or in-person to schedule the intake appointment date within ten (10) business days for all LOCs except for OTP, which is three (3) business days.
    c. If the recommended provisional LOC is unavailable after reasonable attempts have been made, a lower LOC may be used as needed in the interim.
    d. Individuals may also be offered an Out-of-Network (OON) provider if the identified LOC is unavailable within the network.
8. Document all encounters within the Service Connections Log in the Sage system.

Additional Responsibilities of the CENS and/or CORE Centers Only

1. Educate the individual on the benefits of signing a Release of Information (ROI) that includes each Provider Agency, not just the specific provider agency receiving the referral, for Care Coordination purposes, and obtain a signed release if agreed upon. Also, obtain an ROI with the referring and other applicable entities to allow communication for Care Coordination and reporting purposes, if necessary.
2. Provide ancillary service referrals for vocational rehabilitation, educational needs, housing, and other public social services when identified as a need.
3. Coordinate transportation as necessary to support the individual's ability to attend the appointment.
4. Conduct a reminder call in advance of the scheduled appointment and reschedule if requested by the individual.
5. Follow up with the selected provider agency to ensure documentation of whether the client did or did not attend the assessment appointment within the SUD Treatment Referral Tracking Form.
6. If an ROI is signed and as directed by SAPC, report back to the referring entity through relevant data entry systems on the status of the individual's connection to services.

Provider Agency Responsibilities for Service Connection Portals and Direct Referrals

Treatment agencies have the following responsibilities around referrals from SASH, CENS, CORE, and other provider agency referrals:

1. Update the SBAT on at least a daily basis to reflect the number of available beds and/or intake appointments and other required information.
2. Contact your SAPC Contract Program Auditor (CPA) to complete an SBAT survey within five (5) business days when updates need to be made to:
    a. Days;
    b. Hours of operation;
    c. Specialized expertise such as language capability or populations served; and
    d. New site locations.
    e. Respond timely to all service connection portals.
3. Provider agencies are required to ensure the phone number listed on the SBAT is answered at all times during normal business hours and times when intake appointments are conducted; see Hours of Operation section. This ensures that an appointment can be scheduled while the individual is on the line or at the screening interview, whenever possible.
    a. Voicemail and extensive prompt systems are not acceptable alternatives to an individual answering the phone.

For provider agency referrals to another treatment provider agency, the following outlines the requirements:

1. If there is no answer or the calls go straight to voicemail, staff can proceed to the next provider agency site that meets the individual's needs and preferences.
2. Ensure the capability to assess and admit clients who require language assistance services, and/or have sensory (visual/hearing) limitations, even if facility staff cannot perform this responsibility, and/or have mobility limitations, including the ability to accommodate service animals.
3. Limit additional screening questions to only allowable programmatic restrictions (e.g., arson or registered sexual offender status, tobacco use), refrain from duplicating questions from the ASAM CO-Triage® Tool for Adults (age 21 and over) or the ASAM Screener for Youth (age 17 and under) and Young Adults (age 18-20) to create a more client-friendly experience, and support efforts to limit total call-time to ten (10) minutes or less.
4. Schedule intake/assessment appointments within three (3) calendar days of the call, and subsequent immediate admission if medical necessity is established.
5. Conduct a reminder call in advance of the appointment and if the appointment is missed, whenever the individual provides a contact phone number.
6. Schedule an appointment with another appropriate provider agency after the in-person assessment if it indicates a different recommended LOC and:
    a. A bed/slot is not available within five (5) business days at an assessing provider agency site, or it does not offer that LOC; or
    b. A bed/slot is not geographically convenient to the individual or does not meet preference; and
    c. Using the SBAT tool, provide at least two (2) referral options whenever possible and contact the selected provider agency to schedule an appointment on behalf of the individual.

7. Use the Care Coordination benefit to assist enrolled clients to transition between treatment LOCs and successfully connect with the receiving provider agency. Management of these transitions is the responsibility of the referring treatment agency.
8. All providers making referrals to another provider agency NEED TO complete the Referral Connection Form documenting the client's appointment status, scheduled date, and time as applicable, full ASAM assessment status, admitted LOC if different from the provisional LOC, treatment admission details, and admission counselor's name.

Member Support

SAPC's Member Support team is available during normal business hours to assist clients in understanding their benefits and rights, as well as in submitting grievances or appeals. Member Support collaborates with providers to enhance the client experience at their sites, including providing technical assistance on how to effectively utilize client orientation videos and the member handbook. To contact the Member Support team, members can email MemberServices@ph.lacounty.gov at any time or call (888) 742-7900 and press 7, Monday through Friday, from 8:00 a.m. to 5:00 p.m.

Client Engagement and Navigation Services

Since many youth, young adults, and adults are referred for SUD treatment by State, county, city, or other government entities, ensuring successful connections for these multi-systems involved individuals is important. Often, prospective clients may require more hands-on assistance to maximize treatment admission and retention, as well as the likelihood of positive outcomes, including employment, income benefits, health benefits, housing, reunification with children, and satisfaction of probation requirements or pre-plea/post-plea diversion from the court system. CENS counselors are, at a minimum, State-registered or Certified SUD Counselors who serve as liaisons between individuals, their case workers, and the specialty SUD system. CENS counselors provide services, in-person or via phone, to facilitate access to and completion of SUD treatment.

CENS conducts various activities, including screening and referrals to SUD services, client education, Medi-Cal eligibility and enrollment assistance, and navigation services. In accordance with State guidance, BHIN 23-001, effective November 30, 2023, SAPC issued SAPC IN 23-13, directing the CENS providers to bill DMC for services provided to Medi-Cal members via their applicable DMC-ODS contract with SAPC. To bill DMC for CENS activities, providers will deliver the RS benefit to individuals enrolled in Medi-Cal. The services need to be provided at approved co-located CENS sites or at a CENS Area Office site that is DMC-certified for OP treatment services. All CENS activities that are delivered to individuals not enrolled in Medi-Cal will continue to be billed under the CENS Staff Hour contract. Billing for DMC reimbursable activities will be submitted through Sage. **All CENS services that are reimbursable to DMC must be billed to DMC rather than billed under the CENS Staff Hour contract. SAPC will be monitoring this CENS requirement is followed to ensure compliance.**

For additional information, CENS Standards and Practices.

CENS: Outreach and Engagement

Although most clients are referred to a co-located CENS site, some underserved individuals may be engaged by CENS in the field (e.g., streets, encampments, shelters, jails, etc.). Outreach and engagement may require frequent contact over an extended period of time to develop a rapport and a trusting relationship, which ultimately motivates the individual to engage and participate in treatment. Clients who are finally ready to accept SUD treatment must be immediately linked to services. Client outreach and engagement are conducted based on need and at the direction and approval of SAPC.

CENS: Eligibility Determination and Benefits Enrollment

CENS counselors conduct eligibility determinations and income verification to determine Medi-Cal eligibility and facilitate enrollment. CENS assists clients in entering data in the statewide BenefitsCal website for Medi-Cal enrollment. If the individual is eligible for Medi-Cal, CENS counselors initiate the necessary application/paperwork and refer the client to a qualified provider to continue the benefits enrollment process through approval. This includes assisting with transferring Medi-Cal benefits when a client moves from another State or County and has established residency in LA County.

If a client referred to CENS is not eligible for Medi-Cal or the other County-funded programs listed under the *Covered Members and Eligible Individuals* section. CENS counselors may provide referrals to SUD providers that accept clients on a sliding scale basis. Moreover, if a client who is not eligible for Medi-Cal happens to be covered by a County-funded program (e.g., AB 109 or others mentioned above). CENS counselors will refer the client to SUD providers and remind such providers that SUD treatment services are available and free of charge for the client.

CENS: Educational Sessions

When necessary and beneficial, CENS counselors provide clients with a basic overview of SUDs and the treatment system to increase the likelihood of follow-through with treatment initiation. Frequently, clients referred to CENS for an SUD screening may not understand the severity of their substance use problem. CENS counselors use MI and CBT techniques to engage and facilitate behavioral change in clients and encourage them to be more amenable to SUD treatment.

CENS counselors also:

- Discuss coping strategies with clients, including the steps to take in the event of a relapse.
- Provide HIV/AIDS education and referrals for HIV testing and treatment.
- Discuss the availability of addiction MAT medications for any Alcohol Use Disorders (AUDs) and OUDs, and tobacco use disorder (TUD).
- Discuss the availability of naloxone for overdose prevention.

CENS: Screening, SUD Treatment Referral, Appointment Scheduling, Reminders, and Follow-Up

CENS counselors screen clients using the appropriate screener to determine whether a referral to treatment is necessary. If treatment is needed, CENS counselors schedule an assessment appointment with the agreed-upon network provider per the guideline, as outlined in the *Summary of Service Connection Portals Referral Process* section. A CENS counselor calls the individual to remind them of the upcoming appointment. They also call individuals if they fail to show up to for their assessment appointment. CENS also contacts the Network Provider to determine the linked individual's admission and treatment status of the linked individual.

For justice-involved clients, the appropriate LOC and interventions should be determined by a qualified counselor or clinician, not by justice partners. SUD treatment must be individualized and based on medical necessity. For clients who are incarcerated, SUD screening should be based on the client's substance use status 30 days prior to incarceration.

CENS: Service Navigation, Ancillary Referrals, and Linkages

CENS serves as a liaison between the referring State, County, city, and community partner entities, as well as SUD treatment agencies. This helps ensure the referring entities are aware of their client's treatment status, including treatment location and anticipated completion date. For example, CENS counselors co-located at the LA Superior Courts serve as liaisons during regular court appearances or at the request of the bench officer and may provide client status reports on behalf of the treatment agency.

Navigation assistance and linkages to health and social service resources are important CENS functions, particularly when referring entities do not or cannot provide these needed connections. Navigation and linkage services must include assistance with:

- Eligibility determinations
- Completing paperwork
- Appointment reminders and rescheduling missed appointments
- Providing or arranging for transportation to appointments
- Accompanying clients to their appointments to ensure optimal attendance and treatment retention

To support these functions, CENS establishes and maintains cooperative linkages with other providers (e.g., public, private, and other social, economic, health, legal, vocational, and mental health partners) to make appropriate referrals that address unmet client needs. CENS counselors maintain a working knowledge and an up-to-date resource directory that includes, but is not limited to, all SUD providers (via the SBAT), mental health providers, physical health providers, HIV/AIDS and Sexually Transmitted Infection (STI) providers, and Medi-Cal MCPs.

CENS: Adult At-Risk Services for Prevention and Early Intervention

The AAR Program is a no-cost opportunity for eligible individuals to learn about and be aware of SUD through interesting and interactive educational sessions. CENS provides early intervention services for Adults (age 21 and over):

- whose ASAM CO-Triage results do not meet the criteria for SUD treatment services,
- who engage in SUD high-risk behaviors or do not meet medical necessity for SUD treatment but may benefit from an intervention based on high-risk behaviors.

CENS: Locations

To improve access to SUD services, CENS has Area Offices located in each of the eight (8) Service Planning Areas (SPAs). CENS are also co-located at various State, County, city, and community sites to facilitate client entry into and navigation through the specialty SUD system.

CENS are co-located at the following SAPC-approved sites:

- DMH Psychiatric Emergency Services (PES) and Urgent Care Centers (UCCs)
- Driving Under the Influence (DUI) courts
- Family Solutions Centers
- Homeless Encampments
- Interim Housing and PSH sites
- Juvenile Halls
- LA Superior Courts (e.g., Community Collaborative Court and Proposition 47)
- Medical facilities, including Federally Qualified Health Centers (FQHCs) and selective private and public hospital medical emergency rooms (ERs)
- LAC-Probation (e.g., AB 109 HUBS and Adult Area Offices)
- Los Angeles County Sheriff's Department (LASD) (e.g., Community Re-entry and Resource Center (CRRC), Twin Towers)
- Other approved co-locations, as necessary

Target populations serviced at these co-located sites include individuals who are involved in the juvenile or criminal justice system, uninsured, underinsured, PEH, and individuals with co-occurring disorders (CODs), among other vulnerable conditions.

CORE Centers

The CORE Centers aim to increase opportunities for youth, adults, and families and friends throughout LA County to better understand the impact of substance use on individuals and communities, and collectively identify ways to broaden community action, particularly as it relates to supporting healthy families. CORE Centers, which operate with the philosophy "*the opposite of addiction isn't sobriety, the opposite of addiction is connection*" (Johann Hari), operate with Public Health Centers in Antelope Valley, Hollywood/Wilshire, Inglewood, Van Nuys, South LA, Pomona, and Whittier.

The CORE Centers serve as an environment to address questions about substance use and services, including risk reduction (e.g., fentanyl test strips), prevention (e.g., brief intervention, youth development), and treatment (e.g., addiction medications). Additional services include conducting in-person screening and referral services (e.g., linkage to physical or mental health services); trainings on naloxone administration and distribution of supplies/prescriptions; conducting individual education and group discussions; making connections to support services (e.g., benefit acquisition, interim and PSH, family reunification, etc.); and when feasible, serving as a venue for partner entities to conduct supplemental workshops.

Specific programming and workshops to support families and friends of loved ones at risk or experimenting with alcohol/drugs, and/or struggling with addiction include:

1. Being At Risk for Substance Use Disorder
2. Harm Reduction Strategies and Syringe Exchange Programs
3. Health Consequences of Substance Use
4. How to Talk to Your Loved Ones About Substance Use
5. Recognizing and Responding to an Overdose with Naloxone
6. Relapse Prevention and Healthy Coping
7. Stigma and Substance Use Disorders
8. Substance Use in Our Community
9. Teen and Substance Use
10. Teen and Vaping
11. Treatment and Healthcare for People with Substance Use Disorders
12. Understanding the Connection Between Substance Use and Mental Health
13. How to Talk About Substance Use with People You Care About (Youth-Facing)
14. Recognizing and Responding to an Overdose with Naloxone for Youth (Youth-Facing)
15. Vaping & You: What You Need to Know (Youth-Facing)
16. Understanding the Risks of Cannabis

Central to the CORE model will be the ability of the assigned SUD counselors at each site to foster engagement and connection in an environment that educates equally on all service options (risk-reduction to abstinence) without judgment on the individual's readiness to change (e.g., pre-contemplation, contemplation, action, etc.). Services are available to the public, and particularly those who are Medi-Cal eligible or enrolled. Agreement to be referred to treatment (when indicated) is not a condition for receiving other CORE Center referrals or services. Most services are delivered by the SUD counselors. However, prevention and treatment providers, as well as other community-based organizations (CBOs), may be engaged to conduct specialized workshops that support the needs of individuals and families seeking care.

Direct-to-Provider

Individuals seeking specialty SUD services can directly contact or walk into a provider agency without going through SASH, CENS, or CORE. Many people find SUD provider agencies through personal referrals or by using the SBAT or the RecoverLA.org application on mobile devices.

Provider Agency Process and Responsibilities in Receiving Direct Self-Referrals

When individuals call or arrive at a treatment site seeking SUD services, the following steps are required to determine what level of care is needed and to initiate admission:

1. **Comply** with the requirements outlined under provider agency Responsibilities for SASH, CENS, CORE Center, and Direct Referrals.
2. **Identify** the right LOC through screening / assessment:
    a. If the provider agency **offers the full SUD continuum of care**, triaging clients via the screening is less critical because the individual can access any needed LOC. Therefore, provider agencies can choose to complete the screening or proceed directly to the full ASAM CONTINUUM™ Assessment or Assessment Tool - Youth (Paper Version) provided the client can be admitted timely into the identified LOC.
    b. If the Provider Agency **does not offer the full SUD continuum of care**, administer either the ASAM Screener for Youth (age 17 and under) and Young Adults (age 18-20) or ASAM CO-Triage® Tool for Adults (age 21 and over) to prevent clients from completing the full ASAM assessment to determine that the needed LOC is not offered that meets the client's needs.
3. **Connect** to the right LOC to initiate admission within timely access standards (see **Table 4** as follows):
    a. Provide the individual with an appointment and contact information; OR
    b. Identify an appropriate provider agency to arrange an appointment if the LOC is not offered by the provider agency or it is but not within timely access standards:
        i. For Young Adults (age 18-20) and Adults (age 21 and over), use the SBAT to identify and connect the client to an appropriate provider agency that has current availability for the needed LOC.
        ii. For Youth (age 17 and under, use the SBAT to identify and connect the client to an appropriate OP youth provider agency; and for those reporting opioid use within the past 30 days also identify and connect the client to OTP/MAT services.
        iii. Identify and contact a minimum of three (3) other provider agencies. Identify an intake appointment date within ten (10) business days for all LOCs except OTP, which is within three (3) business days, and urgent services within 48 hours. If the recommended provisional LOC is unavailable after reasonable attempts, a lower LOC may be used, as needed, in the interim.
    c. Assist the client in successfully connecting with the receiving provider agency or site, including instances where the assessing provider agency's sites do not meet the individual's geographic and other preferences. Management of these transitions through Care Coordination is the responsibility of the last treatment provider.
    d. When a screening does not result in an admission (i.e., the provider refers the client to another agency, etc.), providers may bill SAPC for the screening for Medi-Cal enrolled clients only. Providers should bill for the screening under the provider agency's RS PAuth.

4. **Document** all Direct-to-Provider encounters in the Referral Connection Form when a referral contact was attempted and/or successfully made (including when it is a provider self-referral). This requirement is for both Primary and Secondary Sage users.

For additional information, see *Intake and Enrollment – Required Process – Assessment* section.

Service & Bed Availability Tool and Provider Directory

SBAT is a web-based directory and dashboard that shows available SUD services across LA County, including RH, RBH, and DUI programs. SBAT supports a more organized SUD delivery system by simplifying the process of searching for appropriate SUD providers, allowing users to tailor their search using various filters based on the LOCs, languages spoken, and types of services delivered.

To add a DMC-certified treatment site to the SBAT, complete the SBAT Survey and submit accurate responses to the assigned CPA with copy to SAPCMonitoring@ph.lacounty.gov.

SASH, CENS, CORE, and the public rely on SBAT to identify treatment provider agencies and locations for referrals. For this reason, provider agencies need to regularly update and verify their information using the SBAT Provider Log-In Site: https://sapccis.ph.lacounty.gov/SBATProviderSite/Account/Login.aspx.

The SBAT New User Form can be accessed at:
www.publichealth.lacounty.gov/sapc/NetworkProviders/Sbat/SBATUserRegistrationForm.pdf.

Intake Slot Availability

SBAT allows provider agencies to enter daily availability for:

- OP services (including IOP)
- Residential services (across all LOCs)

Note: Intake slot and bed availability automatically reset to zero (0) 24 hours after the last Provider Agency update. Provider agencies need to update this information daily for each site. For detailed instructions on using the SBAT, see the SBAT User Manual.

Network Adequacy Compliance

To meet the requirements under 42 CFR Part 438, licensed practitioner information in SBAT is updated monthly through the Network Adequacy Certification Application (NACA) submissions. For additional information, see *Network Adequacy Certification Submissions* section.

Timeliness and Access Standards

Ensuring timely access to services and engaging clients when they are ready to initiate treatment is essential to improving the specialty SUD system's outcomes. All DMC-ODS services are to be delivered with reasonable promptness in accordance with Federal Medicaid requirements and as specified in the contract and herein.

In addition to time, the distance to access treatment has been shown to be linked to client outcomes. Generally, the shorter the distance between a client and their treatment site, the better the client's outcome. Unless otherwise requested by the client, every effort need to be made to refer the client to a treatment program that is within 30 minutes of travel time by personal or public transportation, **or** within 15 miles of the client's preferred location, see **Table 4**. If it is not feasible, every effort should be made to minimize the likelihood that commute or transportation issues will be a barrier to accessing treatment. If the client prefers to have some aspect of treatment delivered in a different region than where they reside or work, this preference needs to be considered and documented in their clinical record.

Table 4: SAPC Access and Services Delivery Standards

Service	Due Date
Distance Standards for Referrals	Every effort needs to be made to refer clients to a treatment program within: • 30 minutes of travel time by personal or public transportation; **or** • 15 miles from the client's location of choice.
Screening for Provisional LOC[3]	Date of first contact (walk-ins only) • In instances where clients were screened for admission but not admitted, treatment agencies need to provide two (2) alternate referral agencies and connect the client within 48 hours to these agencies. Within 72 hours of admission, agencies should administer the ASAM CO-Triage® Tool for Adults (age 21 and over) or the ASAM Screener for Youth (age 17 and under) and Young Adults (age 18-20) to clients admitted to residential LOC, except for WM LOC, if the applicable Assessment Tool (below) has not been administered during this timeframe, to support the client's placement in an appropriate LOC.
Urgent Appointment for WM	When a prospective client is experiencing active withdrawal symptoms and their provisional or assessed LOC determination supports WM levels 3.2, 3.7, and/or 4.0, it is imperative that the provider takes the following action within 48 hours: • Directly initiate the appropriate WM service (WM levels 3.2, 3.7, or 4.0); **or** • Ensure enrollment in the appropriate WM service at another provider agency.
Intake Appointment – Scheduled	Immediately, but no longer than three (3) calendar days of screening/referral. ***Note: SASH may move to the next provider agency if there is no immediate response or available appointment.***
Intake/Assessment Appointment – Conducted	Within 10 business days of screening/referral for non-OTP settings and three (3) business days for OTP settings.

[3] If the provider agency does not offer the provisional LOC or a slot/bed will not be available within timeliness standards, referrals must be provided (**no waitlists allowed**).

Service	Due Date
County Residency Eligibility Verification **Medi-Cal Eligibility Verification** **Member Handbook and Member Orientation Video Provided**	Date of first service intake/appointment.
ASAM CONTINUUM™ Assessment or Assessment Tool - Youth (Paper Version) found on the SAPC website and Medical Necessity Determination	**For clients in <u>Residential</u> treatment settings:** • Within seven (7) calendar days of first service or first intake appointment for Young Adults (age 18-20) and Adults (age 21 and over); **or** • Within 14 calendar days of first service or first intake appointment for Youth (age 17 and under). **For clients in <u>non-residential</u> treatment settings:** • Within 30 calendar days of first service or first intake appointment for Adults (age 21 and over); **or** • Within 60 calendar days of first service or first intake appointment for Youth (age 17 and under) and Young Adults (age 18-20), and all Adults (age 21 and over) who are documented as PEH[4]. For additional information, see *Initial Engagement Authorizations* section. ***If every attempt has been made to complete and finalize the ASAM Assessment and establish medical necessity during the above timeframes, but the client was unable to fully participate, the provider agency needs to include a Progress Note detailing the reason(s) this did not occur and attempts made.***
Data Submission (CalOMS/LACPRS) & AWOL Policy	**CalOMS/LACPRS Data Submission** • Admission Data: Within seven (7) calendar days of a client's entry into treatment. • Discharge Data: On the day of discharge. • Annual Updates: For clients who continue receiving the same LOC at the same facility for over a year since their CalOMS admission, the provider must submit the CalOMS annual update form no later than 12 months from the client's admission anniversary date. Can submit as early as 60 days prior to the individual's admission date anniversary. • Need to report CalOMS data for all clients, irrespective of their funding source (e.g., private pay, commercial insurance) and for all LOCs. **Absence Without Leave (AWOL) Policy:** Clients frequently leave without notice, resulting in varying AWOL policies among providers. These discrepancies often lead to delays in the admission process, particularly in submitting CalOMS/LACPRS data for subsequent providers. To enhance the efficiency of client transitions and admissions to CalOMS across network, the following unified policy is hereby established: **For Non-OTP LOC (ASAM 0.5, OP, IOP, WM, Residential, RS):** If a client misses a scheduled appointment, the provider agency needs to make efforts to reengage the client before discharging the client from CalOMS. Efforts should be made **within <u>14 calendar days</u> from the scheduled appointment date**. If another provider contacts the original agency to open a CalOMS/LACPRS record for the client, indicating the client has started services elsewhere, the original agency should discharge the client promptly. The discharge date should correspond to the date of the client's last face-to-face or telehealth treatment session or addiction medications service. This actual discharge date must also be entered as the "Discharge Process Date" on the appropriate CalOMS Discharge forms.

[4] Documentation of homelessness status must be indicated in a Progress Note.

Service	Due Date
	For OTP: If a client fails to appear for the scheduled appointment, the provider should make efforts to reengage the client before discharging the client from CalOMS and the treatment program **within 30 calendar days from the scheduled appointment date**. If a client misses their scheduled appointment, the provider should endeavor to reengage the client within 30 calendar days before initiating the discharge process from CalOMS and the treatment program. However, if another provider contacts the original provider with the intention of opening a CalOMS record for the client who attended their program, the original provider should promptly discharge the client from CalOMS. The discharge date should correspond to the date of the client's last face-to-face or telehealth treatment session. They need to document the actual date of discharge as the "Discharge Process Date" in the relevant CalOMS Discharge forms. ***For questions regarding CalOMS data submission, visit*** SAPC's CalOMS Resource webpage ***or email*** *hoda_caloms@ph.lacounty.gov*.
Initial Problem List (for non-OTP Services) **Initial Plan (for OTP Services)**	**For clients in OP and IOP treatment settings:** • Within **30 calendar days** of first service or first intake appointment for Adults (age 21 and over); **or** • Within **60 calendar days** of first service or first intake appointment for Youth (age 17 and under) and Young Adults (age 18-20), and all Adults (age 21 and over) who are documented as PEH[3]. • Need to be finalized/signed by an LPHA. **For clients in Residential treatment settings:** • Within **7 calendar days** of first service or first intake appointment for Young Adults (age 18-20) and Adults (age 21 and over); **or** • Within **14 calendar days** of first service or first intake appointment for Youth (age 17 and under). • Need to be finalized/signed by LPHA. Treatment Plans for clients receiving OTP services prior to the completion of the ASAM CONTINUUM™ Assessment or Assessment Tool - Youth (Paper Version) found on the SAPC website) should describe the plan for obtaining this assessment within the required 30- or 60-day timeframe described above. In OTP settings, the Initial Treatment Plan needs to be completed and signed by the client and LPHA within **28 calendar days** of admission. If every attempt has been made to complete and obtain signatures on the Treatment Plan, but circumstances do not allow for full completion, then the provider need to: • Include a Progress Note with justification detailing what prevented completion within the timeframe; • The appropriate LPHA or Medical Director needs to then legibly sign the Treatment Plan within **15 calendar days** of the client signing.

To optimize access to SUD services, SUD provider agencies need to implement an ongoing, systematic evaluation process for identifying physical and/or psychosocial access issues that may impede SUD treatment and any potential barriers. The evaluation process should identify counselor/staff attitudes around substance use, client transportation, or any other accessibility issues. Provider agencies also need to consider client and stakeholder feedback during this process. Once barriers are identified, provider agencies should develop a plan detailing how to address them. The plan may be a Quality Improvement Project (QIP) (see *Quality Improvement Expectations* section), which specifies the barrier(s) and action(s) that will be taken to eliminate or reduce the impact of the barrier, along with the timeline for completing these specific actions.

Table 5: Hours of Operation by Benefit

Benefit	Applicable LOCs	Minimum Hours of Operation*
Early Intervention Services *For Youth (age 17 and under) and Young Adults (age 18-20)*	• Early Intervention Services (ASAM 0.5)	• Need to operate at least 8 hours per day, 5 days a week, including either: ○ One 8-hour day on Saturday or Sunday; **or** ○ One 4-hour day on Saturday and 4-hour day on Sunday; **and** • At least 2 days need to include evening hours (5:00 p.m. – 9:00 p.m., at a minimum)
Outpatient LOC	• Outpatient (ASAM 1.0) • Intensive Outpatient (ASAM 2.1) • Ambulatory-Withdrawal Management (Outpatient) **without** extended on-site monitoring (ASAM 1-WM) • Ambulatory-Withdrawal Management (Outpatient) **with** extended on-site monitoring (ASAM 2-WM)	• Need to operate at least 8 hours per day, 5 days a week, including either: ○ One 8-hour day on Saturday or Sunday; **or** ○ One 4-hour day on Saturday and 4-hour day on Sunday; **and** • At least 2 days need to include evening hours (5:00 p.m. – 9:00 p.m., at a minimum)
Residential and Inpatient LOC	• Clinically Managed Low-Intensity Residential Services (ASAM 3.1) • Clinically Managed Population-Specific High-Intensity Residential Services (ASAM 3.3) • Clinically Managed High-Intensity Residential Services (ASAM 3.5) • Clinically Managed Residential-Withdrawal Management (ASAM 3.2-WM) • Medically Monitored Inpatient Withdrawal Management (3.7-WM) • Medically Managed Intensive Inpatient Withdrawal Management (4-WM)	• Need to operate 24 hours per day, 7 days a week; **and** • Need to accept intakes at least during regular weekday business hours (9:00 a.m. – 5:00 p.m., at a minimum)
Opioid Treatment Program	• Opioid Treatment Programs (1-OTP)	• Need to operate at least 8 hours per day, 5 days a week (including either: ○ One 8-hour day on Saturday or Sunday; **or** ○ One 4-hour day on Saturday and 4-hour day on Sunday
Recovery Bridge Housing	• Recovery Bridge Housing	• Need to operate 24 hours per day, 7 days a week; **and** • Need to accept intakes at least during regular weekday business hours (9:00 a.m. – 5:00 p.m., at a minimum)
Recovery Housing	• Recovery Housing	• Need to operate 24 hours per day, 7 days a week • Need to accept intakes from SAPC staff at least during regular weekday business hours (9:00 a.m. – 5:00 p.m., at a minimum)
***Hours of operation Standards do not apply to approved Field-Based Services (FBS) locations.**		

Holiday Closure Pre-Approval

The minimum and maximum number of hours per week remain unchanged for weeks that include a Federal, State, local, or religious holiday. Provider agencies need to obtain SAPC approval when an OP facility is scheduled to be closed to observe Federal, State, local, or religious holidays. **Provider agencies need to provide written notification to SAPC annually by the beginning of each FY (July 1st) if there are changes.** New provider agencies need to provide their current FY request for holiday closures no later than 60 days from the execution of their contract. Consistent with other health services, OP sites cannot be closed for days other than actual recognized holidays (Federal, State, local, or religious). Provider agencies need to submit the requested closure dates in the coming calendar year at the time of a new contract and/or contract renewal, and thereafter, on December 31, for SAPC review and approval. The closure may only be on the day of a recognized Federal, State, local, or religious holiday. Requests need to be emailed to SAPC's Contracts and Compliance Division (SAPC-CCD) at SAPCMonitoring@ph.lacounty.gov and to the assigned CPA.

Note: For IOP programs, the rate may be lowered to the OP rate for any claims associated with an individual who does not receive the minimum number of service hours/units in any week.

Out-of-Network Policy

Individuals may be eligible to receive medically necessary DMC-ODS services from OON provider agencies in certain circumstances. All OON provider agencies need to meet specified requirements, including but not limited to those required by the DHCS for Medicaid MCPs. Individuals may be eligible to receive OON services under the following circumstances:

- **Indian Health Care Provider (IHCP):** American Indian and Alaska Native (AI/AN) individuals are entitled to receive DMC-ODS services from an IHCP for whom they are eligible, whether or not the IHCP chooses to become part of the DMC-ODS network, in accordance with BHIN 22-053 and, as well as other Federal and State regulations.
    - Effective March 2025, BHIN 25-007 expanded the DMC-ODS benefit to include Traditional Health Care Practices (i.e., interventions provided by qualified Traditional Healers and Natural Helpers) for eligible members, which can only be provided through IHCPs.
- **Alternate Access Standards (i.e., services outside of time/distance access standards):** When an area of the County does not fall within time/distance access standards, individuals may be approved (depending on any alternative standard that may be approved by DHCS) to receive services from an OON provider closer to them.
- **Transition in Care:** Under certain conditions (risk of serious health, hospitalization, or institutionalization), an individual who is transferring to LA County from another DMC-ODS or State Plan DMC County is permitted to retain their current provider for a period of time as an OON provider to ensure access to services.

When a service meets one (1) of the above requirements, then the primary service connection portal staff are responsible for informing the individual about the availability of OON provider agencies. Entryways include:

- SASH
- CENS
- CORE Centers

Provider agencies who receive a request from an eligible member and the service connection portal staff should refer OON requests to SAPC-CCD at (626) 299-4532 or email SAPCMonitoring@ph.lacounty.gov. Requests for OON providers cannot be denied based on travel time or transportation costs.

Network Adequacy Certification Submissions

Overview

DHCS sets forth the requirements for counties' certification of network adequacy. SAPC's network capacity and timely access standards are reviewed regularly to ensure that all required services covered under DMC-ODS are available and accessible to DMC-ODS enrollees in accordance with the applicable state and federal regulations, including those outlined in 42 CFR § 438.68 and California WIC § 14197.

The Network Adequacy Certification Tool (NACT) and the newly required 274 Standard Process are completed by DMC-ODS Counties and used by DHCS to assess whether the County Plan:

- Offers an appropriate range of services for the anticipated number of members;
- Maintains a network of provider agencies, operating within the scope of practice under State law, that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members.

Notifications and Provider NACT Coordinator

Effective May 2024, as required by DHCS and outlined in BHIN 23-042 and BHIN 25-013, DMC-ODS counties are required to submit provider network data on a monthly basis. NACT Coordinators will be responsible for ensuring that provider agency information in the SAPC NACA is updated by the last week of each month.

SAPC will notify provider agencies of the timelines for that annual network adequacy certification and timelines for updating any additional information using the SAPC NACA. The timeline will include training, office hours, deadlines, and other relevant information.

Provider agencies must inform SAPC and update their contact information in the NACA whenever there is a change in the designated NACT coordinator assignments, including the name and contact details. The NACT coordinator is the representative from the provider agency who works with SAPC to coordinate efforts, ensuring accurate and timely submissions. Each provider agency is required to designate a NACT coordinator and a backup who will be responsible for submission and attending NACT-related meetings and trainings related to network adequacy.

Network Adequacy Certification Application

NACA is SAPC's database used to obtain and verify NACT and 274 Standard Process data. The database allows provider agencies to review, update, and validate the required information about their organization more easily. This information includes, but is not limited to, the following:

- Organization information such as:
  - Contract effective and expiration date
  - Name of Chief Executive Officer (CEO) and Chief Financial Officer (CFO)
  - Website URL of agency (if available)
  - Primary, secondary, and alternate NACT Coordinators
- Active service location information such as:
  - General site information, site address, and hours of operation.
  - Maximum and current number of Medi-Cal members by age group and modality
  - Additional LOCs for Residential
  - ADA compliance
  - TTY/TDD (Telecommunications Device for the Deaf) equipment
  - Language capacities
  - Age groups served
- Staff (practitioner) information such as:
  - Personal identifiable information, including gender, DOB, and email address
  - Provider Type, Licensing entity, and number
  - Contact effective (hire) date and expiration date (if open-ended employment, indicate N/A)
  - Age groups served
  - Practitioners' current caseload and maximum number of clients practitioners will accept by age group and modality
  - Language capacity
  - Telehealth capabilities
  - Cultural Competency training and the number of hours completed

To ensure SAPC meets the DHCS NACT and 274 Standard Process submission deadline, provider agencies need to have completed and validated all data in the NACA by the last week of every month, unless otherwise notified by SAPC. Failure to meet the specified deadline may result in consequences, including, but not limited to, the denial of augmentation requests and contract amendments. NACT Coordinators need to finalize their submission by selecting the "Confirm Monthly Submission" on the last page of the Practitioner page. An auto-email notification will be sent to the primary and the back-up coordinator confirming submission.

Initial Engagement Authorizations

SAPC covers clinically appropriate non-residential treatment services for Adults (age 21 and over) and who are not experiencing homelessness for up to 30 days following the initial date of service, whether or not a diagnosis for Substance-Related and Addictive Disorders from the current DSM is established, and for up to 60 days for Youth (age 17 and under) and Young Adults (age 18-20), or if a provider documents that the client is experiencing homelessness and therefore requires additional time to complete the assessment. Providers who exercise these flexibilities to initiate care prior to completing an ASAM assessment and establishing an SUD diagnosis should submit initial engagement authorizations, as described below. **The initial engagement authorization precedes but does not replace medical necessity.**

- If the provider can complete all medical necessity documentation and member has valid financial eligibility coverage, providers may **skip** this type of authorization and submit a standard authorization for the requested LOC.
- Initial Engagement Authorizations are available for non-residential and non-WM LOCs.
- Providers can request for Initial Engagement Authorization(s) **prior** to the establishment of medical necessity.
- To receive an Initial Engagement Authorization, providers need to submit an SAR with a provisional LOC (i.e., ASAM 0.5, 1.0, 2.1, or OTP).
- Providers need to document in the medical necessity justification Progress Note that the request is for Initial Engagement Authorization.
    - For Adults (age 21 and over), providers should indicate whether this is a person who is experiencing homelessness.
        - 30-day Initial Engagement Authorization can be given for Adults (age 21 and over) who are not experiencing homelessness.
          60-day Initial Engagement Authorization can be given for Adults (age 21 and over) experiencing homelessness.
- Youth and Young Adults (under age 21) Authorization will be limited to 30 days for those utilizing the Applying for Medi-Cal benefit, regardless of the member's age and/or homelessness status.
    - For members who are eligible for a 60-day Initial Engagement period, the provider could submit service authorization for the remaining 30 days if:
        - Member has secondary non-DMC funding.
        - Medi-Cal is approved for covered services within the requested timeframe.
- If there is no existing eligibility verification period, a new eligibility verification period will be established and will align with the start date of the Initial Engagement Authorization.
- In cases where the eligibility verification period does not cover the entire initial engagement authorization, a new eligibility verification will be established.
- A standard authorization should be submitted after initial engagement authorization for ongoing care, including documentation of medical necessity.
    - For additional information, see Checklist of Required Documentation.
    - If a member meets medical necessity, authorization will be approved for the remainder of the current eligibility period.
- The Initial Engagement process can restart if the member leaves treatment prior to the establishment of medical necessity.

Determining Medical Necessity

Medical necessity is a standard applied to justify services as reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care. Medical necessity must be consistently applied to ensure equitable access to services, established to demonstrate and maintain DMC eligibility, and also established for provided services (e.g., residential treatment, RBH).

Medical necessity to initiate non-residential services means that services are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain (California WIC § 14059.5(a)). For OTPs, a history and physical exams conducted by an LPHA at admission, pursuant to Federal and State regulations, qualify for medical necessity determination.

Medical necessity for most LOCs (except for WM, RS, and Early Intervention services for Youth [age 17 and under] and Young Adults [age 18-20]) can only be determined **after** a full ASAM CONTINUUM™ Assessment or Assessment Tool - Youth (Paper Version) found on the SAPC website, which includes an SUD diagnosis from the current edition of the DSM, is finalized. Screenings do not generally include sufficient information to determine medical necessity for most LOCs because they do not include a DSM diagnosis determination or contain sufficient information regarding the six (6) ASAM dimensions to constitute a comprehensive biopsychosocial ASAM assessment. RS requires the completion of ASAM CO-Triage® Tool for Adults (age 21 and over) or ASAM Screener for Youth (age 17 and under) and Young Adults (age 18-20). The ASAM Screener for Youth (age 17 and under) and Young Adults (age 18-20) may be used to establish medical necessity for Early Intervention (0.5) services.

Definition of Medical Necessity

To meet medical necessity criteria, clients need to meet the following two (2) criteria:

1. **Diagnostic and Statistical Manual of Mental Disorders – 5th Edition – Text Revision (DSM-5-TR) diagnosis**
    - Youth (age 17 and under) and Young Adults (age 18-20)
        - Meet criteria for at least one diagnosis from the current DSM for Substance-related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders; **or**
        - Meet EPSDT criteria to ameliorate or correct a substance misuse-related condition.
        - For additional information, see *Definition of Early Intervention Services for Youth and Young Adults* section.
        - ***Note: Parental consent is not required for services delivered to youth age 12 and over, but is required for services delivered to youth age 11 and under.***
    - Adults (age 21 and over)
        - To begin service delivery prior to completion of the full assessment:
            - Services are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain (California WIC § 14059.5(a)); **or**

  - For OTPs, a history and physical exam conducted by an LPHA at admission, pursuant to Federal and State regulations, qualifies for the determination of medical necessity.
- To fully establish medical necessity:
  - Meet criteria for at least one (1) diagnosis from the current DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-related Disorders.
  - Meet criteria for at least one (1) diagnosis from the current DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-related Disorders prior to being incarcerated or during incarceration as determined by substance use history.

2. **ASAM treatment criteria for services**
   - DMC-ODS providers need to ensure clients meet the ASAM treatment criteria for services after completing the initial assessment period (30-60 days after first service, depending on the population), including the ASAM adolescent treatment criteria, when applicable. Medical necessity encompasses all six (6) ASAM dimensions and considers the extent and biopsychosocial severity of the various dimensions within the required full ASAM CONTINUUM™ Assessment or Assessment Tool - Youth (Paper Version) found on the SAPC website. Medical necessity is not limited to acute care needs or narrow medical issues (e.g., withdrawal severity in Dimension 1, physical health needs in Dimension 2, or psychiatric concerns such as suicidality in Dimension 3).

Definition of Early Intervention Services for Youth and Young Adults

Youth (age 17 and under) and Young Adults (age 18-20) in the specialty SUD system are eligible for Early Intervention services under EPSDT. Eligibility for EPSDT broadens the definition of medical necessity for youth and young adults to include individuals who need services to ameliorate or correct a substance misuse-related condition and makes the full LA County's SUD Benefit Package available to Youth (age 17 and under) and Young Adults (age 18-20) without any caps or limitations. Early intervention services are covered DMC-ODS services for members under the age of 21 who are screened and determined to be at risk of developing an SUD and thus may receive any service component covered under the OP LOC as Early Intervention services. Parental consent is not required for services delivered to youth age 12 and over, but is required for services delivered to youth age 11 and under.

Note: Federal EPSDT requirements supersede state Medi-Cal requirements, and DMC-ODS does not override EPSDT.

Assessment

Assessments are client evaluations, measurements, and documentation used to determine diagnoses and service needs. In the treatment of individuals with SUDs, assessments are an ongoing process and are essential for identifying client needs and helping the provider tailor their services to best meet those needs. Assessments are also important opportunities for client engagement and developing a Plan of Care. Assessments are typically conducted during the initial phases of treatment, although not necessarily during the initial visit.

A full assessment or initial provisional referral tool for preliminary LOC recommendations is not required to begin receiving DMC-ODS treatment services.

Comprehensive, validated, standardized assessment tools, and their corresponding documentation form the foundation of high-quality SUD services. Assessments based on the required ASAM Criteria® ensure a standardized structure for collecting necessary clinical information to make appropriate SUD LOC determinations. Assessments need to be appropriately documented (see *Clinician Consultation Services - Licensed Clinician Consultation Process - Documentation* section), reviewed, and updated regularly, including at every care transition, to promote engagement and meet the client's needs and preferences.
If the provider determines that adequate progress toward treatment goals has been made during the assessment, plans to build upon these achievements should be made, which may include transitioning to other services and implementing recovery-focused strategies. Similarly, reassessments of the diagnosis, treatment modalities/intensity/goals need to be performed if progress toward agreed-upon goals is not being made within a reasonable timeframe.

LPHAs, whose scope of practice includes behavioral health assessments, and SUD counselors need to have the appropriate experience and training before conducting screening, assessment, and medical necessity determinations. Registered Nurse (RN), Licensed Vocational Nurse (LVN), Licensed Psychiatric Technician (LPT), Licensed Occupational Therapist (LOT), and Registered Pharmacist (RP) practitioners' scope of practice does not include determining medical necessity for SUD treatment. Training is available through SAPC-CST; visit the SAPC Trainings and Events webpage on SAPC's website and refer to the training calendar to register for upcoming sessions.

Process for Determining Medical Necessity

Verification of Medical Necessity

Medical necessity must be verified by an LPHA through an in-person review, telehealth, or telephone consultation with the individual conducting the assessment (e.g., a SUD counselor). At a minimum, the in-person or telehealth review need to involve the LPHA verifying and signing off on medical necessity in an in-person, telehealth, or telephonic collaboration with the SUD counselor who conducted the assessment. The review may include the client, although it is not required.

The LPHA is required to document separately from the Problem List (non-OTP settings) or the Treatment Plan (OTP Settings) the basis for the diagnosis in the form of a Medical Necessity Justification Progress Note within 30 calendar days of each client's treatment admission date. The basis for documenting a diagnosis made by an LPHA should align with the scope of practice for making diagnoses as regulated by that LPHA's relevant licensing board. The basis for the diagnosis, or qualification under EPSDT, should include a statement that the client's personal, medical, and substance use history was reviewed. The Medical Necessity Justification Progress Note need to be signed and finalized by a diagnosing LPHA, dated, and then submitted in the client record in Sage. For additional information on LPHA categories, see **Table 16**.

Timeliness of Medical Necessity Determination

The LPHA need to determine medical necessity as outlined below:

- For clients in residential treatment settings:
  - Within **seven (7) calendar days** of first service or first intake appointment for Young Adults (age 18-20) and Adults (age 21 and over); **or**
  - Within **14 calendar days** of first service or first intake appointment for Youth (age 17 and under).
- For clients in non-residential (e.g., outpatient) treatment settings:
  - Within **30 calendar days** of first service or first intake appointment for Adults (age 21 and over); **or**
  - Within **60 calendar days** of first service or first intake appointment for Youth (age 17 and under) and Young Adults (age 18-20), and for those Adults (age 21 and over) who are documented as a PEH. For additional information, see *Initial Engagement Authorizations section.*

Providers need to make every effort to complete the assessment as soon as is feasible for the client. The initial assessment with the client needs to be performed in-person or via telehealth (where the client is in the community or at home) by an LPHA, licensed-eligible LPHA, or registered/certified counselor, as this will ensure admission to the appropriate LOC. If the completed assessment findings indicate no qualifying SUD diagnosis (except under EPSDT as defined above) to establish medical necessity, services are reimbursable under DMC within the 30- or 60-day initial assessment period timeline by documenting an appropriate diagnosis code outlined in *Reimbursement and Diagnosis Codes* section below.

Providers need to include a Progress Note in the individual client record, which details:

- If applicable, reason(s) that the client was unable to participate in an assessment within the above timeframes; **and/or**
- Basis for the status of the diagnosis and establishment of medical necessity; **and/or**
- Homelessness status if seeking up to 60 days to complete the initial assessment for non-residential LOCs.

If a client withdraws from treatment prior to establishing a DSM diagnosis for SUDs, and later returns, the 30- to 60-day time period starts over. Assessments need to be updated as clinically appropriate and based upon medical necessity when the client's condition changes.

Reimbursement and Diagnosis Codes

Diagnoses must be established and updated as clinically appropriate by an LPHA, within their scope of practice, when a client's condition changes to accurately reflect the client's needs. During the initial assessment period (ranging from 30 to 60 days, depending on the population), provisional diagnoses are used prior to the determination of a definitive diagnosis or in cases where a suspected SUD has not yet been confirmed. Diagnoses are documented using a Centers for Medicare & Medicaid Services (CMS)-approved International Classification of Diseases, Tenth Revision (ICD-10) diagnosis code.

Providers may use the following ICD-10 diagnosis options during the assessment phase of a client's treatment when an SUD diagnosis has yet to be established:

- ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances," may be used by all practitioners during the assessment period prior to
- diagnosis and do not require certification as, or supervision of, an LPHA. For a list of applicable diagnosis codes that can be documented by any DMC-ODS practitioner, see *Appendix D*.
- ICD-10 code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out," may be used by an LPHA during a member's treatment assessment phase when a diagnosis has yet to be established.
- LPHAs may use any clinically appropriate ICD-10 code. For example, these include codes for "Other specified" and "Unspecified" disorders, or "Factors influencing health status and contact with health services."

Services for covered services are reimbursable[5] even when:

- Services are provided prior to the determination of a diagnosis or prior to the determination of whether access criteria are met;
- The assessment determines that the member does not meet the DMC-ODS access criteria after the assessment;
- Prevention, screening, assessment, treatment, or RS were not included in an individual Treatment Plan (in OTP settings) or lack of client signature on the Treatment Plan in OTP settings; **and/or**
- The member has a co-occurring mental health disorder.

Timeliness of Medical Necessity Re-verification

For each client to receive ongoing SUD services, the LPHA must monitor each client's response to SUD treatment to determine medical necessity for continued services no later than six (6) months after the client's treatment admission date or from the last re-verification. The justification of medical necessity must be documented in a Medical Necessity Justification Progress Note signed and dated by the LPHA and include information on the following:

- Description of the continued functional impairment in the domains of current use or risk for relapse, medical issues, cognitive-behavioral challenges, motivation for change, and current barriers, social and environmental factors
- Most recent physical exam
- Progress Notes, Problem Lists (for non-OTP settings), and Treatment Plan goals (for OTP settings)
- LPHA's recommendation for continued treatment
- Client progress toward treatment goals

[5] California WIC § 14184.402(f)

Screening Tools

Screenings are abbreviated evaluations of individuals that allow for a provisional determination about whether and what types of additional SUD services are necessary and appropriate. These abbreviated assessments are less comprehensive than full assessments and therefore do not replace them; they are intended to provide a reasonable estimate of the type and intensity of SUD services that will be necessary to meet an individual's needs.

Screenings do not contain sufficient information to determine medical necessity because they do not include a DSM diagnosis determination and contain insufficient information regarding the six (6) ASAM dimensions to constitute a comprehensive biopsychosocial ASAM assessment. The only exceptions are in determining medical necessity for Early Intervention (ASAM 0.5) Services (using the Youth ASAM screening), RS, and WM.

Allowable Screening Tools

- Youth (age 17 and under) and Young Adults (age 18-20)
  - Parent Screener for Youth developed by SAPC (paper-based)
  - Youth and Young Adult Screener (in PCNX) required to qualify for Early Intervention Services
  - ASAM Screener for Youth and Young Adults (paper-based, use only during Sage downtime)
- Adults (age 21 and over)
  - ASAM CO-Triage® Tool
  - SAPC-approved paper-based brief ASAM triage assessment (use only during Sage downtime)

Assessment Tools

Full ASAM assessments include a comprehensive evaluation of the six (6) dimensions of the ASAM Criteria, in addition to other important clinical elements captured during the assessment interview.

Minus the exceptions listed above, medical necessity need to be determined by a full ASAM CONTINUUM™ Assessment or Assessment Tool - Youth (Paper Version) found on the SAPC website and not solely by a screening tool except for Early Intervention Services, which can be determined using the ASAM screener for Youth (age 17 and under) and Young Adults (age 18-20) or the ASAM CO-Triage® Tool for Adults (age 21 and over) in the CENS AAR Program. Full ASAM assessments determine whether an individual meets the diagnostic criteria for an SUD from the current DSM. A full ASAM assessment does not need to be repeated unless the individual's condition changes.

Allowable Full ASAM Assessment Tools

- Youth (age 17 and under) and Young Adults (age 18-20)
  - Assessment Tool - Youth (Paper Version) found on the SAPC website
- Adults (age 21 and over)
  - ASAM CONTINUUM™ (validated electronic tool)
  - SAPC-approved paper-based full ASAM assessment

Intake and Enrollment

Establishing a comprehensive and standardized intake and enrollment process that balances the need for information with the need to create a streamlined and client-centered experience is important. The sections below describe essential components of the intake process.

Required Forms

Member Rights

Client rights ensure that all clients preserve their basic rights to independence, expression, decision-making, and action, as well as concern for personal dignity and human relationships. As a cornerstone of a client-centered and effective treatment system, specialty SUD providers need to share an individual's member rights with them in writing, either collectively or individually.

SAPC's "Your Rights: Substance Use Disorder Treatment" can be used and posted in visible areas throughout facilities.

Note: The member rights poster is being updated. The current version can continue to be used until replaced with the updated version.

Member Handbook and Client Orientation Video

In accordance with federal and State regulations, including BHIN 24-034, LA County's Behavioral Health Services Member Handbook (Version 1.0, January 2025) and any subsequent iterations outline the DMC-ODS and Specialty Mental Health Services (SMHS) plans, including information on eligibility, accessing provider agencies that meet the member's needs and preferences, rights and responsibilities, and the grievances/appeals process. The Member Handbook is available in all threshold languages and need to be provided to the member, at no charge, upon admission in one (1) of the following ways:

1. Provide a printed copy in person, **or**
2. Mail a copy of the printed copy to the member's mailing address; **or**
3. Provide via electronic format (e.g., email, or text message that includes a hyperlink or QR code to the handbook on the SAPC webpage), after obtaining the member's agreement to communicate by email; **and**
4. Direct the member to the SAPC webpage.

If at any time the member requests a printed copy of the member handbook after being directed to the County website, the provider agency must provide it at no charge to the member within five (5) days of the request. Providers are responsible for informing current clients whenever a new version of the Member Handbook is available. SAPC will notify provider agencies whenever there is a change in the Member Handbook.

Provider Responsibilities: Notice of Significant Change to the Member Handbook

In accordance with BHIN 24-034, current clients need to be notified of any significant changes to the information contained in the member handbook at least 30 days prior to the effective date of the change. Significant changes are typically due to regulatory or other changes. When changes are issued, SAPC will notify provider agencies and provide a copy of the updated document, along with the "Member Handbook Notification of Significant Change Letter."

Providers need to take the following steps:

- Notify all current clients of changes to their Member Handbook, effective as of the stated date.
- Use one (1) or more of the following methods to notify members (this does not require documentation):
    - Provide a printed copy in person or mail a copy with the "Member Handbook Notification of Significant Change Letter" to the client's mailing address; **and/or**
    - Email an electronic copy with the "Member Handbook Notification of Significant Change Letter" after obtaining the client's agreement to communicate by email; **and/or**
    - Direct the client to the handbook published on SAPC's website and give the member the "Member Handbook Notification of Significant Change Letter" during regularly scheduled sessions.

The Client Orientation Video provides clients with a user-friendly summary of the Member Handbook and a description of key benefits under the DMC-ODS. Provider agencies are required to demonstrate that new and existing clients have viewed the video in its entirety within a specified number of days from the date of the first service. The Client Orientation Video is available on SAPC's website with subtitles in all threshold languages.

The Member Handbook and Client Orientation Video Acknowledgment Form provides the client with a summary of the benefits and confirms that they have viewed the client orientation video and/or received the Member Handbook. The Member Handbook and Client Orientation Video Acknowledgment Form is available using the link above or within Sage. Provider agencies are required to do the following:

- Obtain the client's signature upon admission (or upon completion of the orientation video within the identified timeframes).
- Provide a copy of the signed document to the client.
- Ensure the signed document is placed in the client record or completed in Sage. stored in Sage by:
    - For primary Sage users who do not use the document in Sage, they need to upload it using the following title "Client Handbook Summary ##-##-##)" that includes the date signed (e.g., Client Handbook Summary (04-01-25)).

Note: The form is available in English and other threshold languages.

Notice of Privacy Practices

The Notice of Privacy Practices (available in English, Spanish, and other languages) is a required document to be provided to clients that informs them about their privacy rights and the treatment agency's legal duties regarding client health information. The law requires that your PHI be kept private and secure. It need to be made available to all new and continuing clients upon their first service appointment.

Confidentiality/Release of Information

Provider agencies within the specialty SUD system need to thoroughly explain confidentiality options to clients and have them sign the necessary confidentiality forms (e.g., SAPC ROI Forms). All confidentiality and ROI forms need to comply with 42 CFR Part 2, HIPAA, and other pertinent regulations, including regulations governing the collection of written signatures.

As indicated on the SAPC ROI Form, clients can elect to consent to share information with:

- **Option 1:** the entire SUD network of provider agencies, **or**
- **Option 2:** only to specific SUD provider agencies.

The benefits, risks, and alternatives to these options need to be discussed with clients to allow them to make informed decisions about their care. Clients need to sign the SAPC ROI Form for it to be finalized.

The SAPC "Release of Information – In Network" form has been developed within the Sage platform to allow greater visibility and consent management functionality. As such, Primary and Secondary Sage Users are required to complete a client's ROI for SAPC in-network SUD Providers directly in the Sage Electronic Health Record (EHR) system (named Release of Information – In Network). The Sage ROI form offers options to associate the Sage form with an uploaded paper-based copy that includes the client's signature, if the provider was unable to obtain the signature via Sage or if the provider obtained the signature through a separate electronic method. The Sage ROI is applicable to the entire agency and is valid for all sites within a provider.

If the client is transferring from a new location, provider agencies need to ensure that consent forms are signed and appropriately utilized to ensure information exchange while maintaining compliance with applicable confidentiality regulations.

Provider agencies within the specialty SUD system need to update the ROI and consent forms that clients sign as necessary when documents expire or become inactive, based on SAPC, State, and Federal policies.

Note: If a client revokes consent to share their information with a specific SUD provider agency in the network, that agency needs to notify the involved entities of this update.

Why Encourage Information Sharing?

The SUD system encourages appropriate information sharing with physical and mental health systems to improve care coordination and health outcomes. It is important to support appropriate information sharing as SUD clients often have other health conditions that complicate care and can prevent long-term achievement of recovery goals if un/under-treated.

Client Informing – Consent for Treatment and Information Sharing

The foundational principle of consent for treatment is that individuals need to give permission before they receive any type of health treatment, test, or examination. Informed consent generally includes:

- Nature of the decision, treatment, and/or procedure
- Reasonable alternatives to the proposed intervention
- The relevant risks, benefits, and uncertainties related to each alternative
- Assessment of client understanding
- Acceptance of the intervention by the client

It is crucial that provider agencies thoroughly describe and explain the recommended services to equip clients with the necessary information to make informed decisions about the proposed care.

Additionally, the intake process need to include education on the client consent information-sharing process and purposes. Sharing information with other SUD and physical and mental healthcare provider agencies is essential to delivering coordinated care that is in clients' best interests. As such, clients need to be provided with thorough information regarding confidentiality regulations (HIPAA and 42 CFR Part 2) to obtain informed consent that balances the need for information sharing and necessity of maintaining necessary privacy to support high-quality, coordinated care.

To be valid, the consent process need to be free of coercion, voluntary, and the client giving consent need to have decision-making capacity and be deemed competent to make the decision at hand.

Note: Parental consent is not required for services delivered to youth age 12 and over, but is required for services delivered to youth age 11 and under.

Client Informing – Complaint/Grievance and Appeals Process

All clients receiving services within LA County's specialty SUD system have access to a complaint/grievance and appeals process to express dissatisfaction or request reconsideration of an action taken by either the provider or the County (e.g., denial of a requested service). Clients must be informed about their rights and the availability of due process for filing complaints/grievances and appeals, both at the provider agency level and when concerns are more appropriately addressed to the County. Clients should be given a form to sign indicating they have been informed of their rights. This signed form should be maintained in the client file. Providers need to also ensure this information is visibly posted in a public area of each treatment site and available in the client's preferred language. These complaints/grievances and appeals may be filed by the client, practitioner, or another designated entity. For additional information, see *Complaints/Grievances and Appeals Processes* section.

Required Processes

Admission

When individuals interact with provider agencies, they may need to be entered into Sage in order to access forms such as screenings or for eventual billing purposes. Historically, Sage admissions have been limited to one episode per client, per agency, for which they are never discharged. This resulted in difficulty identifying "active clients." To help address this gap, providers are required to complete the Provider Site Admission form. This form need to be completed by all treatment providers within Sage when a client is admitted or re-admitted to a particular contracting provider site for any LOC, including RBH and RS, if provided as a standalone service.

When a client is concurrently enrolled in services, the Provider Site Admission form is completed for each LOC. For example, if a client is enrolled in ASAM 1.0 and RBH at the same agency, there need to be two Provider Site Admission forms.

Assessment

Part of the intake process involves assessing the client by using a full ASAM CONTINUUM™ Assessment to determine medical necessity and confirm LOC placement. For additional information, see *Access to Care – Determining Medical Necessity – Assessment* section.

Problem List Development and Updates in Non-OTP Settings

Non-OTP provider agencies must prepare individualized Problem Lists in coordination with the client, based on information obtained during the intake and assessment process, and update them on an ongoing basis as the client's progress within treatment is noted. The provider staff(s) responsible for the client's care creates and maintains the Problem List.

The minimum timeframes for completing, reviewing, updating, and obtaining LPHA signatures on Problem Lists depend on the LOC in which treatment is delivered. Problem List updates need to be completed by practitioners delivering services to the client whenever a problem is added, modified, or removed from the Problem List and finalized by LPHAs within the timeframes outlined in **Table 17**.

The Problem List is a list of symptoms, conditions, diagnoses, social drivers, and/or risk factors identified through assessment, psychiatric and other diagnostic evaluation, crisis encounters, or other types of service encounters. A problem identified during a service encounter may be addressed by the documenting practitioner (within their scope of practice) during that service encounter, and subsequently added to the Problem List. The Problem List need to be updated on an ongoing basis to reflect the current presentation of the client.

The Problem List includes, but is not limited to, the following:

- Diagnoses identified by a provider staff acting within their scope of practice.
- Associated diagnosis-related specifiers from the current DSM, when applicable.
- Current ICD-CM codes.
- Problems identified by a provider staff acting within their scope of practice.
- Problems or illnesses identified by the client and/or significant support person, if any.
- Name and title of the provider staff that identified, added, or removed the problem, and the date the problem was identified, added, or removed.

Note: Provider staff need to add to or remove problems from the Problem List when there is a relevant change to a client's condition.

Care Planning in Non-OTP Settings

Care planning is an ongoing, interactive component of service delivery rather than a one-time event. Non-OTP provider staff need to engage in ongoing collaboration with clients to identify and prioritize problems, explore EBPs and care options, identify action steps to address problems, and review the effectiveness of these action steps with a client-centered and culturally sensitive approach, which is an integral part of SUD treatment. Standalone Treatment Plans are not required in non-OTP settings. The plan of care should be clearly documented in all clinical documentation**.**

Treatment Plan Development and Updates in OTP Settings

OTP provider staff need to prepare individualized written Treatment Plans in coordination with the client and based on information obtained during the intake and assessment process.

Treatment Plans need to be completed upon intake and submitted within the timeframes outlined in **Table 18**. Every attempt must be made to complete and obtain client and LPHA/Medical Director signatures within the stated timeframe. However, given that it may take time for the client to sign and print their name on the Treatment Plan, the provider staff needs to obtain both the client's and LHPA's signatures no later than 28 days after the first service/first intake appointment. The LPHA or Medical Director sign and print their name on the Treatment Plan within 15 days of the client signing. These are the maximum time frames, but it is best to complete and sign the Treatment Plan as soon as possible, ideally close to the treatment admission date.

Note: Treatment Plan updates need to be completed and signed by both the client and the LPHA, as well as the counselor, if applicable.

Treatment Plans must include:

- Statement of problems to be addressed that are consistent with the qualifying diagnosis
- Goals to be reached that address each problem
- Action steps to be taken by the provider staff and/or client to accomplish identified goals
- Target dates for the accomplishment of action steps and goals
- Description of services, including the type and frequency of counseling to be provided and steps taken to complete the physical exam
- Proposed type(s) of interventions/modalities that include frequency and duration

- Specific, quantifiable goals and treatment objectives (e.g., SMART goal: Specific, Measurable, Attainable, Realistic, and Time-bound) related to the client's SUD diagnosis and multidimensional assessment
- DSM diagnosis for OUD and any other SUDs
- Assignment of a primary therapist or counselor
- Physical exam goal or documentation

Physical Examination

Physical examinations are required to ensure that clients are medically stable and receiving the necessary physical health services to facilitate their biopsychosocial well-being. Clients are required to have a physical examination within the last 12 months on file; and the Physician, Nurse Practitioner (NP), or Physician Assistant (PA) is responsible for reviewing documentation of the most recent (within the last 12 months) physical examination within 30 calendar days of the client's date.

In accordance with CCR Title 22, if the physician, NP or PA is unable to acquire or review a client's physical exam conducted in the last 12 months, the provider staff (registered or certified counselor or LPHA) needs to include a Progress Note detailing efforts made to obtain this documentation; and it needs to be conducted within 30 calendar days of the client's admission, and again it needs to be documented in the clinical notes with the goal of obtaining a physical examination with a specified completion date.

Data Reporting Requirements

Provider agencies are required to collect and submit CalOMS/LACPRS data and Drug and Alcohol Treatment Access Report (DATAR):

- **CalOMS/LACPRS:** Includes data elements that gather information on client characteristics, social factors, physical and mental health, employment, and criminal justice involvement, in well as drug use and treatment. Importantly, CalOMS/LACPRS includes data elements that serve as SUD treatment and/or recovery outcome measures, which are obtained by measuring changes in client responses at admission and discharge.
    - CalOMS/LACPRS admission data is required as follows:
        - New admissions
        - Any changes in services/LOC
        - Any changes in location
        - All clients, regardless of funding source(s) (e.g., private pay, commercial insurance)
        - No concurrent CalOMS/LACPRS allowed for the same type of services/LOCs
        - ASAM 0.5, RS (except standalone services), and "OTP – Detoxification" answer only the core questions that are pre-programmed in CalOMS forms
        - Use the treatment LOC (e.g., outpatient) when RS are provided concurrently
    - When a client transitions from one (1) residential LOC to another within the **same** residential facility (3.1 to 3.3 to 3.5 or reverse order), a new CalOMS Admission is not required; and CalOMS discharge status updates per BHIN 25-001:
        - Standard Discharge status 1, 2, and 3 definitions have been updated to allow for a standard discharge with the client has made satisfactory progress in treatment, discharge planning has commenced, but experiences a life circumstance that prevents

them from completing the discharge interview and/or last treatment service and notifies the program; and the treatment program has the information and client file documentation necessary to accurately complete the discharge questions without having to guess the responses.
        - Discharge status 1, 2, 3:
            - Completed Treatment Plan & Goals – Referred/Standard (status 1)
            - Completed Treatment Plan & Goals – Not Referred/Standard (status 2)
            - Left Before Completion with Satisfactory Progress – Referred/Standard (status 3)
    - CalOMS/LACPRS Submission Deadlines:
        - Admission Data: Full (100%) data need to be submitted **within seven (7) calendar days** of a client's entry into treatment.
        - Discharge Data: Full (100%) data need to be submitted **on the day of discharge** from the treatment.
        - Annual Updates: Full (100%) data need to be submitted **no later than 12 months** from the client's admission anniversary date; and no earlier than 60 days before the client's admission date anniversary.
        - The non-compliance reports for missing CalOMS Annual Updates are sent to provider agencies on the first business day of each month, and all non-compliant annual updates need to be submitted by the 10th of the same month.
        - If a provider agency plans to be temporarily inactive or will not be in operation for the next month and thus **not expecting any CalOMS submissions**, providers needs to promptly email SAPC's Health Outcomes and Data Analytics Division (HODA) CalOMS Team at hoda_caloms@ph.lacounty.gov to report Provider No Activity (PNA).
    - CalOMS/LACPRS Data Quality Report (DQR) includes:
        - Alerts on missing records/data fields, timeliness related to CalOMS/LACPRS data reporting.
        - Selected monthly and year-to-date capacity building and incentive metrics.
        - Notification on the 15th of each month (or the following business day if the 15th falls on a weekend or a LA County holiday).

For questions regarding CalOMS/LACPRS data submission, visit SAPC's CalOMS Resources webpage or email hoda_caloms@ph.lacounty.gov.

- **DATAR:**
    - **Overview:** Requires monthly data submission on:
        - Total and public capacity, availability at the end of reporting month, and number of days enrollment exceeded 90% capacity.
        - Number on waiting list, total number of waiting days, and waiting list by applicant characteristics (e.g., injection drug users, pregnant women).
          Note: Expected practice is to refer client to a facility with available capacity unless the client specifically requests to wait for an opening at the provider agency/site.
        - DATAR weblink: https://portal.dhcs.ca.gov/
    - **Submission Deadlines:**
        - DATAR monthly reports are **due on the 7th of the month** for the previous month's activities to meet the State's deadline on the 10th of the reporting month.
        - SAPC-HODA generates the state's monthly non-compliance report and cross-reference

it with the state DATAR dashboard on the 8th of each month to identify delinquent provider agencies; and sends non-compliance emails mandating submission **no later than the 10th of the month**.

- **DATAR Modalities:** DATAR only displays only contracted modalities (e.g., LOC) at a facility.
  - If a modality (e.g., LOC) listed on the report is not contracted with SAPC, email hoda_datar@ph.lacounty.gov.
  - For abbreviations of the types of services displayed on the DATAR form that are cross-referenced with the ASAM LOC, see **Table 6**.
- **Access to the DATAR Online Application:**
  - Submit a registration form to add, update, or delete provider staff.
  - The provider staff who registers is the "DATAR analyst" and is responsible for submitting monthly reports. Provider agencies should register an additional staff for each provider number to serve as a backup.
  - Request and submit registration forms to hoda_datar@ph.lacounty.gov.

Table 6: ASAM Level of Care vs. DATAR Modalities

ASAM LOC	DATAR	
	Abbreviation	Description
ASAM 1.0 (Outpatient)	ODF	Outpatient Drug-Free
ASAM 2.1 (Intensive Outpatient)	IOT/DCR	Intensive Outpatient Treatment/Daycare Rehab
ASAM 3.1	RES	Residential Drug-Free
ASAM 3.3		
ASAM 3.5		
ASAM 3.2 - WM	RES DTX-NH	Residential Detoxification – Non-Hospital
ASAM 3.7 - WM	Other	Other
ASAM 4.0 - WM	Other	Other
ASAM 1 - OTP	MAINT NTP/OTP	NTP/OPT MAINT
ASAM 1 - WM Ambulatory Withdrawal Management	ODF or IOT/DCR	Outpatient Drug-Free or Intensive Outpatient Treatment/Daycare Rehab
Recovery Services	N/A	N/A

Treatment Perception Survey

Providers are **required** to participate in the annual administration of the Treatment Perceptions Survey (TPS) to clients in October.

- TPS is designed to measure client perceptions across domains of access, quality of care, satisfaction, care coordination, and outcomes.
- TPS is offered to every client aged 12 and older who receives services either face-to-face or via telehealth during the survey period. FBS are considered face-to-face treatment services.
- TPS is available in all threshold languages and can be completed either online or paper survey.
- The SAPC-HODA TPS team distributes online survey links customized by location, LOC, and age group, along with prefilled paper surveys including location, LOC, and provider numbers prior to the TPS data collection period.
    - Prior to designing both the online and paper surveys, the TPS team will send a validation form to confirm facility information (e.g., LOC, facility address) and survey needs (e.g., survey type, need for youth, Spanish, or paper copies). This form need to be completed and returned by the deadline.
- The TPS Guide and training materials are available on SAPC's Treatment Perceptions Survey Resources webpage.

For questions regarding the TPS, email hoda_tps@ph.lacounty.gov.

Service Benefit and Levels of Care

Addiction treatment is delivered across a continuum of services that reflects the severity of the SUD and the intensity of services required. One of the County's key goals is to facilitate SUD service delivery for the right service, at the right time, in the right setting, for the right duration.

Referral to a specific LOC need to be based on a complete assessment of each client. The primary goal is to place the client in the least restrictive setting that supports the goals of recovery and resiliency, learning and development, and enhanced self-sufficiency. Initial referrals may be accomplished with a brief screening tool, either the Youth and Young Adult Screener, **or** ASAM CO-Triage® Tool for Adults (age 21 and over). Then, a more comprehensive assessment can be completed at the treatment program to confirm placement. In LA County, LOC determinations are based on the ASAM Criteria. In general, the preferred and most appropriate LOC is one that is the least intensive while still safely meeting the unique treatment objectives of the client and treatment team.

LOC determinations begin with the full ASAM CONTINUUM™ Assessment, which provides a comprehensive evaluation of a client's risks, needs, strengths, skills, and resources. The ASAM assigns a rating for each of these dimensions. These ratings will help you to decide the correct LOC. If the client has physical or mental health conditions, the priority is to stabilize them immediately. If they have more than one physical or mental health condition, the decision about how to stabilize them should be based on the most severe of these needs. That may mean they are placed within the SUD system of care (including OTPs), or in the physical or mental health systems. Treatment is best conceptualized as a flexible continuum, marked by different ASAM LOCs, with graduations of service intensities for OP, residential, and WM services; see **Table 7**.

Table 7: ASAM Criteria Continuum of Care for SUD Treatment

Benefits	ASAM LOC	Description
Early Intervention Services	0.5	For Youth (age 17 and under) and Young Adults (age 18-20) who do not meet DSM criteria for an SUD but would benefit from psychoeducation and other services to correct or improve a substance-related health condition as part of the EPSDT benefits.
Outpatient	1.0	For clients who are stable with regard to acute intoxication/withdrawal potential, biomedical, and mental health conditions.
Intensive Outpatient	2.1	For clients with minimal risk for acute intoxication/withdrawal potential, medical, and mental health conditions, but need close monitoring and support several times a week in a clinic (non-residential and non-inpatient) setting.
Low-Intensity Residential (Clinically Managed)	3.1	For individuals who need time and structure to practice and integrate their recovery and coping skills in a residential environment.
High-Intensity Residential, Population Specific (Clinically Managed)	3.3	For clients with functional limitations that are primarily cognitive, who require a slower pace to treatment, and are unable to fully participate in the social and therapeutic environment.
High-Intensity Residential, Non-Population-Specific (Clinically Managed)	3.5	For clients who have specific functional limitations and need a safe and stable living environment to develop and/or demonstrate sufficient recovery skills to avoid immediate relapse or continued use of substances.
Opioid Treatment Program	1-OTP	For clients with OUDs that require methadone or other MAT.
Recovery Bridge Housing	N/A	For clients who are homeless or unstably housed; and are concurrently enrolled in an OP, IOP, OTP, or Ambulatory-Withdrawal Management LOCs.
Recovery Housing	N/A	For clients who are homeless or unstably housed; and are voluntarily seeking to live in recovery-oriented housing. Residents are encouraged but not required to be concurrently enrolled in treatment.
Recovery Services	N/A	For clients in care, including CENS, during transition in setting or intensity of care, or following discharge from a treatment episode who require additional support to organize internal and community resources for ongoing self-management.
Ambulatory-Withdrawal Management (Outpatient) *without* extended on-site monitoring	1-WM	For clients with mild withdrawal who require either daily or less than daily supervision in an OP setting (e.g., physician's office or clinic).
Ambulatory-Withdrawal Management (Outpatient) *with* extended on-site monitoring	2-WM	For clients with moderate withdrawal who require daytime WM and support. Includes daily assessments with daytime WM and support and supervision in a non-residential setting (e.g., day hospital).
Clinically Managed Residential-Withdrawal Management	3.2-WM	For clients with moderate withdrawal who need 24-hour support to complete WM and increase the likelihood of continuing treatment or recovery.
Medically Monitored Inpatient-Withdrawal Management	3.7-WM	For clients with severe withdrawal that require 24-hour inpatient care and medical monitoring with nursing care and physician visits.
Medically Managed Intensive Inpatient-Withdrawal Management	4-WM	For clients with severe, unstable withdrawal that requires 24-hour nursing care and daily physician visits to modify WM regimen and manage medical instability.

Source: American Society of Addiction Medicine. (2013). The ASAM criteria: Treatment criteria for addictive, substance-related, and co-occurring conditions (3rd ed.). The Change Companies.

OTPs (also known as Narcotic Treatment Programs or NTPs) are an essential component of the continuum of care for SUDs. As with other levels of SUD care, ensuring a flow of appropriate referrals between OTPs and other SUD providers, as well as referrals into other health systems when necessary, is critical to delivering high-quality OTP services. In addition to the various Federal and State requirements that govern OTPs, the quality and resource management standards and requirements set within the SAPC's Quality Improvement Section (SAPC-QI) and SAPC-UM also pertain to OTPs.

The ASAM Criteria also outlines a continuum of care for WM for Adults (age 21 and over). Since severe withdrawal is less common in adolescents than in adults, WM for adolescents is unique. When an adolescent is in withdrawal and does not require emergency care, every effort should be made to provide WM services in the setting in which adolescent clients are receiving their SUD care. **WM for adolescent populations will be approved by SAPC on a case-by-case basis as clinically warranted and based on medical necessity**. In cases where the recommended LOC is unavailable, providers need to arrange for clients to obtain the necessary services through an alternative program.

Effectiveness and safety should be the priority in these circumstances, which may require that clients be placed in higher LOCs than the ASAM Criteria indicates. In these instances, it is the providers' responsibility to advocate for the client and justify and explain the reason for the alternative LOC or intervention, based on the available clinical documentation.

Services provided at the various LOCs should reflect the client's clinical condition, including consideration for severity level and functional impairment. Services include, but are not limited to: individual counseling, group counseling, family therapy, patient education, psychosocial interventions, medication services, collateral services, Care Coordination, crisis intervention, care planning, Recovery Incentives-Contingency Management (RI-CM), RS, and discharge services.

As clients transition between LOC, progress in all six (6) ASAM dimensions should be formally assessed at regular intervals to monitor for changes in the client's condition, in accordance with the client's severity level and functional impairment, as clinically indicated. These assessments help to ensure that clients are placed in an appropriate LOC based on medical necessity, as reviewed and verified by an LPHA. LOC transitions need to be based on clinical need as the client's condition changes, and not by the type of health coverage the client has, or what is available or more convenient for the provider.

Continuity of care and longitudinal follow-up are critical for SUD clients. Referrals and linkages to different services and LOCs within the SUD, physical, and mental health systems help to ensure that client needs are appropriately addressed. High-quality care is characterized by the seamless linking of different LOCs, both within the SUD system of care and between other healthcare systems. This streamlined system of care can be achieved through Care Coordination, role induction (preparing individuals for treatment by sharing the rationale of treatment, the treatment process, and their role in that process), warm hand-offs, and assertive outreach.

Provider agencies should also be familiar with additional requirements related to SUD treatment. These include CCR Title 22, CCR Title 9, BHIN 17-017, provisions related to LA County's implementation of DMC-ODS and CalAIM, SAPC Bulletins and INs, and contracted Specific Services to be Provided and Definitions of Services. A brief overview of funded services and LOCs are outlined below. For a detailed description of ASAM LOCs, see *The ASAM Criteria* textbook.

Care Coordination

Care Coordination, formerly referred to as Case Management, links clients with appropriate health and social services to address specific needs and achieve treatment goals. Care Coordination is a client-centered service intended to complement clinical services, such as individual and group counseling, and address areas in an individual's life that may negatively impact treatment success and overall quality of life. Care Coordination offers support services to clients to increase self-efficacy, self-advocacy, basic life skills, coping strategies, self-management of biopsychosocial needs, benefits and resources, and reintegration into the community.

Care Coordination is:

- Client-centered (i.e., focused on meeting the varied needs of clients)
- A point of contact between SUD care, mental health care, medical care, and social services
- Advocacy by acting in the client's best interests
- Helping the client navigate and obtain community resources, and integrate into the community after discharge from inpatient or residential services
- Culturally sensitive
- Flexible
- Anticipatory with the understanding that SUDs may be chronic and relapsing

Care Coordination is available to all clients who enter the SUD treatment system. This service is available throughout treatment and may be continued during RS. Care Coordination services may be provided in-person, by telephone, or by telehealth.

Overview of Care Coordination and Services

The primary goal of Care Coordination is to ensure clients in SUD treatment receive the support and services necessary to be successful in meeting treatment and recovery goals. A barrier to successfully completing treatment may be a lack of communication and established referral procedures between health and social systems. Care Coordination is effective at keeping individuals in treatment and moving toward recovery by addressing other life challenges along with substance use.[6] Care Coordination services are especially important for clients with chronic health problems, CODs, PEH, or who are involved with the criminal justice system.

Although an important component of Care Coordination in SUD treatment is connecting clients to outside systems of care, such as physical and mental health systems, it is equally important in transitioning clients through the SUD system of care.

Care coordinators need to have a working knowledge of the appropriate resources to successfully link clients to services and resources (e.g., financial, medical, or community services). Services provided through Care Coordination are tailored to facilitate and track continuity of care across all systems of care.

[6] SAMHSA. (2015). Chapter 4 – Evaluation and Quality Assurance of Case Management Services. *Treatment Improvement Protocol (TIP) Series, No. 27.* https://library.samhsa.gov/sites/default/files/sma15-4215.pdf

Provider staff need to perform three (3) core Care Coordination functions to ensure successful treatment outcomes and recovery: **Connection**, **Coordination**, and **Communication**. Although not an exhaustive list, see **Table 8** for a list of the three (3) functions and the respective activities that can be performed and billed under Care Coordination.

- **Connection**: Establishing connections through referrals that link clients to housing, educational, social, prevocational, vocational, rehabilitative, or other community services. This includes providing high-quality referrals and linkages to resources and services necessary to address the problems documented on the Problem List (for non-OTP settings) or in the Treatment Plan (OTP settings). High-quality referrals and linkages require the care coordinator to play an active role in reducing access barriers and ensuring clients have "actual" access to needed services. This means going beyond providing resource lists to clients to actively establishing relationships and protocols with external providers, ensuring clients are connected with relevant agencies and services upon referral.
  Note: Care coordinators assist clients with applying for and maintaining health and public benefits (e.g., Medi-Cal, Minor Consent Program, GR, and LA County-funded programs/projects); and help clients who have moved transfer their Medi-Cal benefits from the previous county of residence to LA County.
- **Coordination**: Care coordinators act as a bridge between health and human service providers to ensure that information is appropriately exchanged, and clients are successfully linked to needed resources/services. Activities include helping clients set up medical appointments, ensuring SUD providers at the treating agency are aware of the client's other services, following up with clients in service transition, and notable events. For example, care coordinators follow up with clients within a few days of an ER visit, hospital discharge, or discharge from a residential facility. Care coordinators also coordinate successful transitions between SUD LOCs, including setting up an assessment appointment, transferring necessary documentation to the receiving treatment agency, and providing a warm hand-off for necessary services. If clients are transitioned to a higher or lower LOC at a different provider agency, the care coordinator should use the SBAT to identify provider agencies that meet the client's needs. Care coordinators are expected to schedule appointments and track referrals until obtaining confirmation that clients have enrolled at the receiving treatment agency.
- **Communication**: Communication is the primary way in which Care Coordination activities are successfully performed. It is the responsibility of care coordinators to serve as a liaison between clients and their service providers. Communication may include telephone calls, emails, letters, Progress Notes, and/or reports to the County, State, and other service providers on behalf of the client. For example, a client may need a letter sent to a judge verifying that they are participating in SUD treatment. At times, care coordinators also need to advocate on behalf of clients. If client service needs are unmet, care coordinators educate clients about their rights and advocate for them with their service providers.

Table 8: Core Functions of Care Coordination

The 3 Cs of Care Coordination

1. CONNECTION: Referrals that link clients to housing, education, social, prevocational, vocational, rehabilitative, or other community services.
• Establishing and Maintaining Benefits
  ○ Helping clients to apply for and maintain health and public benefits (e.g., Medi-Cal, GR, Perinatal, Housing, etc.).
  ○ Assisting PEH in accessing the Coordinated Entry System (CES), and if needed, assisting in completing any intake/assessment documents such as the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT).
  ○ Transferring benefits from the previous county of residence to LA County for clients who have moved.
• Community Resources
  ○ Coordinating with other service providers to provide individualized connection, referral, and linkages to community-based and governmental services and resources, including direct referrals to local food banks and/or community churches for groceries and meals, clothing assistance, educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.

2. COORDINATION: Acting as a liaison to aid in transitions of care and arranging for health services and social services.
• Transitioning between SUD LOCs
  ○ Facilitating necessary transitions in SUD LOCs (e.g., from Residential to IOP treatment, OP to RS, etc.), including initiating referrals to the next LOC, and coordinating with and forwarding necessary information to the accepting provider agency.
• Mental and Physical Health Services
  ○ Coordinating care with physical health providers (including managed care health plans such as L.A. Care, Health Net, and Kaiser), community health clinic providers, and mental health care providers to ensure a coordinated approach to whole-person care by monitoring and supporting care for other health conditions.
• Social Services
  ○ Coordinating with state and County entities (DPSS, DCFS, LAC-Probation, LA Superior Courts, Housing Providers, etc.) to ensure the social aspects of health and well-being are being coordinated with health services.

3. COMMUNICATION: Correspondence, including emails, letters, and reporting documentation, by the care coordinator to the County, State, and other service providers on behalf of the client.
• Health Providers
  ○ Communicating with physical health (including managed care health plans such as LA Care, Health Net and Kaiser), community health clinics providers, and mental health providers to ensure a coordinated approach to whole-person health service delivery.
  ○ Monitoring and following up with other agencies regarding scheduled services and/or services received by clients.
• Service Partners
  ○ Communicating with DPSS workers, DCFS social workers, DMH workers, LA Superior Courts, LAC-Probation Officers, Housing Providers, etc., to align objectives and activities.
• Advocacy
  ○ Advocating for clients with health/social service providers, County, and community partners, and others (such as officials at schools, juvenile or adult court hearings and/or meetings with corrections staff, and Student Attendance Review Boards or other school-related hearings) in the best interests of clients (e.g., respectfully advocating for necessary services to be provided in a timely manner).

Care Coordination: Considerations for Vulnerable Groups

People with special needs may require more intensive Care Coordination activities. Moreover, some County agencies (DCFS, DPSS, Law Enforcement, LA Superior Courts, etc.) may require providers to submit additional documentation and perform additional activities (e.g., attending court hearings or meeting with case workers to advocate on the client's behalf).

These groups include people living with HIV/AIDS or mental illness, PEH, PPW, youth, and justice-involved individuals. Each population will require coordinated activities to assist individuals in effectively navigating, accessing, and participating in treatment, as well as securing housing and obtaining other supportive services.

People Experiencing Homelessness

A client-centered Care Coordination approach ensures that PEH participate in identifying goals and service needs, and that there is a shared accountability with the care coordinator. Care Coordination aims to empower people, draw on their strengths and capabilities, and promote an improved quality of life by facilitating timely access to the necessary supports to help them obtain and maintain housing. Care coordinators require the right skills and a thorough understanding of the community to succeed. Therefore, it is highly recommended that care coordinators take the Direct Service Training Curricula Courses provided by the Los Angeles Homeless Services Authority (LAHSA) Centralized Training Academy. These courses emphasize the application and adherence to EBPs of Trauma-Informed Care, Cultural Humility, Housing First, Harm Reduction, MI, and Critical Time Intervention.

The courses address how care coordinators can apply these practices to their work with the following subpopulations: chronically homeless; single adults; families; youth; young adults; women; Lesbian, Gay Bisexual, Transgender, Queer (LGBTQ+, "+" represents other identities such as non-binary, asexual, pansexual, two-spirit, and more) people; people with disabilities; domestic violence/intimate partner violence (DV/IPV) survivors; human trafficking survivors; the aging and the elderly; incarceration/reentry; and veterans.

Justice-Involved

The care coordinator communicates with criminal justice staff (e.g., LAC-Probation, LASD, LA Superior Courts, etc.) to ensure that Care Coordination activities meet the respective criminal justice supervision requirements of the referring agency. As needed, care coordinators may be asked to perform the following activities:

- Attend court hearings to report the progress of SUD treatment.
- Arrange letters, phone calls, emails, and/or direct in-person meetings with law enforcement agencies (LAC-Probation, LASD, and Parole) and courts (LA Superior Courts) about client enrollment and SUD treatment progress.
- Receive health records related to in-custody treatment for individuals being released from custody, including those released from facilities outside of LAC.

Children and Family Services

For clients participating in County-funded programs for children and family services, one of the primary focuses for providers should be the family unit (e.g., helping clients meet the requirements set forth in their family reunification plan). Therefore, Care Coordination activities help clients gain access to services and resources that consider family needs. Care Coordination activities for this group may include linkage to parenting classes, childcare, food and clothing assistance, and family planning services.

When working with children, families, and perinatal women, the care coordinator confers with the client's DPSS worker, DCFS social worker, DMH worker, etc., at least once to ensure that the objectives and activities developed in Care Coordination are consistent and do not unintentionally overwhelm the client.
For additional information about these populations and requirements, see the following sections: *Pregnant and/or Parenting Women Population*, *Family Programs – DPSS Programs – CalWORKs*, and *Family Programs – DCFS Programs – RSC Program*.

Care Coordination: Service Requirements and Components

Eligibility Criteria for Care Coordination Services

Care Coordination services are available to all clients who are enrolled in all LOCs under the DMC-ODS. Reimbursement eligibility criteria for Care Coordination services match the DMC-ODS enrollment criteria.

Staffing Requirement

The care coordinator needs to be a registered/certified SUD counselor and/or license-eligible LPHA/LPHA.

Documentation

Planning and documentation are important to a structured and integrated Care Coordination model. Following the ASAM CONTINUUM™ Assessment or Assessment Tool - Youth (Paper Version) found on the SAPC website, a care coordinator needs to discuss the results and collaborate with the client to develop a plan of action that includes the client's Care Coordination needs. The plan should address the problems documented on the client's Problem List and Progress Notes in non-OTP settings, or Treatment Plan and Progress Notes in OTP settings. For CENS RS, see CENS Standards and Practices.

The Care Coordination plan should include tracking key service components, including Care Coordination needs, Connection/Coordination/Communication activities, and advocacy efforts. Progress Notes clearly documenting Care Coordination activities are critical to demonstrating the rationale and details of the activities performed. Care coordinators are responsible for working with clients to implement a Care Coordination plan that addresses the problems listed on the Problem List and follow action steps documented in the plan section of Progress Notes (non-OTP settings), or Treatment Plan (OTP settings), and monitor the client's progress.

Care Coordination activities are documented in the Progress Notes and include a description of the client's prioritized service needs. In non-OTP settings, action steps to address the client's prioritized needs are documented in Progress Notes. In OTP settings, the Treatment Plan includes a problem statement, long-term goals, short-term goals in SMART format, action steps, desired outcomes, and target completion dates. When

appropriate, The Progress Notes (non-OTP settings) or the Treatment Plan (OTP settings) describe barriers, ways for handling anticipated complications, or alternative plans to achieve the stated objectives. Provider staff obtain an ROI documented on SAPC-approved ROI forms whenever a Care Coordination activity requires releasing any client information, including the client's enrollment in an SUD program.

Provider agencies maintain verifiable documentation related to the delivery of care coordination services, including, but not limited to, the amount of time spent by staff for the provision of these services. Documentation is provided upon request(s) for compliance audit and/or review purposes to support billing claims. Compliance activities may include audits/reviews from federal, State, and County departments as part of funding verification, including DMC and SUBG.

Treatment Plan

Evaluating Care Coordination needs can be documented under Assessment, and discussing the Care Coordination component of the Plan of Care can be documented under Individual Counseling. Updating Problem Lists (non-OTP) or Treatment Plans (OTP settings) is not a Care Coordination activity and is not billed under the Treatment Planning billing code. Billing under Care Coordination requires the Care Coordinator to engage in a Care Coordination activity. A Care Coordination activity includes coordination with a person, agency, and/or service to connect the client to a service or resource not being provided to the client by the agency that would support the client in their SUD treatment and recovery goals.

Service Hour Requirements

For most LOCs, Care Coordination services can be billed separately from other services. The only exceptions are WM Levels 3.7, and 4.0, where the benefit is covered by the day rate and is **not** a separate billable service. Care Coordination services may be delivered face-to-face, by telephone, or through telehealth supportive services.

Care Coordination service delivery needs to be consistent with client confidentiality as outlined in 42 CFR Part 2; 42 CFR Part 438; HIPAA; CCR Title 9, Chapter 8: Certification of Alcohol and Other Drug Counselors; and Title 22 CCR § 51341.1 - Drug Medi-Cal Substance Use Disorder Services, and an appropriate ROI needs to be obtained for care coordination that accords with these regulations.

Medi-Cal Peer Support Specialist Certification Program

Since FY 2022-2023, SAPC opted in to participate in the Medi-Cal Peer Support Specialist Certification Program, a statewide initiative designed to certify peer support specialists. In alignment with Senate Bill (SB) 803, DHCS launched this program to officially recognize Certified Medi-Cal Peer Support Specialists (CMPSS), also referred to as "Certified Peers," as a new provider type. The program established Certified Medi-Cal Peer Support Services (commonly known as Peer Support Services or PSS) as a new Medi-Cal reimbursable benefit under the SMHS and DMC-ODS programs.

Additionally, DHCS established the standards for certifying peer support specialists across California and designated the California Mental Health Services Authority (CalMHSA) as the sole certifying entity. CalMHSA is responsible for implementing the Medi-Cal Peer Support Specialist Certification Program, which outlines the eligibility, training, and examination requirements for peer support specialists to become Certified Peers.

For additional information regarding the Medi-Cal Peer Support Specialist Certification Program, see BHIN 21-041 or visit CalMHSA's Medi-Cal Peer Support Specialist Certification Program website.

Certified Peers

Certified Peers provide non-clinical, recovery-oriented, culturally appropriate services that promote engagement, socialization, self-sufficiency, self-advocacy, natural supports, and are trauma-aware. Certification under this policy is designed for individuals who are 18 years of age or older and self-identify as having lived experience with the process of recovering from mental illness, SUD, or both. This includes individuals who have either received these services themselves or are parents or family members of clients. To be certified practitioners in California, peers need to master the 17 Core Competencies and adhere to the Code of Ethics for Certified Medi-Cal Peer Support Specialists.

Certification Fees

To provide DMC-ODS reimbursable PSS, individuals need to complete CalMHSA's Medi-Cal Peer Support Specialist Certification Program. CalMHSA sets all certification guidelines and associated fees. For additional information on certification fees, see CalMHSA's Fee Schedule webpage.

Initial Certification

To become a Certified Peer, an individual needs to meet all of the following qualifications:

1. Be at least 18 years of age.
2. Possess a high school diploma or equivalent degree.
3. Be self-identified as having experience with the process of recovery from a mental illness or SUD, either as a client of these services or as the parent, caregiver, or family member of a client.
4. Be willing to share their experience.
5. Have a strong dedication to recovery.
6. Agree, in writing, to adhere to the Code of Ethics.
7. Successfully complete the required Medi-Cal Peer Support Specialist 80-hour training through a CalMHSA-approved training entity.
8. Pass the certification examination administered by CalMHSA.

Application Process Overview

Candidates interested in becoming a Certified Peer need to register to create an account and submit an application to CalMHSA. Candidates need scanned copies of the following documents prior to beginning the application:

1. Government-issued ID/License/Passport that shows you are over 18 years of age (Note: First and last name on the application need to match exactly as it appears on your uploaded government-issued ID).
2. High school diploma/equivalency or other advanced degree.

CalMHSA reviews the application, which may take up to 30 days. If any revisions are needed, CalMHSA emails instructions on how to update the application. Incomplete applications are held for 90 days, and if still incomplete after that time, the application is voided, fees forfeited, and requires submission of a new application, documentation, and new fees.

Once the application is approved, candidates need to complete the Medi-Cal Peer Support Specialist 80-Hour Training from a CalMHSA-approved training entity. After completion, candidates upload their certificate. CalMHSA then reviews the certificate and notifies candidates of their application status within 14 days.

Once the training certificate is approved, eligible candidates receive an email from CalMHSA, allowing them to schedule and take the Certification Exam within 14 days of paying the exam fee. CalMHSA sends a notification email 7-14 days after the exam, providing the exam status and instructions on accessing the certification document. If a candidate does not pass the exam, they can initiate an exam retake request.

For additional information, visit CalMHSA's Initial Certification Requirements webpage and CalMHSA's How to Apply webpage.

80-Hour Training for Certification

See *Training for Peer Support Specialists* section.

Certification Exam

The Medi-Cal Peer Support Specialist Certification Exam is only offered by CalMHSA. The exam is a 2.5-hour, 120-item multiple-choice exam. It is available in English, Spanish, Chinese, Hindi, Japanese, Korean, Russian, and Vietnamese. It can be taken through live online proctoring or at in-person testing centers in California. The online exam is delivered via Pearson VUE's online delivery system called OnVUE. To aid in exam preparation, CalMHSA released the Medi-Cal Peer Support Specialist Certification Preparation Guide (August 2024) and day of exam preparation tips.

Candidates requiring exam accommodations should refer to CalMHSA's Exam Accommodations webpage. The items listed on the Exam Comfort Aid List do not require an Exam Accommodation Request. However, for requests not included in the list, candidates need to complete the Exam Accommodations Form. This form needs to be submitted to CalMHSA prior to registering for the exam to ensure that accommodation needs are duly considered. CalMHSA reviews all requests for accommodations and provides a response within 30 days.

Certified Medi-Cal Peer candidates receive an email notification regarding exam results within 7-14 days after completion. If a candidate does not pass the exam, CalMHSA sends information on how to retake the exam via email. Candidates can take the certification exam up to three (3) times during a 12-month period. Each retake requires a new retake request, and associated fees need to be submitted to CalMHSA. For additional information, visit CalMHSA's Exam webpage.

Certification Registry

Once a candidate successfully completes all the requirements outlined in the Medi-Cal Peer Support Specialist Certification Program, they will be awarded a certificate. Their certification number is accessible to the public via the CalMHSA Medi-Cal Peer Support Specialist Certification Registry.

Certified Peers are required to maintain an active certification in order to provide DMC-ODS reimbursable PSS. Certifications are valid for two (2) years from the issue date.

Certification Renewal

See *Workforce – Certified Peers – Certification Renewal* section.

Supervision of Certified Peers

Supervision is a crucial component in delivering high-quality behavioral health services, professional development, and overall support. As outlined in BHIN 22-018, a supervisor needs to meet applicable California state requirements, including completing the Medi-Cal Peer Support Specialist Supervisor Training within 60 days of beginning supervision of Certified Peers.

As with all SUD services, PSS needs to be provided as a component of the individualized Plan of Care developed for each client by an LPHA. While the LPHA directing services per an individualized Plan of Care assumes the overall responsibility for the PSS provided to each client, the LPHA is not required to be present at the time-of-service delivery. The direct supervisors of Certified Peers do not need to be LPHAs. Using Certified Peers as supervisors is highly encouraged. Opportunities for career advancement are important as the Certified Peer workforce is established.

Certified Peers must provide services under the direction and supervision of an individual who meets at least one (1) of the following qualifications:

1. Have a Medi-Cal Peer Support Specialist Certification, two (2) years of experience working in the behavioral health system, and completed an approved supervisory training; **or**
2. Be a non-peer behavioral health professional (including registered and certified SUD counselor), have two (2) years of experience working in the behavioral health system, and completed an approved supervisory training; **or**
3. Have a high school diploma or GED, four (4) years of behavioral health direct service experience that may include PSS, and completed an approved supervisory training.

In accordance with the State of California licensure requirements and listed in the California Medicaid State Plan as a qualified DMC-ODS provider, LPHAs need to be licensed, waivered, certified, or registered.

For additional guidance regarding Certified Peer Supervisor standards, see BHIN 21-041. For additional information on the Medi-Cal Peer Support Specialist Supervisor Training, see *Training for Supervisors* section below.

Peer Trainings

Training for Peer Support Specialists

The Medi-Cal Peer Support Specialist training is an 80-hour training that covers 17 Core Competencies and the Code of Ethics for Certified Medi-Cal Peer Support Specialists in California. The training is designed to give Certified Peer candidates the tools to support clients through their recovery process.

Training from an approved provider is mandatory for all Initial Certification applicants. Certificates for Medi-Cal Peer Support Specialist 80-Hour Training issued by a CalMHSA-approved provider are valid for two (2) years from the date of completion and certificate issuance. Training options include virtual, in-person, or hybrid. Training costs vary by approved vendors. For additional information, visit CalMHSA's Training for Medi-Cal Peer Support Specialists webpage.

Training Specializations

There are four (4) areas of specialization for Certified Peers. These specializations focus on additional training that builds on the knowledge, skills, and abilities of Medi-Cal Peer Support Specialists. The training hours and core competencies covered vary by specialization. The four (4) areas of specialization are:

- Parent, Caregiver, and Family Member Peer;
- Peer Services in Crisis Care;
- Peer Services for Unhoused; **and**
- Peer Services for Justice-Involved.

These areas of specialization are not required for certification as a Medi-Cal Peer Support Specialist. For additional information, visit CalMHSA's Training for Specializations webpage.

Training for Supervisors

CalMHSA offers the Medi-Cal Peer Support Specialist Supervisor Training at no cost. The one (1) hour training is based on Substance Abuse and Mental Health Services Administration's (SAMHSA) best practices for supervising peer support specialists. Objectives include identifying supervisor qualifications, understanding peer work principles and competencies, modeling recovery-oriented supervision, and accessing resources to improve supervisory skills. CalMHSA accepts the certificate of completion towards the Continuing Education (CE) requirements for Medi-Cal Peer Support Specialist Certification renewal.

Scope of Practice for Certified Peers

Peer Support Services

PSS are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching designed to set and make progress toward recovery goals. These services aim to prevent relapse, empower individuals through strength-based coaching, provide support linkages to community resources, and educate members and their families about their conditions and recovery.

PSS may be provided to the individual or significant support person and may be provided in a clinical or non-clinical treatment setting, as a standalone service, with or without the member present. They may be delivered in-person or via telephone, telehealth, or at approved FBS sites.

For PSS to be reimbursable, they need to be provided by a Certified Peer. Per DHCS, Certified Peers' scope of practice is limited to the services outlined in the section below and based on a Plan of Care approved by an LPHA or a Certified Peer Supervisor. The Plan of Care need to be submitted in accordance with the guidelines outlined in *Sage for Certified Peers – Documentation for PSS* section. In residential treatment settings, PSS would count toward weekly therapeutic hours. For additional information, visit SAPC's Manuals, Bulletins, and Forms – Bulletins Tab webpage for the most current version of the Provider Staffing Guidelines.

In accordance with BHIN 25-010, Certified Peers can utilize the following codes to provide Medi-Cal reimbursable PSS:

- H0025 Behavioral Health Prevention Education Services:
  - **Educational Skill Building Groups:** Providing a supportive environment in which members and their families learn coping mechanisms and problem-solving skills to help members achieve desired outcomes. These groups promote skill-building for members in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services

    Note: Educational Skill-Building groups are available in all LOCs and are defined as in-person, by telephone or by telehealth contact with a Certified Peer components and needs to be outlined in the member's Individualized Plan of Care. A separate progress note documenting the client's education session is written for each member in the group and documented in the EHR or Sage. Group sign-in sheets need to include printed names (first and last name) and signatures of all group members and group facilitators.

- H0038 Self-Help/Peer Services:
  - **Engagement:** Activities and coaching led by Certified Peers to encourage and support members to participate in behavioral health treatment. Engagement may include supporting members in their transitions between LOCs and supporting members in developing their own recovery goals and processes.
  - **Therapeutic Activity:** A structured non-clinical activity provided by Peer Support Specialists to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support

the member's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the member; promotion of self-advocacy; resource navigation; distribution of naloxone or other overdose prevention supplies in accordance with established distribution policies; and collaboration with the members and others providing care or support to the member, family members, or significant support persons.

Note: Individual Self-Help/Peer Service sessions are designed to support direct communication and dialogue between the Certified Peer and the client to focus on supporting the client in behavioral health treatment and/or the PSS components outlined in the client's Individualized Plan of Care. Individual Self-Help/Peer Service sessions are available in all LOCs and are defined as in-person, by telephone or by telehealth contact with a Certified Peer. Individual Counseling sessions of less than 15 minutes cannot be billed as they are less than the minimum requirement. If Individual Counseling sessions exceed 60 minutes, the Progress Note for that encounter needs to justify the exceeded time. If the counseling session is split into different services (e.g., Care Coordination, Crisis Intervention, etc.), a Progress Note needs to be written for each session and documented in the EHR or Sage.

RI-CM Pilot Program for Certified Peers

In accordance with BHIN 24-031, Certified Peers can also serve as a Contingency Management (CM) Coordinator at a participating DMC-ODS provider agency site and administer RI-CM services. The CM Coordinator is the main point of contact for those in the RI-CM Pilot Program, which ends on December 31, 2026. Certified Peers can utilize the following code to provide Medi-Cal reimbursable RI-CM services:

- H0050 HF Alcohol and/or drug services, brief intervention (HF is the modifier used to identify when CM Services were provided).

For additional information on the RI-CM Pilot Program, see *Recovery Incentives-Contingency Management Program* section.

Reimbursement Rates for Certified Peers

For additional information on billing processes and rates, visit SAPC's Manuals, Bulletins, and Forms – Bulletins Tab webpage for the most current version of the SAPC IN for the Rates and Standards Matrix.

Sage for Certified Peers

Certified Peer User Enrollment

Certified Peers need access to Sage to document reimbursable services. For primary Sage users, SAPC has developed three (3) different access levels for Certified Peers, as indicated below.

1. **Certified Peer Support Specialist:** This access group is intended for Certified Peers who will not be submitting billing.
2. **Financial + Certified Peer Support Specialist:** This access group is intended for Certified Peers who may also submit billing claims.
3. **Peer Support Supervisor:** This access group is intended for supervisors of Certified Peers.

For additional information on accessing Sage, see Sage User Onboarding/Offboarding and Privilege Management.

Documentation for PSS

PSS are based on an approved, individualized Plan of Care to be reimbursable. The Plan of Care need to be documented using the Plan of Care note option in Sage, for primary Sage users or within a SAPC-approved EHR Progress Note format for Secondary Sage users, and approved/signed by a Behavioral Health Professional or a Certified Peer Support Specialist Supervisor as referenced in SAPC's Peer Support Services Guide (January 2024). Certified Peers can develop a Plan of Care, but it needs to be reviewed and signed by an LPHA **or** a Certified Peer Supervisor.

The Plan of Care is documented:

- Using Plan of Care service type option on the Progress Note form in Sage for a primary Sage user; **or**
- Within a SAPC-approved EHR Progress Note form for a secondary Sage user.

The Plan of Care is approved/signed by an LPHA **or** a Certified Peer Supervisor within the time frames listed below:

- For clients in non-residential treatment settings:
    - Within 30 calendar days of first service or first intake appointment for Adults (age 21 and over); **or**
    - Within 60 calendar days of first service or first intake appointment for Youth (age 17 and under) and Young Adults (age 18-20), and all Adults (age 21 and over) who are documented as a PEH.
- For clients in residential treatment settings:
    - Within seven (7) calendar days of first service or first intake appointment in residential settings for Young Adults (age 18-20) and Adults (age 21 and over); **or**
    - Within 14 calendar days of first service or first intake appointment in residential settings for Youth (age 17 and under).

The Plan of Care is reviewed and updated when clinically appropriate to reflect significant changes in the client's treatment and signed by an LPHA **or** a Certified Peer Supervisor:

- No later than every 90 calendar days after the initial Plan of Care approval in OP settings, **or**
- No later than every 30 calendar days after the initial Plan of Care approval in residential settings.

Plan of Care Guidelines for PSS

The documented Plan of Care needs to be developed with client involvement and include the client's long- and short-term goals. The Progress Note needs to specify when there's an updated Plan of Care, or a review of the Plan of Care. Provider agencies can adapt the guidelines below in accordance with their current documentation formatting. In addition, PSS need to be documented in a Progress Note within three (3) business days. For documentation examples, see SAPC's Peer Support Services Guide (January 2024).

These guidelines are intended to be used within a Progress Note with "Peer Support Services – Plan of Care" Service Type. Below are the minimum requirements of what to include in a Plan of Care.

1. Indicate if this is a new Plan of Care, updated plan, or review of an existing Plan of Care
2. Long-term Goals
3. Short-term Goals (in SMART format)
4. Indicate that the client participated in and agreed with the Plan of Care.
5. Signatures: Certified Peer and license-eligible LPHA/LPHA **or** Certified Peer Supervisor

Complaints, Appeals, and Actions for PSS

DHCS conducts a review of a Medi-Cal Peer Support Specialist Certification Program upon receipt of a complaint regarding the violation of an applicable law or guidance. Complaints may only be submitted by those who have applied for Medi-Cal Peer Support Specialist Certification, their designated representative, a staff member from the Medi-Cal Peer Support Specialist Certification Program, or a county staff member.

Complaints regarding Medi-Cal Peer Support Specialist Certification Programs may be submitted to DHCS at peers@dhcs.ca.gov or submitted by mail to:

Department of Health Care Services
Behavioral Health MS 2710
P.O. Box 997413
Sacramento, CA 95899-7413.

CalMHSA investigates all complaints made against Certified Peers and approved training entities. CalMHSA will also review:

- Appeals related to denials of application for certification
- Suspension or revocation of a certification
- Denials for certification renewal
- Denials for training provider applications.

CalMHSA completes the investigation of a complaint within 90 days upon receipt of a complaint. Information on how to file a complaint is available on the CalMHSA Certification Registry. The registry posts updates regarding complaints about a Certified Peer within 72 hours of the change in certification status.

For additional information regarding CalMHSA's complaints, appeals, and actions, see CalMHSA Medi-Cal Peer Support Specialist Certification – Guidelines, Standards & Procedure Manual.

In addition to CalMHSA's process, complaints regarding agencies delivering PSS or a Certified Peer can be submitted directly to SAPC at SAPCMonitoring@ph.lacounty.gov.

Early Intervention Services for Youth and Young Adults (ASAM 0.5)

Early Intervention services are covered DMC services under EPSDT (ASAM 0.5) for Youth (age 17 and under) and Young Adults (age 18-20) who have been screened and determined to be at risk of developing an SUD (i.e., but who do not meet DSM criteria for an SUD) and would benefit from psychoeducation (using the "*Healthy YOUth: An Early Intervention Service Model for Addressing Substance Use Risk and Promoting Wellness Among At Risk Youth*" Curriculum) and any other services covered under the OP LOC as early intervention services and in accordance with the EPSDT benefit to correct or ameliorate a substance use condition. This includes services that sustain, support, improve, or make more tolerable an existing substance misuse or an SUD condition. The Early Intervention services benefit also includes receipt of any DMC reimbursable service available in OP settings. For a description of service components available in Early Intervention and OP treatment settings, see *Early Intervention and Treatment Service Components* section.

Early Intervention services are provided in an OP modality and need to be available as needed based on individual clinical needs, even if the member is not participating in the full array of OP treatment services. A full assessment utilizing the ASAM criteria is not required for a DMC member to receive Early Intervention services. To establish medical necessity for Early Intervention services, providers need to screen youth (age 17 and under) and/or young adults (age 18-20) using the ASAM Screener for Youth and Young Adults. For additional requirements, see Checklist of Required Documentation for Utilization Management.

While an SUD diagnosis is not required to provide Early Intervention services, claims for Early Intervention services need to include a CMS-approved ICD-10 diagnosis code. For example, these include codes for "Other specified" and "Unspecified" disorders, or "Factors influencing health status and contact with health services." ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances," or ICD-10 code Z03.89, "Encounter for observation for other suspected diseases and conditions ruled out." If the member meets the diagnostic criteria for an SUD, a full ASAM assessment needs to be performed, and the member needs to receive a referral to the appropriate LOC indicated by the assessment.

ASAM 0.5: Service Requirements

Treatment services at this LOC include screening, assessment/intake (if applicable), care planning, and/or physical exam, group counseling, client education, individual counseling, crisis intervention, family therapy, collateral services, medication services (including the provision of, or referral for addiction medication services for clients who use alcohol, opioids, and/or tobacco products, unless the client's declining addiction medications is documented in Progress Notes), alcohol/drug testing, RS, discharge services, and Care Coordination.

Early Intervention services are delivered as medically necessary and appropriate to ameliorate or correct a substance use condition and may be delivered in a wide variety of settings, and can be provided in-person, by telehealth, or by telephone.

Outpatient Treatment (ASAM 1.0)

ASAM 1.0 treatment services are provided in an environment that facilitates recovery, directed toward alleviating and/or preventing alcohol and drug problems. ASAM 1.0 treatment services do not include residency at a provider agency's facility as part of the treatment and recovery process. Services are provided to clients when medically necessary. This LOC is appropriate for clients who are stable with regard to acute intoxication/withdrawal potential, biomedical, and mental health conditions.

ASAM 1.0: Service Requirements

Treatment services at this LOC include screening, assessment/intake care planning, completing the health status questionnaire (Health Status Questionnaire Form 5103) and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, medication services (including provision of or referral for addiction medication services for individuals who use alcohol, opioids, and/or tobacco products, unless the client's declining addiction medications is documented in Progress Notes), alcohol/drug testing, RS, discharge services, and Care Coordination.

Services may be provided up to:

- Six (6) hours per week for Youth (age 17 and under)
- Nine (9) hours per week for Young Adults (age 18-20) and Adults (age 21 and over)

Services may exceed the maximum based on individual clinical needs and supported by medical necessity. Services may be provided in-person or via telehealth services for individuals who consent to receive SUD services. Some services may be provided via telephone. For additional information, see *Service Delivery Options* section.

Provider agencies are required to either offer addiction medications directly or have effective referral mechanisms in place to connect clients to clinically appropriate addiction medication services (or MAT).

Intensive Outpatient Treatment (ASAM 2.1)

ASAM 2.1 treatment services are appropriate for clients with minimal risk regarding acute intoxication/withdrawal potential, biomedical conditions, and mental health conditions. They are also appropriate for clients who need close monitoring and support several times a week in a clinic (non-residential and non-inpatient) setting. Services are provided to clients when medically necessary.

ASAM 2.1: Service Requirements

Treatment services at this LOC include screening assessment/intake, care planning, health status questionnaire (Health Status Questionnaire Form 5103) and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, medication services (including provision of or referral for addiction medication services for clients who use alcohol, opioids, and/or tobacco products, unless the client's declining addiction medications is documented in Progress Notes), alcohol/drug testing, RS, discharge services, and Care Coordination.

Treatment services need to be provided between:

- Six (6) and 19 hours per week for Youth (age 17 and under); more than 19 hours per week may be provided when determined to be medically necessary and when a higher LOC is not clinically appropriate. Service hours can exceed the maximum of 19 hours and are submitted under DMC claims.
- Nine (9) and 19 hours per week for Young Adults (age 18-20) and Adults (age 21 and over); more than 19 hours per week may be provided when determined to be medically necessary.

If it is determined that the client no longer consistently requires at least 6-9 hours of service per week, they should be stepped down to a lower LOC (e.g., OP). Reviews occur to determine if clients are served in the appropriate LOC and if reimbursement needs to be modified (i.e., reduced to the OP rate) based on a consistently insufficient number of service hours. Services may be provided in-person or via telehealth for individuals who consent to receive SUD services. Some services may be provided via telephone. For additional information, see *Service Delivery Options* section.

Provider agencies are required to either offer addiction medications directly or have effective referral mechanisms in place to connect clients to clinically appropriate addiction medication services (or MAT).

Residential Services

All residential treatment services are primarily be provided in-person. Telehealth and telephone services, when provided, supplement but do not replace the in-person service. For additional information, see *Service Delivery Options* section. These services are tailored to address the functional deficits identified in the ASAM Criteria.

All provider agencies delivering Residential Treatment services Levels 3.1, 3.3, and 3.5 billed to DMC-ODS need to have either a DHCS LOC Certification and/or an ASAM LOC Designation. Each client lives on the premises and is supported in their efforts to restore, maintain, and apply interpersonal and independent living skills and access community support systems.

Provider agencies are required to either offer addiction medications directly or have effective referral mechanisms in place to connect clients to clinically appropriate addiction medication services (or MAT).

As outlined in CCR Title 9, Chapter 5 - Licensure of Residential Alcoholism or Drug Abuse Recovery or Treatment Facilities: Every resident needs to be tested for tuberculosis (TB) under licensed medical supervision six (6) months prior to or 30 days after admission.

The residential bundled day rate and Room and Board are not billable on the date of discharge. Unbundled residential services such as Care Coordination, PSS, and medication services remain billable on a client's date of discharge.

Incidental Medical Services (IMS) are services provided at a licensed residential facility by a healthcare practitioner or staff under the supervision of a healthcare practitioner to address medical issues associated with detoxification, treatment, or rehabilitation services. IMS does not include general primary medical care or medical services required to be performed in a licensed health facility as defined by California HSC § 1200 or California HSC § 1250.

Low-Intensity Residential Services (ASAM 3.1)

ASAM 3.1 Residential services are 24-hour non-medical, short-term rehabilitation services for clients with an SUD diagnosis. It is appropriate for clients needing time and structure to practice and integrate their recovery and coping skills in a supportive residential environment. IMS may be approved by the State to allow for addiction medications, including medication services for withdrawal, to be provided in residential settings. The facility needs to have a DHCS LOC Certification to deliver care under this designation.

ASAM 3.1: Service Requirements

Treatment services at this LOC include screening, assessment/intake, care planning, health status questionnaire (Health Status Questionnaire Form 5103) and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, safeguarding medications and medication services (including provision of or referral for addiction medication services for individuals who use alcohol, opioids, and/or tobacco products, unless the client's declining addiction medications is documented in Progress Notes), transportation, alcohol/drug testing, RS, discharge services, Care Coordination, and room and board.

Clients enrolled in full-scope Medi-Cal are exempt from paying fees for room and board and/or treatment services. SAPC has provided recommended guidance to DPSS on this policy of transferring GR and/or CalFresh benefits to a residential provider. While SAPC awaits DPSS's guidance, SAPC residential providers may continue collecting GR/CalFresh benefits from residential clients. Those fees need to be reported to SAPC in the year-end cost report. It is allowable to collect these types of fees for children staying in a residential facility with a parent, as these costs are not reimbursed by SAPC.

At least **one (1) 15-minute unit** of Clinical Services is required for individual-based services (Intake and ASAM Assessment, Individual Counseling, Family Therapy, Collateral Service, Crisis Intervention, Care planning, Discharge Services, and Care Coordination) or **four (4) to six (6) 15-minute units** for group-based services (Group Counseling and Patient Education) per client per day. Treatment services need to be provided **at least 20 hours per week** and include preparation for step-down into less intense levels of treatment, when appropriate. At a minimum, Clinical Services equal at least half of the weekly treatment hour standard (10 hours or 40 units of services). The remaining treatment hour requirements may be fulfilled by eligible Therapeutic, Support, OTP, and/or Mental and Physical Health services **(up to two (2) hours weekly for both on-site and off-site services)**.

For a detailed list of approved services at Residential Treatment Programs, see SAPC Bulletin 18-13.

If the client receives less than ten (10) hours or 40 units of services per week:

- For more than two (2) weeks for Youth (age 17 and under) and Young Adults (age 18-20); **or**
- For more than three (3) weeks for Adults (age 21 and over);

then the client needs to be moved to a lower LOC, and no further reimbursement is allowed.

When services provided are less than the minimum, it needs to be clinically necessary (e.g., hospitalized, on pass) and documented in a Progress Note.

Provider agencies may choose to hold a client's bed if the client is anticipated to return to treatment within seven (7) calendar days. However, in these instances, residential beds that are held are only reimbursed for room and board and do not receive the full residential day rate for treatment, since services are not provided for held beds.

The facility requires 24-hour care with trained personnel, including staff on the overnight shift who are awake to address client needs.

Residential clients need to meet medical necessity requirements. For additional information, see **Table 15**.

High-Intensity Residential Services: Population Specific (ASAM 3.3)

ASAM 3.3 Residential services are 24-hour non-medical short-term rehabilitation services for clients with an SUD diagnosis. They are appropriate for clients with functional limitations that are primarily cognitive, who require a slower pace of treatment, and who are unable to fully participate in the social and therapeutic environment. These functional limitations may be either temporary or permanent and may result in problems in interpersonal relationships, emotional coping skills, or comprehension. The facility needs to have a DHCS LOC Certification to deliver care under this designation.

IMS may be approved by the State to allow for addiction medications, including medication services for withdrawal, to be provided in residential settings.

Level 3.3 services are available to Young Adults (age 18-20) and Adults (age 21 and over). ASAM Level 3.5 (High-Intensity Residential) is recommended for Youth (age 17 and under) requiring high-intensity clinical services in a manner that meets functional limitations.

ASAM 3.3: Service Requirements

Treatment services at this LOC include screening, assessment/intake, care planning, health status questionnaire (Health Status Questionnaire Form 5103) and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, safeguarding mediations and medication services (including provision of or referral for addiction medication services for individuals who use alcohol, opioids, and/or tobacco products, unless the client's declining addiction medications is documented in Progress Notes), transportation, alcohol/drug testing, RS, discharge services, Care Coordination, and room and board.

Clients enrolled in full-scope Medi-Cal are exempt from paying fees for room and board and/or treatment services. SAPC has provided recommended guidance to DPSS on this policy of transferring GR and/or CalFresh benefits to a residential provider. While SAPC awaits DPSS's guidance, SAPC residential providers may continue collecting GR/CalFresh benefits from residential clients. Those fees need to be reported to SAPC in the year-end cost report. It is allowable to collect these types of fees for children staying in a residential facility with a parent, as these costs are not reimbursed by SAPC.

At least **one (1) 15-minute unit** of Clinical Services is required for individual-based services (Intake and ASAM Assessment, Individual Counseling, Family Therapy, Collateral Service, Crisis Intervention, care planning,

Discharge Services, and Care Coordination), or **four (4) to six (6) 15-minute units** for group-based services (Group Counseling and Patient Education) per client per day. Treatment services need to be provided **at least 24 hours per week** and include preparation for step-down into less intense levels of treatment, when appropriate. At a minimum, Clinical Services need to equal at least half of the weekly treatment hour standard (12 hours or 48 units of services). The remaining treatment hour requirements may be fulfilled by eligible therapeutic support, OTP, and/or Mental and Physical Health services **(up to two (2) hours weekly for both on-site and off-site services)**.

For a detailed list of approved services at Residential Treatment Programs, see SAPC Bulletin 18-13.

If the client receives less than 12 hours or 48 units of services per week:

- For more than two (2) weeks for Youth (age 17 and under) and Young Adults (age 18-20); **or**
- For more than three (3) weeks for Adults (age 21 and over);

then the client needs to be moved to a lower LOC, and no further reimbursement is allowed.

When services provided are less than the minimum, it needs to be clinically necessary (e.g., hospitalized, on pass) and documented in a Progress Note.

Provider agencies may choose to hold a client's bed if the client is anticipated to return to treatment within seven (7) calendar days. However, in these instances, residential beds that are held are only reimbursed for room and board and do not receive the full residential day rate for treatment, since services are not provided for held beds.

The facility requires 24-hour care with trained personnel, including staff on the overnight shift who are awake to address client needs.

Residential clients need to meet medical necessity requirements. For additional information, see **Table 15**.

High-Intensity Residential Services: Non-Population Specific (ASAM 3.5)

ASAM 3.5 Residential services are 24-hour non-medical short-term rehabilitation services for clients with an SUD diagnosis. It is appropriate for clients who have specific functional limitations and need a safe and stable living environment to develop and/or demonstrate sufficient recovery skills to avoid immediate relapse or continued use of substances. The facility needs to have a DHCS LOC Certification to deliver care under this designation.

IMS may be approved by the State to allow for addiction medications, including medication services for withdrawal, to be provided in residential settings.

ASAM 3.5: Service Requirements

Treatment services at this LOC include screening, assessment/intake, care planning, health status questionnaire (Health Status Questionnaire Form 5103) and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, safeguarding medications and medication services (including provision of or referral for addiction medication services for

individuals who use alcohol, opioids, and/or tobacco products, unless the client's declining addiction medications is documented in Progress Notes), transportation, alcohol/drug testing, RS, discharge services, Care Coordination, and room and board.

Clients enrolled in Medi-Cal are exempt from paying fees for room and board and/or treatment services. SAPC has provided recommended guidance to DPSS on this policy of transferring GR and/or CalFresh benefits to a residential provider. While SAPC awaits DPSS's guidance, SAPC residential providers may continue collecting GR/CalFresh benefits from residential clients. Those fees need to be reported to SAPC in the year-end cost report. It is allowable to collect these types of fees for children staying in a residential facility with a parent, as these costs are not reimbursed by SAPC.

At least **one (1) 15-minute unit** of Clinical Services is required for individual-based services (intake and ASAM assessment, individual counseling, family therapy, collateral service, crisis intervention, care planning, discharge services, and Care Coordination), or **four (4) to six (6) 15-minute units** for group-based services (Group Counseling and Patient Education) per client per day. Treatment services need to be provided **at least 22 hours per week** and include preparation for step-down into less intense levels of treatment, when appropriate. At a minimum, Clinical Services need to equal at least half of the weekly treatment hour standard (11 hours or 44 units of services). The remaining treatment hour requirements may be fulfilled by eligible Therapeutic, Support, OTP, and/or Mental and Physical Health services **(up to two (2) hours weekly for both on-site and off-site services)**.

For a detailed list of approved services at Residential Treatment Programs, see SAPC Bulletin 18-13.

If the client receives less than 11 hours or 44 units of services per week:

- For more than two (2) weeks for Youth (age 17 and under) and Young Adults (age 18-20); **or**
- For more than three (3) weeks for Adults (age 21 and over);

then the client needs to be moved to a lower LOC, and no further reimbursement is allowed.

When services provided are less than the minimum, it need to be clinically necessary (e.g., hospitalized, on pass) and documented in a Progress Note.

Provider agencies may choose to hold a client's bed if the client is anticipated to return to treatment within seven (7) calendar days. However, in these instances, residential beds that are held will only be reimbursed for room and board and will not receive the full residential day rate for treatment, since services are not provided for held beds.

The facility requires 24-hour care with trained personnel, including staff on the overnight shift who are awake to address client needs.

Residential clients need to meet medical necessity requirements. For additional information, see **Table 15**.

Withdrawal Management

Withdrawal Management (WM), also known as detoxification or detox, is a set of treatment interventions aimed at medical and clinical management of acute intoxication and withdrawal from alcohol and other substances. WM services provide the appropriate level of medical and clinical support to allow for client safety during the withdrawal period, which then allows the client and treatment team to work together on determining the best ongoing treatment strategy. WM services may be provided in an OP, residential, or inpatient setting. Members who receive WM in a residential setting need to be residents of that facility. Inpatient treatment services are primarily provided in-person. Telehealth and telephone services, when provided, supplement but do not replace the in-person service. For additional information, see *Service Delivery Options* section.

WM is an opportunity to initiate abstinence and begin substance use treatment. The primary goal is client safety to minimize the health risks associated with withdrawal. All SUD clients, particularly those with sedative, AUD, and OUDs, should be considered for WM and have access to these essential treatment services. Whether or not the client's goal includes sustained abstinence from all substances, the WM services are provided to clients with medical necessity, and clients' WM services need to be offered referral for ongoing care.

The science of comprehensive and effective SUD treatment supports the use of medications for withdrawal and the use of medications that treat SUD during WM and in all other LOCs where clients with SUDs are treated. Research has consistently shown that the use of medications for withdrawal and addiction medication helps to improve client engagement and SUD outcomes, especially when combined with other evidence-based interventions. Providers are required to either offer addiction medications directly or have effective referral mechanisms to the most clinically appropriate addiction medication services in place. Medications for withdrawal and addiction medications **need to** be discussed as a treatment option for all clients for whom it may be appropriate and helpful.

Required components of WM at any LOC include:

- **Intake:** The intake process should, at minimum, include a thorough evaluation, establishing the diagnosis of substance withdrawal syndrome, and formalizing an individual assessment; it may also include a physical exam and/or laboratory testing.
- **Observation:** At a minimum, a client need to be monitored during withdrawal as frequently as deemed appropriate based on the client's unique presentation. This may include, but is not limited to, monitoring the client's health status.
- **Medication Services:** Medications need to be offered to all clients for whom there are medication options to help manage withdrawal and/or treat the underlying use disorder.
- **Documentation:** Documentation of medications prescribed, administered, and/or the assessment of side effects and the results of medication use is required. If medications are available but not utilized, documentation need to be provided as to the reason medications were not used (e.g., client refusal).
- **Discharge Services:** Clients should be referred to another LOC following WM, and/or connected to appropriate community treatment (e.g., mental health), housing, or other social service resources, as needed.

Table 9: Withdrawal Management

Treatment/Service Type	ASAM LOC	Description
Ambulatory-Withdrawal Management (Outpatient) without extended on-site monitoring	1-WM	Mild withdrawal with daily or less than daily OP supervision.
Ambulatory-Withdrawal Management (Outpatient) with extended on-site monitoring	2-WM	Moderate withdrawal with daytime OP WM, support, and supervision in a non-residential setting.
Clinically Managed Residential-Withdrawal Management	3.2-WM	Moderate withdrawal that is not manageable in OP settings and needs 24-hour support which can be managed by non-medical staff) to complete WM and increase likelihood of continuing treatment or recovery.
Medically Managed Inpatient-Withdrawal Management	3.7-WM	Severe withdrawal in addition to medical or psychiatric co-morbidities; needs 24-hour nursing care and physician visits as needed; unlikely to complete WM without medical monitoring.
Medically Managed Intensive Inpatient-Withdrawal Management	4-WM	Severe, unstable withdrawal with documented risk for acute medical complications requiring 24-hour nursing care and daily physician visits to modify WM regimen and manage medical instability.

WM should consist of three (3) essential features:

1. Assessment of needs
2. Stabilization
3. Facilitation of follow-up, including readiness for and entry into SUD treatment

WM: Assessment

- Substance withdrawal and the client's related needs need to be assessed during every initial SUD assessment when a client shows up for treatment. This assessment needs to be performed by appropriate personnel operating within their scope of practice and licensure and includes a determination of anticipated risks that will inform the need for WM, the intensity of services needed, and the most appropriate treatment setting.
- Best practice includes using an age-appropriate assessment tool (ASAM CONTINUUM™ Assessment or Assessment Tool - Youth (Paper Version) found on the SAPC website), which should result in a determination about whether WM services are necessary. If additional clinical assessment information is needed for Dimension 1 (withdrawal potential), additional withdrawal assessment tools such as the Clinical Institute Withdrawal Assessment (CIWA) or Clinical Opioid Withdrawal Scale (COWS) may be used.
- If the assessment indicates WM is needed, qualified SUD treatment providers need to determine the most appropriate LOC (ambulatory WM vs. residential WM vs. inpatient WM) and explain the WM options, including medication, available to the client.
- Individuals recommended for ambulatory (OP) WM (e.g., 1-WM or 2-WM) should be at lower risk for complications and have a greater likelihood of successful WM than individuals recommended for

withdrawal services in residential or inpatient settings. Assessments need to also take into consideration the unique situation of the individual, the severity of symptoms, history of previous withdrawal episodes, and client preference.

- If the client needs a LOC not provided at the current location, SUD treatment providers have two options:
  - Call the SASH to schedule an intake appointment with another agency; **or**
  - Identify and call another agency directly by using the SBAT to set up an intake appointment.
- Provider agencies need to make every effort to facilitate a warm hand-off with the receiving treatment agency. The new intake appointment needs to be rescheduled within three (3) business days. If the agency does not use the County's EHR, Sage, the assessment results need to be sent to the receiving provider agency either electronically or via fax within 24 hours.

WM: Stabilization

Following a comprehensive assessment of WM needs, the stabilization period focuses on developing a Plan of Care to effectively manage the client's withdrawal symptoms while also considering the potential general medical and psychiatric complications that may accompany withdrawal.

- The SUD treatment team work with the client to develop a comprehensive Plan of Care that considers the biopsychosocial needs of an individual to effectively manage withdrawal symptoms, which may include the use of medications.
- Stabilization should consist of a combination of psychosocial intervention and medications, when appropriate.
- If it is determined that a client would benefit from and is interested in addiction medications, a determination needs to be made about the most appropriate medication intervention for withdrawal symptoms and initiation of medications for OUD.
- Although not all clients will be in a state of mind to engage in behavioral/talk therapy during WM, psychosocial interventions are an important component of the services that should be offered in the WM setting. MI, for example, can be skillfully used during WM to better understand clients' readiness to change and help them progress along the readiness continuum to encourage them to continue treatment after withdrawal symptoms are addressed.
- Throughout WM, qualified staff need to continually evaluate the client for changes in their condition and health status.
- The provider agency need to assign the client a care coordinator to assist them with transitioning to an appropriate LOC.
- WM is not eligible for bed holds. In the case where a client needs to leave WM, providers should support the client with discharge, transition to another LOC as appropriate, and readmission to WM when this is medically necessary.

WM: Facilitation of Follow-Up

In and of itself, WM does not constitute adequate addiction treatment, and thus, clients who receive withdrawal services should be connected with ongoing SUD treatment.

- As early during the withdrawal process as is feasible and appropriate, provider agencies need to engage their clients in discussions about their readiness for change and begin preparing them for entry into ongoing SUD treatment at the next point along the continuum of SUD care. Care Coordination can and should support this LOC transition.
- This preparation need to include engaging the client in discussion regarding comprehensive SUD treatment, the fact that WM is typically only the first component of treatment, and the Care Coordination priorities and activities outlined in *Eligibility Verification – Transitions in Care section.*

The duration of WM services needs to be based on individual client needs as determined by qualified personnel operating within their scope of practice and licensure.

WM for Youth (age 17 and under)

WM is generally not indicated for youth (17 and under) because they typically have not consumed substances for sufficient duration, intensity, or frequency to cause significant withdrawal symptoms. However, WM should be provided to youth when clinically warranted, based on medical necessity, and consistent with EPSDT requirements for youth and young adults (under 21). Parental consent is not required for services delivered to youth age 12 and over, but is required for services delivered to youth age 11 and under.

Ambulatory-Withdrawal Management

Ambulatory-Withdrawal Management without extended on-site monitoring (ASAM 1-WM)

ASAM 1-WM ambulatory services are provided in OP settings for clients with mild alcohol, sedative, and/or opioid withdrawal symptoms. Clients treated in this setting should require daily or less than daily OP supervision and are generally likely to complete WM and continue treatment or recovery.

Individuals treated in this setting should be physically and psychiatrically stable enough to be managed in an OP setting. Clients should be at a lower risk for withdrawal complications and have a greater likelihood of successful WM than individuals recommended for withdrawal services in residential (ASAM 3.2-WM) or inpatient (ASAM 3.7-WM and 4-WM) settings.

ASAM 1-WM services do not require pre-authorization (prior to services being provided) but are not reimbursed beyond 14 calendar days unless medical necessity warrants extended treatment in this setting. Care should be transitioned to an appropriate LOC, as clinically indicated.

ASAM 1-WM: Staffing

ASAM 1-WM services are staffed by interdisciplinary staff who are appropriately trained and credentialed to assess the client and manage mild withdrawal. Although they need not be present at all times physicians/prescribers and nurses should be readily available to assess, evaluate, and confirm that clients are stable to be managed in an OP setting.

ASAM 1-WM: Service Requirements

Treatment services at this LOC include screening, assessment/intake, care planning, Health Status Questionnaire Form 5103, and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, ambulatory detoxification, medication services (including provision of or referral for addiction medication services for individuals who use alcohol, opioids, and/or tobacco products, unless the client's declining addiction medications is documented in Progress Notes), alcohol/drug testing, RS, discharge services, and Care Coordination.

Ambulatory-Withdrawal Management with extended on-site monitoring (ASAM 2-WM)

ASAM 2-WM ambulatory services are provided in OP settings for clients with mild-moderate alcohol, sedative, and/or opioid withdrawal symptoms. Clients treated in this setting require daily OP supervision and serial medical assessments. They are likely to complete WM and to continue treatment or recovery.

Individuals treated in this setting should be physically and psychiatrically stable enough to be managed in an OP setting. Clients should have access to psychological and psychiatric consultation when needed. Clients should be at lower risk for withdrawal complications and have a greater likelihood of successful WM than individuals recommended for WM in residential (ASAM 3.2-WM) or inpatient (ASAM 3.7-WM and 4-WM) settings.

ASAM 2-WM services do not require pre-authorization or authorization but are not reimbursed beyond 14 calendar days unless medical necessity warrants extended treatment in this setting. Care should be transitioned to a lower LOC, as clinically indicated.

ASAM 2-WM: Staffing

Care at level 2-WM is delivered by interdisciplinary staff trained and credentialed to assess the client. As with all other WM LOCs, 2-WM services are medically and clinically focused. Although they do not always need to be present, physicians/prescribers and nurses should be readily available to assess, evaluate, and confirm that clients are stable enough to be safely managed in an OP setting.

ASAM 2-WM: Service Requirements

Treatment services at this LOC include screening, assessment/intake, care planning, Health Status Questionnaire Form 5103, and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, ambulatory detoxification, medication services (including

provision of or referral for addiction medication services for individuals who use alcohol, opioids, and/or tobacco products, unless the client's declining addiction medications is documented in Progress Notes), alcohol/drug testing, RS, discharge services, and Care Coordination.

Residential-Withdrawal Management (ASAM 3.2-WM)

ASAM 3.2-WM services are 24-hour short-term rehabilitation services provided in residential settings for clients with moderate alcohol, sedative, and/or opioid withdrawal who need 24-hour support to successfully complete WM. IMS may be approved by the State to allow for medication treatments and IMS, including WM, to be provided in residential settings.

Clients appropriately treated in Residential-WM settings typically exhibit, have a history of exhibiting, or are at risk for exhibiting moderate withdrawal symptoms with a greater need for support than can be provided in Ambulatory-WM settings (ASAM 1-WM and 2-WM), but less need for medical supervision and support than is provided in inpatient WM settings (ASAM 3.7-WM and 4.0-WM).

ASAM 3.2-WM: Staffing

The care provided at level 3.2-WM is medically and clinically focused and is delivered by interdisciplinary staff who are appropriately trained and credentialed to assess the client and manage moderate withdrawal from opioids, alcohol, or sedatives. Withdrawal from stimulants is not an indication of WM.

Although it is not a requirement that a physician/prescriber is always on-site, medical evaluation and consultation are available 24 hours a day. In addition, the facility requires 24-hour care with trained personnel, including staff on the overnight shift who are awake to address client needs. The additional training required for staff who monitor or supervise the provision of WM services includes: certification in cardiopulmonary resuscitation and first aid, training in the use of naloxone, six hours of orientation for providing, monitoring, and supervising WM services, repeated orientation training within 14 days for returning staff following a 180 continuous day break in employment, and eight (8) hours of training annually that covers the needs of residents who receive WM services.

Training documentation need to be maintained in personnel records. Personnel training need to be implemented and maintained by the licensee pursuant to Title 9 CCR § 10564(k). It is recommended that a licensed physician/prescriber with specific training in addiction be available for consultation as medically necessary (for example, a physician/prescriber prescribes medications, and a nurse on-site can coordinate providing the prescribed medications to clients without the physician/prescriber needing to be on-site). Individuals in 3.2-WM should receive both medications and psychosocial therapies. Necessary services need to be coordinated or referred to other LOCs as needed, either through direct affiliation or an external referral process.

Note: To participate in 3.2-WM, providers are required to arrange for medications to be available on-site. Providers can coordinate medication services with off-site physicians or other licensed prescribing clinicians to arrange for medications medically necessary to treat withdrawal. ASAM 3.2-WM services do not require pre-authorization but are not reimbursed beyond 14 calendar days unless medical necessity warrants extended treatment in this setting. Care should be transitioned to a lower LOC, as clinically indicated.

ASAM 3.2-WM: Service Requirements

Treatment services at this LOC include screening, assessment/intake, care planning, Health Status Questionnaire Form 5103, and/or physical exam, group counseling patient education, individual counseling, crisis intervention, family therapy, collateral services, safeguarding medications, and medication services (including provision of or referral for addiction medication services for individuals who use alcohol, opioids, and/or tobacco products, unless the client's declining addiction medications is documented in Progress Notes), transportation, alcohol/drug testing, RS, discharge services, Care Coordination, and room and board (which cannot include financial participation by the client in the form of payment/transfer of Federal, State, or local benefits such as CalFresh).

Inpatient-Withdrawal Management – Medically Monitored (ASAM 3.7-WM)

ASAM 3.7-WM services are short-term medically monitored settings for clients with severe alcohol, sedative, and/or opioid withdrawal or stimulant intoxication that offer 24-hour nursing care and physician visits, as necessary. Clients treated in this setting have severe problems in Dimensions 1, 2, or 3 that require inpatient-level care with medical oversight and are unlikely to complete WM without medical monitoring. Treatment in Inpatient-WM settings should be reserved for those who cannot be successfully managed at a lower LOC. Withdrawal from stimulants, cannabis, dissociatives, and/or hallucinogens alone does not require an inpatient level of medical intervention. In some instances, acute stimulant intoxication and/or withdrawal from multiple substances, including alcohol, opioids, and/or sedatives, may be considered for inpatient admission.

ASAM 3.7-WM: Admission Criteria

Criteria for admission to 3.7-WM includes one (1) or more of the following within 14 days of the client's most recent use of opioids, alcohol, sedatives, or stimulants:

1. The diagnosis of delirium tremens (DTs), also known as alcohol withdrawal delirium (AWD), also includes any combination of the following clinical manifestations resulting from cessation or reduced intake of alcohol and/or sedatives:
    a. Hallucinations
    b. Disorientation
    c. Tachycardia
    d. Hypertension
    e. Fever
    f. Agitation
    g. Diaphoresis
2. A severe score on a validated withdrawal scale, including the Clinical Institute Withdrawal Assessment Scale for Alcohol, revised (CIWA-Ar), Prediction of Alcohol Withdrawal Severity Scale (PAWSS), Clinical Assessment of Narcotic Assessment (CINA), and COWS.
3. A moderate score on a validated withdrawal scale, including the CIWA-Ar, PAWSS, CINA, COWS, and one or more of the following high-risk factors:
    a. A current serum ethanol level over 0.10mg%
    b. Serum chloride under 96mEg/L (if known)
    c. Use of multiple substances
    d. History of AWD

   e. Inability to receive necessary medical assessment, monitoring, and treatment at a lower LOC
   f. Medical co-morbidities that make detoxification in a lower LOC unsafe
   g. History of failed OP treatment
   h. Psychiatric co-morbidities
   i. Pregnancy
   j. History of seizure disorder or withdrawal seizures
4. Complications of alcohol, sedative, and/or opioid withdrawal that cannot be adequately managed in the OP setting due to:
   a. Presenting with persistent vomiting and diarrhea from withdrawal
   b. Dehydration and electrolyte imbalance that make managing withdrawal in a lower LOC unsafe
5. Stimulant intoxication complications that impair client stability or significantly reduce the client's ability to safely participate in treatment at a lower LOC.
6. Recent history of severe withdrawal symptoms.

Note: Substances with a higher risk of causing illness and death (e.g., alcohol, opioids, sedatives) are often more appropriate for inpatient WM than substances with lower risk that may be able to be managed at a lower LOC. Level 3.7-WM and 4-WM are both inpatient LOCs for WM and offer similar services, with the key difference being in the level and availability of medical staffing available in these settings. Level 4-WM requires greater availability of medical staffing and 24-hour direct observation and nursing care compared to Level 3.7-WM. For additional information, see the respective Staffing sections in Level 3.7-WM and 4-WM.

ASAM 3.7-WM services do not require pre-authorization but are not reimbursed beyond 14 calendar days unless medical necessity warrants extended treatment in this setting. Care should be transitioned to a lower LOC, as clinically indicated.

Transitions to and from this LOC are critical and need to be managed carefully, with the plan to transition to an appropriate lower level of SUD care, when clinically indicated.

ASAM 3.7-WM: Staffing

All 3.7-WM programs are staffed by physicians/prescribers who are available by phone 24 hours per day. A physician/prescriber needs to assess the client within 24 hours of admission (or earlier if needed) and is available on-site daily. The facility requires 24-hour care with trained personnel, including staff on the overnight shift who are awake to address client needs. An RN or other licensed nurse is available to do a nursing assessment upon admission and is responsible for oversight of the client's progress and medication administration on an hourly basis (if needed). The level of nursing care is consistent with the severity of client needs.

ASAM 3.7-WM: Service Requirements

Treatment services at this LOC include screening, assessment/intake care planning, Health Status Questionnaire Form 5103, and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, safeguarding medications and medication services (including provision of or referral for addiction medication services for individuals who use alcohol, opioids, and/or tobacco products, unless the client's declining addiction medications is documented in Progress Notes), transportation, alcohol/drug testing, RS, discharge services, Care Coordination, and room and board (which

cannot include financial participation by the client in the form of payment/transfer of Federal, State, or local benefits such as CalFresh). These services are intended to be individualized to treat functional deficits identified in the ASAM criteria.

Inpatient-Withdrawal Management – Medically Managed (ASAM 4-WM)

ASAM 4-WM services are short-term medically managed settings for clients with severe and unstable alcohol, sedative, and/or opioid withdrawal or stimulant intoxication that offer 24-hour nursing care and daily physician visits. Clients treated in this setting are unlikely to complete WM without medical management and have severe problems in Dimensions 1, 2, or 3 that require inpatient-level care with medical oversight. Treatment in inpatient WM settings should be reserved for those who cannot be successfully managed at a lower level of WM care. Withdrawal from stimulants, cannabis, dissociatives, and/or hallucinogens alone does not require an inpatient level of medical intervention. In some instances, acute stimulant intoxication and/or withdrawal from multiple substances, including alcohol, opioids, and/or sedatives, may be considered for inpatient admission.

ASAM 4-WM: Admission Criteria

Criteria for admission to 4-WM includes one (1) or more of the following within 14 days of the client's most recent use of opioids, alcohol, sedatives or stimulants:

1. The diagnosis of DT that also includes any combination of the following clinical manifestations resulting from cessation or reduced intake of alcohol and/or sedatives:
    a. Hallucinations
    b. Disorientation
    c. Tachycardia
    d. Hypertension
    e. Fever
    f. Agitation
    g. Diaphoresis
2. A severe score on any one of the following scales CIWA-Ar, PAWSS, CINA, and COWS.
3. A moderate score on any one of the following withdrawal scales CIWA-Ar, PAWSS, CINA, COWS, and one or more of the following high-risk factors:
    a. A current serum ethanol level over 0.10mg%
    b. Serum chloride under 96mEg/L (if known)
    c. Use of multiple substances
    d. History of AWD
    e. Inability to receive necessary medical assessment, monitoring, and treatment at a lower LOC
    f. Medical co-morbidities that make detoxification in a lower LOC unsafe
    g. History of failed OP treatment
    h. Psychiatric co-morbidities
4. Pregnancy
5. History of seizure disorder or withdrawal seizures
6. Complications of withdrawal that cannot be adequately managed in the OP setting due to:
    a. Presenting with persistent vomiting and diarrhea from withdrawal
    b. Dehydration and electrolyte imbalance that make detoxification in a lower LOC unsafe

7. Complications from stimulant intoxication that result in medical or psychiatric conditions that impair the client's stability or drastically reduce the client's ability to safely participate in treatment at a lower LOC.

Note: Substances with a higher risk of causing illness and death (e.g., alcohol, opioids, sedatives) are often more appropriate for inpatient WM than substances with lower risk that may be able to be managed at a lower LOC. Level 3.7-WM and 4-WM are both inpatient LOCs for WM and offer similar services. The key differences are in the level and availability of medical staffing in these settings. Level 4-WM requires greater availability of medical staffing and 24-hour direct observation and nursing care compared to Level 3.7-WM. For additional information, see the respective Staffing sections in Level 3.7-WM and 4-WM.

ASAM 4-WM services do not require pre-authorization but are not reimbursed beyond 14 calendar days unless medical necessity warrants extended treatment in this setting. Care should be transitioned to a lower LOC, as clinically indicated.

Transitions to and from this LOC are critical and need to be managed carefully, with the plan to transition to an appropriate lower level of SUD care, when clinically indicated.

ASAM 4-WM: Staffing

All 4-WM programs are staffed by physicians/prescribers who are available 24 hours per day. A physician or prescriber is required to assess the client within 24 hours of admission (or sooner if necessary) and provide daily follow-up visits. The facility requires 24-hour direct observation and nursing care.

ASAM 4-WM: Service Requirements

Treatment services at this LOC include screening, assessment/intake care planning, Health Status Questionnaire Form 5103, and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, safeguarding medications and medication services (including provision of or referral for addiction medication services for individuals who use alcohol, opioids, and/or tobacco products, unless the client's declining addiction medications is documented in Progress Notes), transportation, alcohol/drug testing. RS, discharge services, Care Coordination, and room and board (which cannot include financial participation by the client in the form of payment/transfer of Federal, State, or local benefits such as CalFresh). These services are tailored to address the functional deficits identified in the ASAM criteria.

Opioid Treatment Programs

OTPs are treatment settings that dispense medications for OUD, including methadone, buprenorphine, naltrexone, and dispense naloxone for opioid overdose prevention and disulfiram for AUD. If the OTP is unable to directly administer or dispense medically necessary medications covered under DMC-ODS, they need to prescribe the medication to a pharmacy or refer the member to a provider who can dispense it.

OTPs are the only setting that can legally provide methadone treatment for addiction. OTP services are provided in DHCS-licensed facilities pursuant to the California CCR Title 9, Chapter 4, Division 4, and 42 CFR Part 2. OTPs offer a range of services, including medical, prenatal, and psychosocial support.

An OTP is classified as an ASAM LOC. Medical necessity for OTP services needs to be established, including a DSM-5 diagnosis of an SUD and an appropriate LOC designation based on an ASAM assessment.

Practitioners including counselors and non-medical LPHAs, play an important role in identifying who may benefit from addiction medications and treatment at an OTP. For example, SUD service practitioners should explain the potential benefits of addiction medications alongside other services and refer clients to appropriate medical professionals for further assessment. SUD providers from across disciplines need to work together to ensure familiarity with and access to addiction medications in OTP and non-OTP SUD treatment settings.

OTP: Service Requirements

Treatment services at this LOC include screening, assessment/intake, care planning, Health Status Questionnaire Form 5103, and/or physical exam, group and individual counseling, patient education, crisis intervention, family therapy, collateral services, medication services (including ordering methadone, naltrexone, buprenorphine, and naloxone to be dispensed from the OTP or prescribed, as allowed by federal and state regulations, through a community pharmacy to meet the client's needs), alcohol/drug testing, syphilis testing, HIV testing, Hepatitis C testing, TB testing, RS, discharge services, medical psychotherapy, and care coordination.

Clients served in OTP settings need to receive between 50 and 200 minutes of counseling services per calendar month. OTPs may be reimbursed for additional counseling when the medical necessity for additional counseling is justified through documentation in the client record and completed within 14 days of that month's counseling sessions. Counseling services provided in OTP can be in-person, by telehealth, or by telephone. The medical evaluation for medication services needs to be conducted in-person or via telehealth, subject to DHCS approval of the protocol that includes medical evaluations conducted via telehealth.

OTPs need to comply with all Federal and State licensing requirements. If they cannot comply, they need to assist the client in choosing another addiction medication provider, ensure continuity of care, and facilitate a warm hand-off to ensure engagement. OTPs are regulated under CCR Title 9.

OTP: Documentation

All OTP providers need to complete an initial ASAM CONTINUUM™ Assessment for all clients. Reimbursement for cases in which ASAM assessments were not completed within the required timeframes will be subject to recoupment.

Consistent with CCR Title 9 requirements, OTP provider agencies need to re-verify DMC eligibility and perform justification every 12 months from the treatment admission date for clients who need ongoing OTP care. An annual ASAM assessment is not required. A narrative justification of the ongoing need for OTP services is sufficient to re-establish medical necessity.

Recovery Services

RS are support services designed to help individuals remain engaged in care, support their recovery, and reduce the likelihood of relapse.[7] They emphasize a client's central role in managing their health and recovery, promoting the use of effective self-management and coping strategies, as well as interval and community resources to support ongoing self-management. Clients may receive services based on a self-assessment or provider assessment of relapse risk, which should be listed on the Problem List. Clients do not need to be in remission to access RS.

RS can be provided prior to admission, concurrently with admission to any other LOC, and following discharge from another LOC; and may be delivered as a standalone service or concurrently with other DMC-ODS services and LOCs as clinically appropriate. For clients admitted to RS concurrently or immediately following SUD treatment at a higher LOC where medical necessity had been established for that higher LOC, no additional screening is required. If there is a lapse between treatment discharge and receipt of RS, or RS are discontinued, completion of ASAM CO-Triage® Tool for Adults (age 21 and over) or ASAM Screener for Youth (age 17 and under) and Young Adults (age 18-20) needs to occur to determine if RS is appropriate for the client.

How to Ensure Client Engagement in Recovery Services

- Ensure that clients connect with other individuals in recovery to establish a supportive network for their recovery.
- Emphasize the client's central role in managing their health.
- Emphasize the importance of effective self-management and coping strategies to manage stress and overcome setbacks.
- Facilitate access to internal and community resources to provide ongoing self-management support to clients.
- Facilitate autonomy by linking clients to necessary resources (e.g., vocation, education, housing, transportation) to ensure needs are met, enabling them to navigate the health and social service system independently in the future.

RS are available for Youth (age 17 and under), Young Adults (age 18-20), and Adults (age 21 and over) clients prior to enrollment in another LOC, who are currently participating in or discharging from any LOC, and immediately upon discharge from another LOC or upon release from incarceration based on pre-incarceration SUD history (and regardless of receipt of in-custody treatment services). Clients may receive RS based on either self-assessment or a provider's assessment of relapse risk. Clients enrolled in RS as a standalone service are required to have a new CalOMS/LACPRS admission and Financial Eligibility form completed. Continued participation is based on the client's continued financial eligibility for DMC-ODS services. For CENS RS, see CENS Standards and Practices.

RS may be conducted in-person in a contracted DMC-certified treatment facility, at an approved FBS site, and/or by telephone, or by telehealth; and can be delivered by either an experienced registered or certified SUD counselor, LPHA, or license-eligible LPHA, and will be offered when they are deemed medically necessary by an LPHA or license-eligible LPHA (e.g., during a treatment episode or after completion of a treatment episode).

[7] SAMHSA. (2024, March 26). Recovery and Recovery Support. www.samhsa.gov/find-help/recovery.

Participation is voluntary for the client. Therefore, provider agencies should make every effort to educate and engage clients and facilitate their acceptance while ultimately honoring the client's choices and preferences.

RS are billed via PAuth. Each agency is configured in Sage with a PAuth for the FY to allow for services to be billed without a member authorization for the client. DHCS requires that RS are billed with the U6 LOC modifier as well as an additional LOC modifier, which indicates the LOC the site is certified to deliver.

RS: Prior to Admission to SUD Treatment

The RS benefit allows for pre-admission contact with clients prior to formal enrollment in treatment. Clients enrolled in RS as a standalone treatment are required to complete a new CalOMS/LACPRS admission and Financial Eligibility form.

RS: During SUD Treatment

Given the value of RS, the provider agency should explain the benefits at the beginning, during, and at the end of treatment; and should introduce the client to any designated counselor/clinicians and ensure that a warm hand-off is completed. This is particularly important when the RS provider agency is different from the treatment provider agency. Clients can be enrolled in RS and another LOC at the same time.

RS: Following SUD Treatment

Following discharge from treatment, an assigned counselor/clinician needs to contact the client within two (2) business days from their last treatment service to ensure that the client is receiving necessary support. Counselors are required to demonstrate efforts to engage a client in this benefit prior to terminating follow-up efforts. If the client does not consent to services, at least three (3) documented attempts to engage clients on three (3) separate days are required. If the counselor has neither heard from nor contacted the client for 60 calendar days after the last attempted contact, the client should be discharged from RS; and the provider staff documents all follow-up contacts in the client's EHR.

For the first 60 calendar days following a client's discharge from treatment, the counselor/clinician contacts and engages the client at a frequency according to clinical need if the client consented to participate. Clients who reconnect with RS more than six (6) months since their last DMC-ODS clinical service need to be screened to determine if it continues to be an appropriate service.

RS: Service Requirements

Services at this LOC include assessment, care planning, recovery monitoring, relapse prevention, group counseling, individual counseling, family therapy, Care Coordination, and discharge services.

Individuals can continue to receive RS as long as they continue to meet financial eligibility requirements for DMC-ODS services. An LPHA at the provider site needs to document the justification in a progress note for ongoing services at least every six (6) months. Individuals may receive services while enrolled in other DMC-ODS services and LOCs, as clinically appropriate.

Note: CalOMS/LACPRS discharge needs to be completed when a client is discharged from the program on the day of discharge. The discharge date should correspond to the date of the client's last face-to-face or telehealth treatment session or addiction medication service. They need to document the actual date of discharge as the "Discharge Process Date" in the relevant CalOMS Discharge forms.

RS: Counseling

The goal of individual or group counseling is to allow the client to gain/develop personal autonomy (managing stress, free time, and activities of daily living):

- Personal care (grooming, managing finances), health, and wellness (exercise options, nutrition)
- Social skills, coping skills, and learning adaptive behaviors (coping with cravings or triggers that could result in relapse)
- Individualized Recovery Plan

Counseling services may be provided one-on-one or in group settings. Groups should consist of 2-12 individuals per group and these services need to be delivered in-person or via telehealth. Clients enrolled in RS, OP (ASAM 1.0), and IOP (ASAM 2.1) can participate in the same group counseling, if clinically appropriate. Clients enrolled in RS are not eligible to participate in the same group counseling and patient education sessions as those in residential treatment services.

RS: Recovery Monitoring

This service provides clients with dedicated guidance and recovery management to help them learn practical strategies to prevent relapse and address real-world triggers for drug or alcohol misuse. Recovery Monitoring targets SUD behavior and associated symptoms of use/relapse (stress, mood, and self-efficacy). This service can be delivered in-person, by telephone, or by telehealth.

RS: Care Coordination

Individual service coordination, providing linkages with other services, including:

- Support for education and job/life skills, employment services job services, job training, and legal and educational services.
- Parenting support for childcare, parent education, child development support services, and family/marriage education.
- Linkages to benefits, mental and physical health, self-help and support groups, spiritual and faith-based support, and peer-delivered support services and groups.
- Ancillary services, such as housing assistance and transportation. Providers should identify service gaps and link the client to ancillary supports to help address those gaps.

Note: Care Coordination can be delivered in-person, by telephone, or by telehealth.

RS: Relapse Prevention

Relapse prevention focuses on identifying a client's current stage of recovery and establishing a recovery plan to identify and manage the relapse warning signs and cope with the potential for relapse.

For definitions, see respective sections on *Care Coordination*, *Group Counseling*, and *Individual Counseling*.

RS: Required Documentation

Counselors/clinicians need to document each client encounter, capturing relevant recovery details such as a summary of status and progress, pertinent changes, relapse potential, etc.

RS provided in the community, by telephone, or by telehealth requires equivalent quality and comprehensiveness of documentation as in-person services provided within a certified facility.

Recovery Bridge Housing

Housing and residing in a safe and stable living environment are often critical to achieving and maintaining recovery from SUDs. Research shows that SUD treatment outcomes are better for PEH, particularly those who experience chronic homelessness, when they are stably housed. People with SUDs need access to safe, stable, and supportive living environments to help them initiate and sustain their recovery and reduce the risk of relapse. RBH is a type of recovery-oriented, peer-supported housing that provides a safe interim housing environment for individuals who are homeless, according to the United States Department of Housing and Urban Development (HUD), and are considered unstably housed. Clients in RBH need to also be concurrently enrolled in treatment, such as OP, IOP, OTP, or Outpatient (aka Ambulatory) Withdrawal Management (OP-WM) settings.

The goal of RBH is to provide safe interim housing that is supportive of recovery for clients who are receiving OP/IOP/OTP/OP-WM treatment for their SUD. RBH is available for Young Adults (age 18-20) and Adults (age 21 and over), including PPW, who are:

- In need of a stable, safe living environment to best support their recovery from SUD; **and**
- Concurrently enrolled in OP/IOP/OTP/OP-WM treatment settings

PPW clients may be accompanied by up to five (5) dependent children (age 0-16) in RBH. RBH providers authorized by the County to provide PPW services need to ensure that all services being provided to the parent and child(ren) are in accordance with DHCS's Substance Use Disorder Perinatal Practice Guidelines (August 2024).

Clients who are discharged from treatment in OP/IOP/OTP/OP-WM settings are no longer eligible to receive the RBH benefit. As such, provider agencies may not bill for RBH services after a client has been discharged from treatment. RBH provider agencies may hold beds for up to seven (7) days for clients who need to leave the interim housing facility for reasons such as hospitalization, a therapeutic pass (violation of post-release supervision), or a lapse in treatment or Discharge Against Medical Advice (AMA). Beds held for this timeframe and for the reasons listed are billable through the provider's RBH contract.

Certain populations, such as PEH, are particularly at risk for relapse without access to housing and should be prioritized for this benefit. Other vulnerable populations will be prioritized for RBH, see **Table 10** (*Number 3*).

The RBH Requirements are based on the characteristics defined by HUD and recommendations from DHCS around best practices. RBH aligns with the spirit of the ASAM Criteria in the sense that clients should be appropriately placed in the least restrictive treatment environment necessary to meet their clinical needs. While RBH is not officially an ASAM LOC, it serves as a bridge between the more intensive and restrictive residential treatment setting and OP/IOP/OTP/OP-WM treatment settings. Clients cannot be required to accept treatment with addiction medications as a condition for admission to RBH.

Table 10: RBH Requirements

Recovery Bridge Housing Requirements	
1	RBH beds are available to any eligible member, especially those in one of the prioritized groups for this benefit. RBH providers: • Cannot restrict access to this benefit only to their treatment clients; • Are required to accept referrals to available RBH beds from other network provider agencies; **and** • Need to refer their clients to other available RBH beds if they have met their capacity.
2	SAPC-contracted beds can only be dedicated for SAPC members. Providers utilizing SAPC-contracted beds for non-SAPC members are out of compliance with SAPC contract requirements.
3	SUD provider agencies need to prioritize the following high-risk populations for RBH according to the following ranking: • CARE Court program individuals • PPW • History of IV drug use • Clients with high utilization of treatment services (as defined by high utilizer criteria for high-tier care management[8]) • People experiencing chronic homelessness (according to HUD definition[9]) • People who are justice-involved without alternative options for RH • Young Adults (age 18-20) • People living with HIV/AIDS • PEH stepping down from residential treatment into RBH, also known as “residential step down” • LGBTQ+ populations ***Populations not on the prioritized list will be considered for RBH only if there is enough capacity to accommodate those on the prioritized list first.*** ***Note: Undocumented homeless adult members who meet the prioritization criteria listed above and are receiving concurrent SUD treatment through Medi-Cal or other programs listed under the Covered Members and Eligible Individuals section are eligible for placement in RBH.***
4	Eligible clients should be medically and psychiatrically stable enough to benefit from RBH.

[8] **High tier care management inclusion criteria**: All individuals diagnosed with SUD who meet any of the following criteria: **(a)** 3+ emergency department (ED) visits related to SUD within the past 12 months; **(b)** 3+ inpatient hospital admissions within the past 12 months for physical and/or mental health conditions and co-occurring SUD; **(c)** Homeless with SUD (as defined by HUD homelessness definition); **(d)** 3+ residential SUD treatment admissions within the past 12 months; **(e)** 5+ incarcerations with SUD in 12 months.
[9] Clients in RBH meet the HUD chronic homelessness definition. For clients who are chronically homeless upon entering RBH, they maintain their chronic homeless status even by staying in RBH for 90 days or longer.

Recovery Bridge Housing Requirements	
5	Program participation is self-initiated, and member chooses recovery-oriented housing. Clients who receive RBH benefit are expected to be abstinent from drugs and alcohol. However, abstinence is not defined as including abstinence from addiction medications. Clients placed in RBH need to be allowed to continue receiving addiction medications, when clinically indicated and cannot be excluded from admission. RBH provider agencies need to have policies and procedures to ensure a client-centered process for RBH clients receiving addiction medications.
6	Program policies and operations are consistent with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) and ensure individual rights of privacy, dignity, respect, and safety.
7	Program emphasizes the personal recovery goals of clients and long-term housing stability to minimize the likelihood of homelessness.
8	Program design establishes minimal barriers for entry into programs.
9	Programs are to meet or exceed National Alliance for Recovery Residences (NARR) standards of care, including ensuring that there is 50+ sq. ft. bed per sleeping room (NARR standard Core Principle E.14.d) and that there is a minimum of one sink, toilet and shower per six residents (NARR standard Core Principle E.14.e): www.narronline.org/wp-content/uploads/2018/11/NARR_Standard_V.3.0_release_11-2018.pdf.
10	Holistic services and peer-based supports are available to all clients.
11	A relapse or lapse should not be an automatic cause for eviction from housing or termination from the program. Provider staff need to work with the clients to refer them to a higher LOC or a more appropriate housing type if the client is no longer interested in stopping substance use or engaging in treatment.
12	Incorporate low-barrier policies as follows: • Whenever possible, separate beds (or housing) for clients who lapse so they can sober up while still maintaining housing placement, but not being disruptive to other residents. • Establishing a "buddy support system" after a client lapses to support individuals during this transition phase to maintain their recovery and recovery-oriented housing. • When a resident lapses, increase participation in self-help meetings, as applicable. • In instances where clients need to be discharged, provide a warm hand-off to an appropriate LOC or other service, with an open-door policy for them to return, when ready. • Streamlining the intake process for RBH. • Implement contingency plans for intoxication and overdose that are clear to clients and staff, including having overdose medications readily available for use. • Host, at a minimum, monthly house meetings to ensure staff and clients are trained in administering overdose medications. • Allowing staff within an RBH setting to be part of the process of shaping low-barrier policies • Encourage social activities and team-building opportunities
13	Discharge from housing only occurs under two (2) conditions. • A client's behavior substantially disrupts or impacts the welfare of the recovery community. • The client is no longer able to benefit from RBH due to becoming medically or psychiatrically unstable. Clients may apply to reenter the program if they express a renewed commitment to living in a recovery-oriented housing setting.
14	Clients who determine they are no longer interested in living in recovery-oriented housing or who are discharged from the program are aided in accessing other housing and service options.
15	Throughout the duration of program participation, programs assist clients in transitioning into permanent housing to ensure a smooth transition once they are ready to leave RBH.

RBH: Considerations

- RBH is voluntary. Clients must actively choose to be placed in recovery-oriented housing before being considered for RBH.
- RBH is appropriate for members who have minimal risk regarding acute intoxication/withdrawal potential biomedical and mental health conditions.
- Activities in RBH may include peer support, group and house meetings, self-help, and other recovery-focused services. Life skills training such as budgeting, paying bills, shopping, cooking, managing a household, and developing social skills is essential to support self-sufficiency and independent living.
- RBH clients cannot receive in-person SUD treatment services or Care Coordination at RBH sites.
- RBH provider agencies may conduct alcohol/drug testing or urinalysis, or coordinate with the treatment provider to request testing. Client consent must be obtained before releasing test results to the RBH provider. A positive test result should not automatically lead to removal from the program. Instead, the RBH provider should work with the client to refer them to a more appropriate LOC or housing option.
- Individuals appropriate for RBH may be stepping down from residential or may be entering the SUD treatment system directly into OP/IOP/OTP/OP-WM LOCs.
- RBH clients need to be screened for TB or provide evidence of being screened (e.g., for those stepping down from residential treatment) within six (6) months prior to or 30 days after admission into RBH.
- Whenever possible and as preferred by the client, they should be placed in an RBH site that is located within 30 minutes or 15 miles of their treatment provider site.
- RBH sites should be in geographic areas that will not hinder recovery and should not be near alcohol outlets and/or high drug trafficking areas.

Note: Youth (age 17 and under) who require recovery-oriented housing may be eligible for placement in a group home that provides treatment and ancillary services in sites licensed by DPSS.

RBH: Authorization Process

If RBH is deemed appropriate, SUD treatment provider agencies need to refer the client to the appropriate RBH provider within one (1) business day of determination. The SUD treatment provider agency and RBH provider need to coordinate very closely to ensure the client's safe and timely arrival at the RBH facility.

- The RBH provider agency need to submit a Sage authorization request and supporting documentation to ensure the client meets RBH eligibility criteria and receives reimbursement for RBH from SAPC.
- The RBH provider need to collaborate with the treatment provider to submit the needed documentation, ensuring the client's concurrent enrollment in OP/IOP/OTP/OP -WM treatment.
- When the SUD provider and RBH provider are different agencies, there must be clear communication, policies, and procedures in place to confirm bed availability and coordinate care. These policies should outline the referral and admission process, coordination responsibilities, and how to resolve any disagreements between the providers.
- If a bed is not available within 24 hours of the determination of RBH need, then the SUD treatment provider agency needs to make efforts to connect the client to appropriate interim housing.[10]

[10] SAPC. (2024, January). Recovery-Oriented Housing Assessment and Intervention Workflow. http://publichealth.lacounty.gov/sapc/docs/providers/trainings/Recovery-Oriented-Housing-Assessment-Intervention-Workflow.pdf.

SAPC-UM staff will review the Sage authorization request form and supporting documentation (e.g., justification for RBH, Financial Eligibility, and concurrent treatment in an outpatient LOC), and render a decision on authorization, which is required for a provider agency to receive reimbursement for RBH services. SAPC reimburses up to seven (7) days of RBH services while the client enrolls in OP treatment. Referring treatment provider agencies need to document the need for RBH in the client's Problem List (non-OTP settings) or Treatment Plan (OTP settings). Both RBH and treatment provider agencies should refer to the most recent version of the Checklist of Required Documentation for Utilization Management and Eligibility Verification and Member Authorizations on SAPC's Clinical Forms and Documents - Treatment Services Related webpage.

RBH: Duration

Services for Young Adults (age 18-20) and Adults (age 21 and over), including PPW clients, may be authorized in 90-day increments. The initial 90 days are not required to be continuous and may be used throughout a 12-month period starting from the date of initial RBH admission.

A provider agency may request a maximum of three (3) reauthorizations that extend the time RBH clients continue to reside in RBH for longer than 90 days if they meet medical necessity and as long as the client continues to meet the RBH eligibility criteria specified above, including concurrent enrollment in OP/IOP/OTP/OP-WM. Reauthorizations past the initial 90 days will be granted if the provider agency offers documentation showing active progress or steps taken to secure housing (e.g., actively working with a Housing Navigator, CES, Housing Authority, etc.).

If a client utilizes the first authorization and the additional three (3) reauthorizations, RBH clients can receive a maximum of 360 days in a 12-month period. Once a client has resided in RBH for a total of 360 calendar days within the past 12 months or has met the 12-month period since the first day of RBH admission (e.g., June 1st – May 31st), whichever occurs first, the benefit period ends and cannot restart until 30 days after the most recent discharge date.

SAPC-UM reviews the authorization requests and issue a response to the RBH provider agency in accordance with established UM response timelines for RBH authorization requests.

RBH: Discharge Procedure

SUD treatment provider agencies should initiate discharge planning for PEH's housing needs upon admission to treatment. Housing Navigators need to work with clients to create a housing plan to ensure a smooth transition to stable housing upon RBH discharge. Once RBH clients finish their stay or no longer receive the benefit, the RBH provider agency needs to fill out the RBH Discharge Form in Sage on the same day of discharge.

Note: The day rate for RBH is not billable on the date of discharge.

RBH: Eligible Provider Agencies

RBH provider agencies are currently limited to SAPC-contracted provider agencies with experience delivering RBH to clients receiving treatment in OP/IOP/OTP/OP-WM settings. Also, RBH provider agencies need to be members of an RH organization such as Sober Living Network (SLN), or California Consortium of Addiction Programs and Professionals (CCAPP) that adheres to NARR standards and best practices. RBH provider agencies need to enter into a separate agreement with each client placed in RBH. It is best practice for RBH provider agencies to maintain a naloxone kit for overdose prevention on-site and ensure that RBH House Managers or other designated staff and clients receive training in administering naloxone.

RBH: Hours of Operation

RBH need to operate 24 hours per day, seven (7) days a week, and need to accept intakes during regular weekday business hours (9:00 a.m. to 5:00 p.m., at a minimum).

RBH: Staffing

RBH provider agencies need to ensure that on-site house managers oversee the facility's day-to-day operations. This includes ensuring adherence to policies and procedures, rules, and requirements, the facility's quality, and clients' health and safety. RBH house managers need to receive appropriate on-site orientation and training prior to performing assigned duties, have appropriate experience and necessary training at the time of hiring, and should be familiar with SUD client record confidentiality regulations under 42 CFR Part 2. Further, housing managers should be trained in and practice, at a minimum, trauma-informed cultural humility and implicit bias awareness.

RBH staff submit reports requested by the County and/or County partners, including required information and supporting documentation (e.g., daily client sign-in/out logs). RBH staff are responsible for completing authorization applications and other required documentation in Sage and coordinating with the treatment provider agency if the client receives treatment elsewhere. Coordination examples include verifying with the treatment provider agency that the client is still concurrently receiving OP/IOP/OTP/OP-WM treatment, informing the treatment provider agency if the client leaves or has been discharged from RBH, reminding the treatment provider agency to conduct housing activities and/or refer the client to interim or permanent housing resources, and sharing requested information with the treatment provider agency to accurately complete the client's CalOMS/LACPRS records. The RBH staff needs to document coordination efforts with the treatment provider agencies.

Recovery Housing

Recovery Housing (RH) is a low-barrier recovery-oriented interim housing provided for Young Adults (age 18-20) and Adults (age 21 and over) who have SUDs and minimal risk of acute biomedical and mental health issues that would prevent them from being safely housed. Certain populations, such as PEH, are particularly at risk for relapse without access to housing and should be prioritized for this benefit. Clients in RH need to be interested in living in recovery-oriented housing and be interested in following RH requirements. However, while it is encouraged, concurrent enrollment is treatment is not a condition of residing in RH.

RH: Program Eligibility

- In need of a stable, safe, and recovery-oriented living environment to best support their substance use recovery.
- Engaged in SUD treatment and/or RBH in the last 90 days at a SAPC provider agency.
- Able to conduct activities of daily living independently.

Participation is voluntary, and the client need to choose recovery-oriented housing. Those placed in RH are allowed to continue receiving addiction medications when clinically indicated and cannot be excluded from admission. RH provider agencies need to have policies and procedures to ensure a client-centered process for receiving addiction medications.

Additionally, the RH provider agencies need to ensure clients are continuously engaged in SAPC Housing Navigation (HN) or other HN services, unless they have already established a housing plan for when they are discharged from RH.

RH: Program Length

Young Adults (age 18-20) and Adults (age 21 and over) may be authorized and reimbursed for a cumulative total of up to 12 months within the last two (2) years (does not need to be consecutive) if they meet the eligibility criteria specified above. SAPC wants to avoid planned transitions out of RH to unsheltered homelessness. SAPC will consider one extension up to three (3) months beyond the 12-month allowance on a case-by-case basis. If a provider would like to request an extension, they need to submit a written request to SAPC explaining the circumstances, and SAPC will make a final determination.

RH: Referral Process

Referrals for RH are made directly to SAPC. The referral can be made by:

- Any SUD treatment provider agency within the SAPC network
- A service provider (e.g., DMH, Interim Housing Provider)
- The individual themselves (self-referral)
- One (1) of the SAPC entryways:
    - CORE Centers
    - SASH
    - CENS

RH: Admission/Referral Procedure

1. Referring party completes the Recovery Housing Intake Form (SAPC IN 25-04, Attachment I) up to 30 days but no later than three (3) days prior to the intended intake date.
2. Submit Recovery Housing Referral Form via a secure email to DPH-SAPC_HSU@ph.lacounty.gov.
3. SAPC will review the referral and respond with a disposition within one (1) business day.
4. If beds are available, SAPC staff will coordinate with the referring party and the RH provider agency to place the individual in the available bed. Only individuals approved by SAPC will be placed in the beds.
5. If there are no current available beds, the individual will be added to a waitlist.

RH: Discharge Procedure

Complete and submit the Recovery Housing Discharge Form (SAPC IN 25-04, Attachment II) to SAPC at DPH-SAPC_HSU@ph.lacounty.gov within one (1) business day of client discharge.

Relapse is not treated as an automatic cause for eviction from housing or termination from the program.

Discharge from housing only occurs under the following conditions:

- Client is no longer interested in residing in RH and voluntarily leaves on their own accord.
- Client's behavior substantially disrupts or impacts the welfare of the recovery community.
- Client is no longer able to benefit from RH due to becoming medically or psychiatrically unstable.

In all cases, the provider agency needs to work with the client to support a transition to a more appropriate treatment or housing setting. Clients who choose to leave recovery-oriented housing or are discharged from the program need to be assisted in accessing other housing and service options.

Clients may reapply to the program if they express a renewed commitment to recovery-oriented housing and have not exceeded the 12-month program limit within the past two (2) years.

RH providers authorized by the County to provide RH services need to ensure that all services being provided are in accordance with SAPC IN 25-04. For additional information regarding RH, see SAPC IN 25-04 and the Recovery Housing Billing Procedure (SAPC IN 25-04, Attachment IV).

Housing Navigation

HN is an integral part of the process of assisting people in identifying housing options, resources, and services. Housing navigators help individuals prepare, find, move into, and retain affordable and permanent housing opportunities. Providing HN services to clients residing in RBH and RH will ensure that clients can actively work towards securing a permanent housing plan, thus mitigating the risk of homelessness and relapse with SUD.

HN: Program Eligibility

- PEH and are enrolled in SAPC-SOC.
- Individuals enrolled in RBH or RH need to enroll in HN services.
- Clients have the option to opt out of these services if:
    - Have already established a housing plan when they complete RBH and/or RH, **or**
    - Are already engaged in HN services through another agency/provider.

HN: Program Length

Clients have access to HN services during their enrollment in any SAPC SUD treatment program or enrollment in RBH or RH, and for up to 30 days after leaving either housing or SUD treatment program.

HN: Referral Process

Housing Navigators are limited to providing services to individuals seeking or enrolled in SAPC-SOC. Housing navigators notify the RBH/RH agencies within their respective SPA locations about any individuals who would benefit from a linkage. RBH/RH agencies are required to connect individuals in either housing setting to HN services, unless the individuals are connected to another HN service, as reported by the client. Provider agencies are expected to document when a client declines participation in the client file.

HN: Documentation

The Housing Navigator:

- Develops an Individualized Housing Plan for each client and documents progress on the plan.
- Completes the Homeless Management Information System (HMIS) Intake and Referral Form.
- Maintain a file documenting all occurrences and services provided as part of HN services.
- Submits billing with all the required documentation as directed by SAPC.

HN: Participant Assistance Funds

As funds are available, HN includes distributing Participant Assistance Funds of up to $500 to enrolled PEH to remove barriers and mitigate stress that may contribute to behavioral health conditions while assisting in meeting their immediate housing needs (e.g., assistance obtaining identification and related vital documents, transportation, food, and hygiene products). Funds may also be used to support individuals in completing housing applications or for costs associated with credit reports, security deposits, utility hookups, and moderate furnishings.

HN provider agencies are tasked with distributing Participant Assistance Funds as part of HN services and should follow the steps described below to document distribution; and submit an invoice for reimbursement as directed.

HN: Length for Use of Funds

Clients will receive Participant Assistance Funds while enrolled in HN services. Clients are eligible for HN while they are enrolled in RBH (180 days) or RH (12 months) and up to 30 days after leaving the program.

HN: Documentation for Funds

Records of all Participant Assistance Funds distributed should be documented and logged in accordance with the County's accounting manual and should include:

- Name and contact information of clients who received them
- Date the funds were received
- What the funds were used for
- Agency staff and client signature that funds were received

Recovery Incentives-Contingency Management Program

The RI-CM is a 24-week outpatient treatment program that provides CM services as a DMC-ODS benefit for members with moderate to severe stimulant use disorder (StimUD) or those in remission, including individuals with cocaine, amphetamine, and methamphetamine use disorders. RI-CM is a pilot program under the CalAIM 1115(A) Demonstration Waiver, which will extend to through December 31, 2026. CM is an evidence-based treatment that uses motivational incentives for negative stimulant urine drug tests, to treat individuals living with StimUD and support their path to recovery.

https://www.dhcs.ca.gov/Pages/DMC-ODS-Contingency-Management.aspxAll RI-CM providers need to comply with requirements outlined in:

- SAPC IN 23-06: local implementation guidance specific to LA County
- BHIN 24-031: statewide DHCS policies for CM services

Providers need to ensure that services are delivered according to SAPC and DHCS requirements, including limits on incentive amounts and client eligibility.

For all RI-CM-related inquiries, email SAPC-SOC at SAPC_ASOC@ph.lacounty.gov and include the reason for the inquiry (e.g., billing, claims, service authorization, program protocols, incentive issues) in the subject of the email. This will help ensure timely response and proper tracking. Include any relevant attachments (e.g., support ticket number, Warm Line Form confirmation, etc.) to support your inquiry and facilitate appropriate follow-up.

For provider agencies who are interested in providing RI-CM services, email SAPC-SOC at SAPC_ASOC@ph.lacounty.gov.

Clinician Consultation Services

Clinician Consultation Services are available to SAPC network LPHAs. Clinician Consultation Services consist of DMC-ODS LPHAs consulting with LPHAs, such as addiction medicine physicians, addiction psychiatrists, licensed clinicians, or clinical pharmacists. It is designed to support DMC-ODS licensed clinicians with complex cases and may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or LOC considerations. It includes consultations between clinicians designed to assist DMC clinicians seeking expert advice on treatment needs for specific DMC-ODS clients. DMC-ODS counties may contract with one or more physicians, clinicians, or pharmacists specializing in addiction to provide consultation services. These consultations can occur in-person, by telehealth, by telephone, or by asynchronous (not in real-time) telecommunication systems such as email.

Clinician Consultation Services available to physicians within the specialty SUD system in LA County are provided by the University of California, San Francisco (UCSF) Substance Use Warmline.

Note: Clinician Consultation is not a direct service provided to DMC-ODS clients.

Licensed Clinician Consultation Process

Licensed clinicians within the specialty SUD system who seek consultation are responsible for initiating the consultation with specialists outside of their agency for expert clinical consultation. One option for expert clinician consultation is through the **UCSF Substance Use Warmline** at **(855) 300-3595**. For additional information, visit www.nccc.ucsf.edu/clinical-resources/substance-use-resources/.

Eligible Clients

Clinician Consultation requests are intended for **licensed clinicians only** and need to not be initiated by non-licensed clinicians or clients.

Service Hours

These services are available Monday through Friday (excluding holidays) between 6:00 a.m. and 5:00 p.m. Pacific Time. Voicemail is available 24 hours per day. Every effort is made to respond to consultation requests in a timely manner.

All consultation requests need to include a clear explanation of the reason for the consultation and any relevant history and clinical details that help inform and provide context for the concern/question. Additional details related to consultation topics include:

- The content of the consultative advice offered through Clinician Consultation Services is limited to addiction expertise, and these consultations may involve, but are not limited to, the management of complex cases and questions involving addiction medications.
- Consultation requests that are non-clinical in nature, administrative, or more appropriate for County staff are not appropriate for this line. For example, if a clinician has a question regarding DMC eligibility, service availability, or questions regarding policies/procedures related to SUD treatment, these questions should be directed to the applicable SAPC Division. The UCSF Substance Use Warmline provides general addiction expertise and will not be able to answer non-clinical or administrative questions specific to LA County.
- For the protection of clients and providers, Clinician Consultation Services are strictly limited to routine consultation requests. Emergency and urgent consultation needs should be directed to more appropriate resources (e.g., ED, PES). If the Consultant Specialist determines that a consultation request is emergent or urgent, or that the consultation request is otherwise inappropriate (e.g., client's condition is not consistent with services provided by the consult service), the Referring Clinician will be notified of this determination, and will be provided an explanation for this decision.
- The Consultant Specialist from UCSF will utilize the information provided by the Referring Clinician to provide recommendations focused on the question/concern. The question asked by the Referring Clinician may be posed to other addiction specialists within the UCSF Substance Use Warmline to elicit alternative clinical options and ideas.
- In conjunction with the consultant's expert opinion, the Referring Clinician will then utilize their own professional judgment and other considerations (e.g., client preferences, family concerns, other health conditions, and psychosocial factors) to provide comprehensive and client-centered treatment.

Documentation

Documentation expectations for services provided as a result of Clinician Consultation Services are the same as documentation requirements in other client care scenarios. A Progress Note need to be completed within three (3) business days by an LPHA or MD, practicing within the scope of their practice. Progress Notes need to include:

- Client's name;
- Purpose of the service;
- Date of consultation;
- Start and end times of each service; and
- Identify if services were provided in-person, via telehealth, or by telephone.

If the Referring Clinician utilizes the Clinician Consultation Service, the Referring Clinician is also responsible for thoroughly documenting the client encounter and the role of the Clinician Consultation Service in informing that encounter. All documentation should use clear and comprehensible language to non-physician LPHA and SUD counselors.

Billing

Clinician Consultation Services are provided free of charge for the specialty SUD system. The time clinicians spend seeking consultation from the Clinician Consultation Service is not billable.

All Federal, State, and local confidentiality requirements involving HIPAA and 42 CFR Part 2 need to be followed during the Clinician Consultation process.

Early Intervention and Treatment Service Components

Below is a description of various Treatment Services that are available to clients. For additional services, see the following sections: *Allowable Screening Tools* for Screening, **Table 2** for Assessment, *Care Coordination*, and *Recovery Services*.

For additional information on how these services are billed and any service minimums or maximums, visit SAPC's Manuals, Bulletins, and Forms – Bulletins Tab webpage for the most current version of the SAPC IN for the Rates and Standards Matrix.

Group Counseling

Group Counseling sessions are designed to support discussion among clients, with guidance from the facilitator to support understanding and encourage participation in psychosocial issues related to substance use. This does not include recreational activities, skill-building sessions (e.g., employment, education, tutoring), or time spent viewing videos/DVDs (although discussion time is generally allowable). Group Counseling sessions need to incorporate techniques such as MI and CBT. To ensure that clients are aware of upcoming Group Counseling and Client Education sessions, a monthly calendar need to be posted in areas accessible to clients, including the topic, location, date, time, and facilitator.

Group Counseling sessions are available at all LOCs and are defined as in-person or telehealth contact between up to two (2) practitioners within their scope of practice and 2-12 clients at the same time. This includes family members and non-Medi-Cal clients. Only services to eligible clients (Medi-Cal clients or individuals participating in programs listed under the *Covered Members and Eligible Individuals* section receiving treatment) can be claimed to SAPC.

Services are reported in 15-minute increments with sessions ranging from 60 to 90 minutes in length. A separate Progress Note need to be written for each client and documented in the EHR or Sage. Group sign-in sheets need to include the signatures and printed full names (first and last name) of all clients (including clients not reimbursed by SAPC and family members) and group facilitators, as well as the date, start/end times, location, and group topic.

The frequency of Group Counseling sessions, in combination with other Treatment Services, needs to be based on medical necessity and individualized client needs rather than a prescribed program required for all clients.

Note: Youth (age 17 and under) and Young Adults (age 18-20) are only allowed to participate in the same Group Counseling sessions in school-based settings.

Client Education

Client Education sessions aim to teach clients and encourage discussion on research-based educational topics such as SUDs, SUD treatment, including addiction medications, recovery, and associated health consequences. The goal of these sessions is to minimize the harms of SUDs, lower the risk of overdose, and reduce the severity of substance use. This does not include recreational activities, skill-building sessions (e.g., employment, education, tutoring), or time viewing videos/DVDs (although discussion time is generally allowable). Client Education sessions need to include EBPs that incorporate youth or adult learning styles and support information retention.

A SAPC-approved early intervention curriculum entitled "*Healthy YOUth: An Early Intervention Service Model for Addressing Substance Use Risk and Promoting Wellness Among At Risk Youth*" is available for Youth (age 17 and under) and Young Adults (age 18-20) enrolled in Early Intervention services. All youth and young adult provider agencies need to complete the required Early Intervention Curriculum training before delivering the early intervention client education sessions.

To ensure that clients are aware of upcoming Group Counseling and Client Education sessions, a monthly calendar need to be posted in areas accessible to clients, including the topic, location, date, time, and facilitator name.

Client Education sessions are available at all LOCs and are defined as in-person, by telephone, or by telehealth contact between up to two (2) practitioners within their scope of practice, and

- 2-12 clients at the same time in non-residential settings, **or**
- 2-30 clients at the same time in residential settings.

Client Education sessions may include family members and legal guardians. Services are reported in 15-minute increments, with sessions ranging from 60 to 90 minutes in length. A separate Progress Note documenting the Client Education session need to be written for each client and documented in the provider's EHR or Sage. Group sign-in sheets need to include signatures and printed names of clients and group facilitators, date, start/end times, location, and group topic.

The frequency of Client Education sessions, in combination with other Treatment Services, needs to be based on medical necessity and individualized client needs rather than a prescribed program required for all clients.

Individual Counseling

Individual Counseling sessions are designed to support direct communication and dialogue between staff and clients and focus on psychosocial issues related to substance use, outlined in the client's individualized Problem List (non-OTP settings) or Treatment Plan (OTP settings). They need to incorporate techniques such as MI and CBT.

Individual Counseling sessions are available at all LOCs and are defined as in-person, by telephone, or by telehealth contact between one (1) DHCS-approved practitioner type and one (1) client.

Services are reported in 15-minute increments with sessions ranging from 15 to 60 minutes. Individual Counseling sessions of less than eight (8) minutes cannot be billed as they are less than the minimum requirement. If Individual Counseling sessions exceed 60 minutes, the Progress Note for that encounter need to justify the exceeded time. If the counseling session is split into different services (e.g., Care Coordination, Crisis Intervention, etc.), a Progress Note need to be written for each session and documented in the EHR or Sage.

The frequency of Individual Counseling sessions, in combination with other Treatment Services, needs to be based on medical necessity and individualized client needs rather than a prescribed program required for all clients.

Crisis Intervention

For DMC-ODS, DHCS's DMS-ODS Billing Manual (June 2023) defines a crisis as an "actual relapse or an unforeseen event or circumstance, which presents to the member an imminent threat of relapse." SUD Crisis Intervention Services include direct communication and dialogue between the staff and the client. These are unscheduled sessions, but need to be available to the client as needed during the agency's normal operating hours or according to after-hours crisis procedures.

These sessions are immediate and short-term encounters limited to the alleviation and/or stabilization of the client's immediate situation and provided in the least intensive LOC that is medically necessary to treat the condition.

Note: Crisis Intervention sessions need to incorporate techniques such as MI and CBT.

Though the crisis definition does not include a threat to the physical and/or emotional health, such as suicidal and/or homicidal ideation, practitioners should attend to these concerns immediately. These encounters should be documented as an individual counseling or family therapy service, depending on who was present, as it is outside of DHCS's crisis definition under the DMC-ODS treatment standards.

A component of this service includes linkages to ensure ongoing care following the crisis. Crises that are not responsive to intervention need to be escalated to urgent (e.g., urgent care clinic) or emergent (e.g., medical or psychiatric ER) care. Crisis situations should not be confused with emergency situations, which require immediate emergency intervention, such as calling 911.

Crisis Intervention sessions are available at all LOCs and are defined as in-person contact between one (1) practitioner and one (1) client. Services may, however, involve a team of care professionals. Services are reported in 15-minute increments. A Progress Note need to be written for each session and documented in the EHR or Sage. Crisis intervention sessions conducted via phone or telehealth need to be documented as individual counseling or family therapy, as appropriate, as the State did not include telephone or telehealth as available delivery options for SUD crisis intervention services. Family Therapy is a form of psychotherapy that involves both clients and their family members and uses specific techniques and EBPs (e.g., family systems theory, structural therapy, etc.) to improve the psychosocial impact of substance use and the dynamics of a social/family unit. Sessions also need to incorporate techniques such as MI and CBT.

Family Therapy sessions are available at all LOCs and are defined as in-person, by telephone, or by telehealth contact between one (1) therapist-level LPHA, one (1) client, and their family member(s). Services are billed in 15-minute increments, with sessions ranging from 15 to 60 minutes. A Progress Note need to be written for each session and documented in the EHR or Sage.

The frequency of Family Therapy sessions, in combination with other Treatment Services, needs to be based on medical necessity and individualized client needs rather than a prescribed program required for all clients.

Collateral Services

Collateral Services are sessions between significant persons in the client's life (i.e., personal, not official, or professional relationship with the client) and SUD counselors or LPHAs. CalAIM has changed the format and billing for collateral services. Collateral services are only available as part of other services to the client, including assessment, individual counseling, and PSS. Per DHCS, collateral may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the member. As such, collateral services need to be documented and billed as part of the primary service being delivered to the client and are not a standalone service and do not have a separate billing code.

The frequency of Collateral Services sessions, in combination with other Treatment Services, needs to be based on medical necessity and individualized client needs rather than a prescribed program required for all clients.

Alcohol and Drug Testing

Alcohol and drug testing examines biological specimens (e.g., urine, blood, hair) to detect the presence of specific substances and determine prior substance use. While there is not a widely agreed-upon standard for drug testing in SUD treatment, it is often a useful tool to monitor engagement and provide an objective measure of treatment effectiveness and progress to inform treatment decisions. The frequency of alcohol and drug testing should be based on the client's progress in treatment, and the frequency of testing should be higher during the initial phases of treatment when continued alcohol and/or drug use has been identified to be more common. In general, alcohol and drug testing should not exceed more than twice (2x) a week. OTP requires monthly testing at a minimum.

Drug Testing as a Therapeutic Tool

Drug testing should be viewed and used as a therapeutic tool. A punitive approach to drug testing generally does not facilitate a productive relationship with clients and should be avoided. Consequences to drug testing should also be communicated in a therapeutic manner. Use of accurate language such as negative or positive to report the results of drug testing is encouraged.

Drug testing is best when administered randomly instead of scheduled, and the method of drug testing (e.g., urine, saliva) should ideally vary as well. When body fluid testing is performed, practitioners should balance the need to protect against the falsification and/or contamination of any urine sample with client privacy. Reasonable steps should be taken to ensure specimens are not switched, substituted, or adulterated before analysis. Direct observation specimen collection is not routinely necessary unless clinically indicated, such as when there is a discrepancy between a client's clinical examination and prior toxicology results.

Decisions about appropriate responses to positive drug tests and relapses should consider:

- Chronic nature of addiction.
- Relapse is a part of the condition for which people are seeking SUD treatment.
- Medications or other factors may, at times, lead to false or appropriately positive drug test results.

Alcohol and Drug Testing is allowable at all LOCs. Testing is not allowable for RBH. While it is not a reimbursable service for all practitioner types, a Progress Note need to be written for each test, and the service reported in the EHR or Sage.

Medications for Addiction Treatment

MAT, also known as addiction medication, service components include Assessment, Care Coordination, Individual Counseling, Group Counseling, Family Therapy, Medication Services, Client Education, RS, Crisis Intervention, and WM services. MAT may be provided in clinical or non-clinical settings and can be delivered as a standalone service or as part of all LOCs. For a list of FDA-approved addiction medications that SAPC requires providers to offer clients, see **Table 11**.

Table 11: Required Medications for Addiction

Opioid Use Disorder (OUD)	Alcohol Use Disorder (AUD)	Tobacco Use Disorder (TUD)[11]
Methadone *(oral methadone for the indication of OUD is only available via OTPs)*	**Naltrexone** Oral and long-acting injectable formulations are effective for AUD	**Varenicline** Oral formulation
Buprenorphine Sublingual or injectable extended-release buprenorphine formulations for the indication of OUD	**Disulfiram** Oral formulation	**Bupropion** Oral formulation
Naltrexone Long-acting injectable formulation is preferred to oral for OUD	**Acamprosate** Oral formulation	**Nicotine Replacement Therapy** Transdermal patch, transmucosal gum/lozenge, inhaler, nasal spray formulations
Medications FDA-Approved to Reverse Opioid Overdose[12] Injectable or Intranasal Formulations that Reverse Opioid Overdose		

Addiction Medications as a Core Component of SUD Treatment

Just as medications are commonly accepted for the treatment of other chronic conditions, the evidence shows that addiction medications can help decrease alcohol- and opioid-related cravings and ease withdrawal symptoms. While interventions such as counseling are critical for recovery, the use of medications for the treatment of addiction is also important and necessary in many cases. **Addiction Medications are a best practice** and a **core component of SUD treatment** for individuals for whom it is clinically appropriate because it facilitates recovery and improves outcomes.

Medi-Cal covers the use of medications that can be used outside of their FDA-approved indications (off-label) to treat SUD, including off-label medications effective at treating methamphetamine, cocaine, and cannabis use disorders through the Medication Services benefit. Treatment providers should make clinically effective off-label medications that treat SUD available to clients in their care. Provider agencies should refer to the latest SAPC IN 24-01 (along with corresponding attachments, specifically Required Addiction Medications [Attachment B]) and the SAPC Training webpage for additional information and resources about clinically effective medications that can be used outside of their FDA-labeled indication to treat SUD.

[11] TUD cannot be a primary diagnosis for DMC-ODS services, but SAPC programs should treat TUD as a component of other DMC-ODS services as long as a non-tobacco SUD is the primary diagnosis for DMC-ODS services. Given the high co-occurrence of TUD and other SUDs, tobacco use can be a topic for client education groups, included as part of risk reduction groups and individual counseling services, and as part of a client's overall treatment for the primary SUD.
[12] Medications FDA-Approved to Reverse Opioid Overdose should be prescribed to clients who received treatment within the SAPC network. Naloxone does not require a prescription to be distributed, and should be distributed to clients, their family members, and the community when it is impractical to prescribe Medications FDA-Approved to Reverse Opioid Overdose to people (such as those who are not enrolled as clients).

MAT Services for Youth (age 17 and under)

Research and clinical experience have not identified any age-specific safety concerns for addiction medications, and all treatment options should be considered for clients of all ages. Providers treating Youth (age 17 and under) with addiction medications should obtain parental/guardian consent when required to provide medication services. A minor 16 years of age or older may consent to OUD treatment that uses buprenorphine outside of an OTP setting, whether or not the minor also has the consent of their parent or guardian.[13]

MAT Services Requirements

Treatment agencies are required to create and update, as necessary, active policies and procedures related to the provision of addiction medications either directly to their clients or via linkage with other providers (e.g., FQHCs, primary care providers [PCPs]) that offer addiction medication services. SAPC encourages formal arrangements such as a Memorandum of Understanding (MOU) between agencies in order to optimize referral relationships and processes. California HSC § 11831, California HSC § 11834.28, and BHIN 23-054 require active policies and procedures related to the provision of addiction medications either directly to their clients or via linkage with external agencies that offer addiction medications.

Treatment agency practitioners must provide clients and any adult collateral contacts (including but not limited to adult family members) with information about addiction medications at intake, during treatment, and at discharge in accordance with the client's Plan of Care. The information provided need to be specific to each type of addiction medication that is clinically effective for treating that client's specific SUD(s) to support informed client consent. Clients who are not actively being treated with addiction medications should continue to be offered addiction medications, as clinically appropriate, in accordance with the client's Plan of Care.

Provider agencies need to provide clients with information using SAPC-approved materials about addiction medications that clearly explain the benefits of addiction medications and the risks of not accepting addiction medications; see Client Information About Addiction Medications (SAPC IN 24-01, Attachment A). Provider agencies need to document specifically which addiction medications information was provided to clients, the client's response upon receiving this information, and all medication services offered to the client, including a description of the client's clinical history and prior use of addiction medications when applicable.

Every client admitted to a treatment agency's care need to have access to all required addiction medications, either directly or through referral to external partners. For a list of required addiction medications, see Required Addiction Medications (SAPC IN 24-01, Attachment B).

Direct Provision of MAT Services to Clients On-Site

Each provider agency needs to have available to its staff and keep an updated list of addiction medications available directly via practitioners providing on-site services, including when these medications are prescribed through fee-for-service (FFS) Medi-Cal and picked up at an off-site pharmacy. Each client with a documented

[13] California FAM § 6929.1, amended by AB 816, effective January 1, 2024.

SUD meets the criteria to receive a medical evaluation, which needs to include the client being offered all addiction medications clinically appropriate to treat the client's particular SUD(s). Each provider agency needs to ensure that initial and follow-up addiction medication service appointments are arranged in accordance with the client's individualized Plan of Care. Treatment agencies that offer on-site medication services need to maintain sufficient medical LPHA staffing operating within the scope of practice of their license (licensed prescribing clinician) to meet client demand for addiction medication services, which may include employment of, or contracts with, prescribing clinicians and arranging coordination of telehealth medication services if applicable.

Documentation of Medication Services Provided to Clients On-Site

Medication services billed to SAPC require documentation of the eligible (non-tobacco) SUD diagnosis. The documentation must also specifically describe the medication services provided and how they relate to the treatment of each applicable SUD. Provider agencies need to offer TUD treatment, including medications appropriate for the client when TUD is present with a non-tobacco SUD. For TUD treatment services offered on-site with treatment of non-tobacco SUD(s), the applicable (non-tobacco) SUD(s) should be listed as the primary diagnosis on the claim. Other conditions treated by the licensed prescribing clinician, such as psychiatric or general medical care, can also be addressed during the same visit, provided that the eligible (non-tobacco) SUD was documented as the primary focus of the visit. Medication services associated with documentation that lacks both where there is no mention of an eligible (non-tobacco) SUD diagnosis and a documented treatment focus on the SUD are not billable to SAPC and may be subject to disallowance.

Referral for Addiction Medication Services through External Partners

Each treatment agency that does not directly offer each required addiction medication via practitioners operating on-site must coordinate care, as clinically appropriate, to ensure client access to each remaining addiction medication through one or more external partners. Provider agencies need to:

- Maintain a list of referral locations that include (at minimum) the name, address, phone number, website (when available), and distance to the external partner.
- Ensure that at least one (1) external partner offers each remaining required addiction medication is identified.
- Maintain procedures for client transportation to/from these external partners.

Client Eligibility for Addiction Medication Services

Provider agencies must obtain a history of the client's substance use during intake and provide the client with information about addiction medications, as clinically appropriate, in accordance with SAPC-approved materials addressing addiction medications. For additional information, see SAPC IN 24-01.

For clients who indicate a history of substance use (outlined in SAPC IN 24-01), each provider agency needs to perform a diagnostic assessment confirmed by an LPHA within the first 24 hours of the initial date of service to determine whether the client meets the current version of the DSM criteria for one or more substance-related and addictive disorders.

All clients who meet the current version of the DSM criteria for one (1) or more substance-related and addictive disorders (outlined in SAPC IN 24-01) should be offered an evaluation by a licensed prescribing clinician within the first 48 hours of the initial date of service. The licensed prescribing clinician needs to determine which addiction medications, if any, are appropriate for the client and need to either prescribe the addiction medication(s) directly and/or initiate a referral for addiction medication services to one or more external partners as described above. The addiction medications need to be provided to the client in alignment with the treatment agency's approved policies and procedures.

Administration, Storage, and Disposal of Addiction Medications

Each provider agency needs to create and keep updated a policy that describes the appropriate administration, storage, and/or disposal of each addiction medication (outlined in SAPC IN 24-01), as is aligned with the agency's LOC and in accordance with which addiction medications are available on-site and/or through referral to external partners. This policy needs to describe the medication self-administration requirements, the documentation requirements for self-administered medication, the medication storage requirements (including location, accessibility, inventory, handling, and documentation), and the medication disposal procedures (including how often medications are disposed of, the methods of destruction, and documentation). This policy needs to be aligned with the most current version of the SAPC Bulletin addressing addiction medications, see SAPC IN 24-01.

Staff Training Requirements for Addiction Medications

Each provider agency must ensure that all staff interacting with clients receive SAPC-approved training (outlined in SAPC IN 24-01) on the benefits and risks of addiction medications and the agency's addiction medication policy. This training must occur within 90 days of hire and not less frequently than annually thereafter. Provider agencies need to document their staff's training in each staff member's personnel file.

Procedures for Client Use of Addiction Medications

Each provider agency's Medical Director or their licensed prescribing clinician designee, with appropriate input from the client, determines when a current medication treatment, including treatment with controlled medications, is clinically beneficial. When the client is being treated with clinically beneficial medication(s), the treatment agency needs to, at a minimum, do all of the following:

- Ensure access to the facility is not denied because a client is being treated with addiction medication(s).
- Assure the client that the full range of medically necessary treatment services are available and not contingent upon the client changing their addiction medication(s).
- Support the client's continued receipt of addiction medication(s).
- Confirm that a client will not be compelled to taper, discontinue, decrease the dosage, or abstain from addiction medications as a condition of entering or remaining in treatment.
- Assure the client that they will not be denied access to addiction medications if they do not participate in all services offered by a facility.
- Assure the client that they will not be denied access to addiction medication services if they use non-prescribed intoxicants.

Clients diagnosed with OUD need to receive information about the medications available for OUD, including through treatment agencies and external partners (outlined in SAPC IN 24-01). Medications for OUD are available through both OTP and non-OTP sites of care.

Procedures for Care Coordination for OTP Services

Provider agencies without on-site OTP services need to arrange referrals within 24 hours for clients requesting addiction medication evaluations through an OTP. Medications dispensed from OTPs need to be stored in accordance with the Administration, Storage, and Disposal of Addiction Medications (SAPC IN 24-01, Attachment D) for applicable LOCs. Provider agency sites without on-site OTP services need to create and keep updated a plan to submit requests to the treating OTP for exceptions to take-home limits when additional take-home doses are clinically appropriate in accordance with the client's individualized Plan of Care.

Provider agencies need to coordinate the continuation of clinically beneficial OTP-dispensed addiction medications(s) at intake, throughout admission, and at discharge. This needs to include coordinating OTP services arranged prior to discharge to ensure that sufficient medication is available until the next scheduled follow-up appointment.

Procedures for Treatment with Buprenorphine

Licensed prescribing clinicians registered with the DEA may treat clients with buprenorphine at treatment agency sites of care. Residential facilities with practitioners who offer on-site addiction medication services, including treatment with buprenorphine, should be certified to provide IMS; see Incidental Medical Services (SAPC IN 24-01, Attachment G). Clients with OUD need to be informed about the scientific evidence base, effectiveness, associated risks and benefits, and clinical considerations for treatment with buprenorphine; see Client Information About Addiction Medications (SAPC IN 24-01, Attachment A). All clients with OUD being treated in sites without buprenorphine medication services available on-site should be offered a referral and care coordination for addiction medication services through external partners where treatment with buprenorphine is available. Provider agencies need to coordinate continuing clinically beneficial treatment with buprenorphine on intake, throughout the admission, and at discharge. This needs to include arranging follow-up appointments scheduled prior to discharge, with coordination of access to addiction medication services arranged to ensure that sufficient buprenorphine is available until the next scheduled follow-up appointment.

Note: Provider agencies need to provide a copy of their current addiction medication policy to their assigned SAPC CPA and the assigned DHCS licensing analyst.

Medications FDA-Approved to Reverse Opioid Overdose

Naloxone is a critical tool in responding to the opioid crisis. Naloxone is a life-saving medication used to reverse an opioid overdose, including heroin, fentanyl, and prescription opioid medication overdoses. Naloxone works by blocking the opioid receptor sites, reversing the toxic effects of the overdose. Naloxone is administered when a client is showing signs of opioid overdose and can be quickly administered by intranasal spray, intramuscularly, subcutaneously, or by IV injection. Naloxone is safe and easy to use, works almost immediately, and has no abuse potential. Naloxone is available to all Medi-Cal members with a prescription and may also be furnished by community pharmacists to individuals without a prescription.

Provider agencies need to establish protocols for both prescribing FDA-approved medications to reverse an opioid overdose, such as naloxone, and to distribute FDA-approved medications to reverse an opioid overdose obtained outside of pharmacy-dispensing and OTP-dispensing sources, such as the DHCS's Naloxone Distribution Project (NDP) for California, to all clients within the SAPC treatment network. NDP can be accessed via the NDP online application form.

Provider agencies must:

- Maintain, at all times, at least two (2) unexpired doses of naloxone or any other FDA-approved opioid antagonist medication for the treatment of an opioid overdose on their premises.
- Have at least one (1) staff member, at all times, on the premises who knows the specific location of the naloxone or other FDA-approved opioid antagonist medication **and** who has been trained in its administration. Training includes a review of educational resources provided by SAPC to respond effectively to an opioid-associated overdose emergency.
- Staff are required to certify that they have reviewed and undergone training in opioid overdose prevention and treatment. Document proof of completion of the training in the staff member's individual personnel file.

Naloxone should be readily available and not stored in locked cabinets or offices. Providers should develop written policies and procedures for labeled naloxone, whether prescribed or received through community distribution, to be kept on the person or at the bedside while in DHCS-licensed treatment facilities, similar to how a person may keep an inhaler on their person to treat asthma.

Provider Agencies can provide **or** arrange for naloxone to be prescribed and provided to each client by leveraging Medi-Cal. For example, practitioners whose scope of practice includes prescribing medication can prescribe naloxone to each client who is under their care and arrange for staff to routinely fill these naloxone prescriptions at a pharmacy on behalf of the members. Additionally, providers can coordinate the delivery of the naloxone from a pharmacy to the client's location.

Medical Directors and prescribing clinicians are also able to establish a Standardized Protocol that authorizes designated staff working in a DMC-ODS provider agency (using a standardized procedure and standing order specific to prescribing medications FDA-approved to reverse opioid overdose) to issue prescriptions on behalf of the Medical Directors or prescribing clinicians to a local pharmacy for medications FDA-approved to reverse opioid overdose. The pharmacy bills these prescriptions for medications FDA-approved to reverse opioid overdose through Medi-Cal. The staff may bring this dispensed medication back to the DMC-ODS provider site, or the pharmacy may arrange delivery to furnish these medications directly to clients. This method enables DMC-ODS providers to better facilitate on-site access to medications FDA-approved to reverse opioid overdose reimbursement through Medi-Cal. DMC-ODS providers may also refer clients to pharmacies that will dispense FDA-approved medications to reverse opioid overdose directly to the client.

Bystanders are often present when an overdose is occurring, and everyone can act to prevent overdose deaths. Anyone can carry naloxone and administer it to someone experiencing an overdose and potentially save that person's life. During an overdose, a person's breathing can dangerously slow down or stop, causing brain damage or death. It is important to recognize the signs and quickly administer naloxone, even before emergency workers arrive.

Clients who return to substance use should be encouraged not to use alone, carry naloxone, and let others around them know they have it in case they experience an overdose, since naloxone cannot be used on oneself during an overdose. California has a "Good Samaritan" law in place to protect those who are overdosing and anyone assisting them in an emergency from arrest, charges, or a combination of these. California's Good Samaritan law may be found at California HSC § 1799.102. Additionally, California HSC § 11376.5 provides limited protections from criminal arrest and prosecution for people who seek medical assistance at the scene of a suspected drug-related overdose. California's naloxone access laws may be found at California CIV § 1714.22, and California BPC § 4052.01 and California BPC § 4119.9.

Medication Services and Safeguarding Medications

Medication Services include the prescription, administration, or supervised self-administration (in residential settings) of medication related to SUD treatment services or other necessary medications that are not already reimbursed as a medication dosed through an OTP. Medication Services may also include assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services and/or order laboratory testing within their scope of practice or licensure. SAPC does not cover the drug product costs for addiction medications outside of the pharmacy or OTP/NTP benefit. SAPC reimburses for addiction medication services even when provided by DMC-ODS providers in non-clinical settings and as a standalone service. These are billed under Addiction Medication Services (or MAT).

All MAT must be prescribed in accordance with generally accepted standards of medical practice and best practice guidelines for the condition being treated.

Safeguarding of medications in accordance with regulations is required in residential and WM settings, and may be performed by qualified staff (e.g., LVN or Medical Assistants [MA]). For a complete list of staff who may assist with medication services, visit SAPC's Manuals, Bulletins, and Forms – Bulletins Tab webpage for the most current version of the Provider Staffing Guidelines.

Medication Services are available at all LOCs and are defined as in-person, telephone, or telehealth contact between clients and medical staff (e.g., physicians, NPs, or PAs) regarding the use of FDA-approved medications or other medications clinically effective to treat SUDs. Medication Services are reported in 15-minute increments, with sessions ranging from 15 to 30 minutes in length. A separate Progress Note need to document the encounter with each client.

Note: Medication Services provided in residential settings require IMS approval from the State for the specified residential site. Despite this allowance from the State, there is no current billing mechanism. As a result, Medication Services provided in residential settings are not DMC reimbursable.

Transportation Services

Providers need to make every effort to provide transportation or make arrangements for transportation to and from medically necessary, but non-emergent, treatment. The client's Medi-Cal may cover transportation services MCP (LA Care, Health Net, or Kaiser). Transportation services may require pre-authorization from the health plan, and the client's care coordinator is responsible for arranging for services ahead of time. The time spent coordinating transportation services is billable under Care Coordination, but not the transportation services.

In accordance with BHIN 22-031 and All Plan Letter (APL) 22-008, transportation services are available for members receiving behavioral health services as outlined at these links and below. For additional information, see APL 22-008 FAQs.

There are two (2) types of transportation on the Medi-Cal program:

1. Non-medical transportation (NMT) for members who do not need medical assistance during transit.
2. Non-emergency medical transportation (NEMT) for when the member's medical and physical condition is such that transport by ordinary public or private means is medically contraindicated.

The client's Medi-Cal MCP may cover NMT and NEMT services for the following situations:

1. Transportation to medical, dental, or behavioral health appointments for all Medi-Cal services (available to clients receiving outpatient, inpatient, or residential services).
2. Transportation for transfer from general acute care hospitals or EDs to psychiatric facilities, including psychiatric hospitals, skilled nursing facilities, and mental health rehabilitation centers.
3. Transportation after discharge.

Clients in need of NEMT will require the treating physician to submit an approved physician certification statement form from the client's MCP authorizing the NEMT. For additional information about Medi-Cal covered transportation services, visit DHCS's Transportation Webpage.

Exceptions include when providing treatment services at a SAPC-approved FBS site, the performing provider will be able to bill for mileage. For additional information on how these services are billed, visit SAPC's Manuals, Bulletins, and Forms – Bulletins Tab webpage for the most current version of the SAPC IN for the Rates and Standards Matrix.

For each Provider Agency with a DMC Perinatal Contract and site certification with SAPC, non-emergency transportation is billable under Perinatal Transportation (up to 80 miles per month, per member family unit) for outpatient LOCs. For additional information, see *Pregnant and/or Parenting Women Population* section.

Also, select costs can be added to the budget, which includes but is not limited to transporting the client to and from medical appointments, mileage for staff vehicle (a log for odometer readings before and after trip need to be properly maintained), or provider vehicle costs (e.g., gas, maintenance, depreciation). Bus and metro tokens can also be included in the budget, provided a log of total purchases and distribution to each client is maintained and available to auditors upon request. Rideshare services (e.g., taxi, Uber, Lyft) cannot be included in the budget.

Transportation costs need to be reported under the "Transportation" line item under the "Services and Supplies" category and be clearly tracked and managed. Since transportation costs are included in the day rate for residential treatment, transportation is not billable as a separate service in residential treatment. However, for Non-Emergency Transportation services to count towards the Residential weekly treatment hour standard, providers need to document how transportation contributes to client care and recovery in a Progress Note. Start and end times per trip need to be captured in the note.

Discharge Planning

Discharge planning is the process of preparing the client for referral to another LOC, post-treatment return, or reentry into the community, and/or the linkage of the individual to essential community treatment, housing, and human services. The discharge planning process should be initiated at the onset of treatment services to ensure sufficient time to plan for the client's transition to subsequent treatment, RS, or the next step in their recovery journey. It also helps to convey that recovery is an ongoing life process, not a unit of service. Transition to RS needs to be included in this process. Discharge planning should identify a description of the client's triggers, a plan to avoid relapse for each of these triggers, and an overall support plan.

Discharge planning sessions are available at all LOCs and are defined as in-person, by telephone, or by telehealth contact between one (1) practitioner and one (1) client. If permitted by the client, a trainee may observe for training purposes. Services are reported in 15-minute increments, with sessions ranging from 15 to 60 minutes. A Progress Note need to be written for each session and documented in the EHR or Sage.

The Discharge and Transfer Form in Sage is required to be completed by both Primary and Secondary directly in Sage-PCNX. This form, when combined with the Provider Site Admission Form, will accurately track each client admission and enable census tracking within Sage. The Discharge Form need to be completed on the day of the last in-person treatment/telephonic contact or dispensed or administered medication (OTP) for all LOCs unless the client's discharge is unplanned. For unplanned discharges, the form needs to be completed within 30 calendar days of the last date services were provided. For RBH, the Discharge Summary Form need to be completed for each client and submitted into Sage at the time of discharge from RBH.

Culturally and Linguistically Appropriate Services

CLAS promotes respect and understanding of how culture and language shape individual experiences and interactions. This includes race, ethnicity, faith, gender identity, sexual orientation, housing status, education, ability, and class. The National CLAS Standards were created to support the delivery of equitable and high-quality care, including for individuals receiving SUD services. Research shows that when services lack cultural relevance, diversity, and inclusivity, it can negatively affect outcomes such as access, engagement, help-seeking behaviors, treatment participation, goal setting, and family involvement.

SAPC's requirements for ensuring equitable services are outlined in SAPC IN 24-02. These requirements reflect a commitment to providing services that respect each person's culture, language, identity, developmental stage, and any physical, psychiatric, sensory, or cognitive disabilities. Providers need to ensure that their policies, practices, and daily operations support culturally, linguistically, and population-appropriate care.

Services for Persons with Disabilities

Providers need to comply with all aspects of the Americans with Disabilities Act of 1990 (ADA). This includes offering access to assistive technologies (e.g., TTY, magnification, audio, etc.) and policies that allow for the use of service animals.

As outlined in BHIN 24-007 and SAPC IN 24-02, providers need to have clear policies to accommodate the communication needs of all qualified individuals. They should be prepared to offer information in alternative formats, such as braille, audio recordings, large print, and accessible electronic formats, including data CDs. Other auxiliary aids and services also need to be provided when appropriate.

SAPC offers resources to help providers implement accessibility, including "Creating Accessibility: An ADA Toolkit for Service Providers", available on the SAPC-LNC platform. Providers can also refer to the DHCS Alternative Format website to identify member preferences for accessible materials.

TGI-Inclusive Services

In accordance with BHIN 25-019 and SAPC IN 24-02, SAPC and its contracted provider agencies need to comply with requirements under Senate Bill 293 to provide trans-inclusive care to individuals who identify as Transgender, Gender Diverse, or Intersex (TGI) consistent with the standards of care for individuals who identify as TGI, honors the individual's personal bodily autonomy, does not make assumptions about an individual's gender, accepts gender fluidity and nontraditional gender presentation, and creates spaces of inclusivity and belonging, treating everyone with compassion, understanding, and respect.

Under SB 923 and BHIN 25-019, SAPC is required to ensure that staff who have direct contact with clients are trained on a specific set of training curriculum requirements, as well as to track, monitor, and report complaints for failure to provide TGI-inclusive care and submit them to DHCS. Trainings will be provided by SAPC and tracked using the SAPC Learning & Network Connection (SAPC-LNC) platform.

Language Assistance Services

SAPC and its contracted provider agencies need to comply with Federal, State, and contract requirements for ensuring access to language assistance services (e.g., oral interpretation, sign language, written translation, etc.) at no cost for members who are monolingual, non-English speakers, or LEP, including posting of notifications about the availability of such services.

When a member requests services in a non-English language, providers should (as outlined in SAPC IN 24-02):

- Input member self-reported preferred language for treatment services into the EHR-Sage and the relevant data fields in CalOMS.
- Offer language assistance services for treatment in their preferred language.
- Use the Care Coordination benefit to refer members for treatment in their preferred language, when requested by the member.
- If a client refuses interpreter services, document in the client's chart that free interpreter services were offered and declined.

- Where applicable, providers should use the language assistance add-on when using a third-party interpreter during DMC-ODS eligible services; see SAPC IN 25-02 (or most recent version).
- Do not use family members, friends, etc., as interpreters unless specifically requested by the member. In such cases, the family member, friend, or other individual cannot be used in the normal course of providing contracted services, and the client should sign an ROI form to ensure they are fully informed of the information that may be disclosed. A minor child **may not be used as an interpreter** except when an emergency involves an imminent threat to the safety or welfare of the individual or the public and a qualified interpreter is unavailable.

In very limited circumstances, SAPC may assist Provider Agency with the identification of interpretation services. For any questions related to language assistance services, email eas@ph.lacounty.gov or visit SAPC's Cultural Responsiveness and Language Assistance (CRLA) webpage.

Service Delivery Options

Field-Based Services

FBS is a method of delivering SUD treatment services to clients outside of DMC-certified facilities and delivered in community settings where clients live, work, learn, and receive other services. FBS aims to improve access to treatment services, enhance client motivation and engagement, and reach underserved populations.

The DMC-ODS benefit allows for the provision of FBS as a method of service delivery for OP-type services as classified by ASAM. Provider Agencies need to apply to provide FBS at SAPC-approved sites, referred to as Community FBS (e.g., community centers, schools, homeless services facilities, government offices), and/or at locations/settings where a client lives, referred to as In-Home FBS.

FBS: Allowable Settings and Types

FBS can only be delivered to locations approved by SAPC. Provider Agencies need to submit an FBS application and receive approval to provide FBS.

FBS can be delivered at community settings with approval from SAPC or at a location where a client resides. “Community FBS” involves delivering SUD treatment services in community settings, including schools, community centers, clinics, shelters, and interim or permanent housing. When delivering services at a community site, providers need to establish an agreement with the site operator to deliver SUD treatment services. SAPC Provider Agency delivering FBS at a community site operates as a co-located service provider with a regular presence at the field-based location. These locations function as service hubs where multiple clients may receive treatment.

FBS may also be provided where a client resides or “in-home FBS”, which may include homes, shelters, street encampments, and interim or permanent housing. “In-home FBS” can be delivered to clients in a variety of housing situations, including those who are unhoused, unstably housed, and transitioning between different housing situations. Providing FBS to clients where they reside or “in-home FBS” involves providing services to an individual client, whereas Community FBS involves establishing a location for delivering services.

FBS may not be provided at locations that SAPC Provider Agencies own, operate, rent, or lease. Additionally, the delivery site need to not have SUD treatment as its primary focus or line of business. All FBS services need to be voluntary and delivered in accordance with DMC-ODS requirements. FBS cannot be utilized in lieu of obtaining a DHCS DMC Site Certification for providers' directly operated sites (e.g., rented, leased, and owned sites) where delivery of SUD or mental health treatment services are the primary business and where services are delivered by individuals employed by the agency managing the service site.

Note: In-custody/carceral services (e.g., jails, prisons) provided for youth or adults are not permissible as an FBS delivery site nor reimbursable through the DMC-ODS program.

FBS: Allowable Services

FBS is a method of mobile service delivery for Early Intervention (ASAM 0.5), OP services (ASAM 1.0), IOP services (ASAM 2.1), Care Coordination, and RS. Based on the ASAM Criteria, the following service components are allowable: Screening, Assessment/Intake, Individual Counseling, Group Counseling, Care Coordination, Problem List/Treatment Planning, Discharge Planning, Crisis Intervention, Client Education, Family Therapy, Collateral Services, MAT, and PSS.

FBS: Expectations

- **Culturally Competent Services:** Provider Agencies need to provide culturally competent services. Provider Agencies need to ensure that their policies, procedures, and practices are consistent with the principles outlined in CLAS and are embedded in the organizational structure.
- **Age and Developmentally Appropriate Services:** Provider Agencies need to deliver services that align with the client's age and developmental level to ensure engagement in the treatment process.
- **MAT:** Provider Agencies need to maintain procedures for linkage/integration to MAT services. Clients receiving MAT need to not be discriminated against and need to have equal access to services. The prescribing of MAT should follow established prescribing standards from the ASAM and the SAMHSA. Provider staff will regularly communicate with prescribers of MAT to ensure coordination of care, assuming the client has signed a 42 CFR Part 2 compliant ROI for this purpose.
- **Reaching the 95% (R95) Initiative:** Supporting access to the 95% of people who need treatment but who do not want or access it, oftentimes because of a lack of current treatment or abstinence goals.
- **Naloxone Training and Availability:** FBS providers need to carry naloxone, or other FDA-approved opioid antagonist medication, at all times and be trained and ready to administer this medication in response to overdose, with exceptions only for the rare circumstances where carrying and administering naloxone is expressly prohibited by site-specific local regulation. To access naloxone resources, visit: http://publichealth.lacounty.gov/sapc/public/harm-reduction/?tm#access-naloxone.
- **EBP:** Provider Agencies need to implement, at minimum, the following two (2) EBPs: MI and CBT. Providers are encouraged to implement additional EBPs, including relapse prevention, trauma-informed treatment, and psychoeducation.
- **Care Coordination:** Provider Agencies need to deliver a variety of care coordination services, including transitioning clients from one LOC to another, navigating mental health, physical health, and social service delivery systems, including housing referrals, as appropriate.
- **Confidentiality Regulations:** Provider Agencies need to adhere to all applicable confidentiality laws, including but not limited to 42 CFR Part 2; HIPAA Privacy Regulations; 45 CFR § 164.508(b)(2) and 45

CFR § 164.501; and the California CIV § 56.11, when providing FBS.

- **Employee Safety Regulations:** Provider agencies need to update their Injury and Illness Prevention Plan as required by CALOSHA (Title 8 CCR § 3203) to account for FBS. Updates to the plan need to include assignment of the responsibility, assessment of hazards, investigation of occupational accidents, injuries, and illnesses, correction of hazards, communication plan, training, systems for ensuring employee compliance with safety procedures, and recordkeeping and documentation.
- **Minor Consent:** For in-home services delivered to Youth (age 17 and under), the provider need to obtain consent from the parent or guardian allowing the youth to receive in-home services. Additional consent need to be obtained if in-home services need to be provided while a parent or guardian is not home. The provider need to obtain signed consent from the youth client to communicate with a parent or guardian. Emancipated youth and/or youth who meet the conditions of California FAM § 6922 may consent to in-home services; providers need to verify eligibility and document it.

For additional information on FBS, see SAPC Bulletin 23-14.

FBS: Mobile Outreach Services

Travel to the FBS site is reimbursable. For FBS staff's personal vehicle mileage reimbursement rate, visit SAPC's Manuals, Bulletins, and Forms – Bulletins Tab webpage for the most current version of the SAPC IN for the Rates and Standards Matrix. Each FBS staff member need to have a permanent headquarters, namely the office in which they spend most of their office work time or receive their supervision. Mobile Outreach Services is not intended to reimburse a workforce member for traveling to and from the basic work location, temporary or otherwise. Providers may bill up to 500 miles per month, per FBS site, when agencies are not also leveraging transportation services funded by other programs.

FBS: Staff Experience Requirements

FBS may be delivered by:

- Registered SUD counselors with 1 year (12 months) of relevant experience working to provide SUD prevention, harm reduction, treatment, or RS (close supervision of the registered SUD counselor is required);
- Certified SUD counselors;
- LPHAs;
- Certified Peers;
- Community Health Worker, Traditional Healer, Natural Helper

Staff providing FBS to youth clients need to either have at least two (2) years of experience providing behavioral health services to youth OR at least one (1) year of experience providing behavioral health services to youth AND have completed 11 hours of SAPC-required youth-specific trainings prior to delivering FBS (a list of required trainings can be found in SAPC's Field-Based Services: Standards and Practices (v3, December 2023).

FBS: Procedures

FBS: New Site Application

Providers need to get approval from SAPC to provide FBS. To apply for FBS, SAPC Provider Agencies need to email a complete application package with the subject line "Field-Based Services Application" to SAPCMonitoring@ph.lacounty.gov and SAPC_ASOC@ph.lacounty.gov.

Please review the FBS Application Instructions (SAPC IN 23-14, Attachment II) and FBS New Application Form (SAPC IN 23-14, Attachment III)

FBS: Site Renewal

FBS providers need to submit a renewal application annually by **May 31st**. To renew, the following need to be emailed to SAPCMonitoring@ph.lacounty.gov, and the providers assigned CPA:

- FBS Renewal Form (SAPC IN 23-14, Attachment V)
- Cover letter including sites to be renewed and/or discontinued with documentation of all significant changes (if applicable).

Any sites that are not renewed via this process will be removed from the Contract, and subsequent services will be denied. Your CPA will conduct compliance reviews as a part of the standard monitoring process for any sites maintained in the contract for subsequent years.

FBS: Site Modification

A Provider Agency approved for FBS need to notify SAPC of any significant changes to FBS operations, including but not limited to FBS being paused, ended, or modified.. A memo documenting all changes need to be submitted to SAPC within 30 days of implementation of operational changes by emailing SAPCMonitoring@ph.lacounty.gov,SAPC_ASOC@ph.lacounty.gov and the providers assigned CPA, with the subject line "FBS Modification."

FBS: Documentation

FBS need to be documented as outlined in the current version of the SAPC Provider Manual. Claims may be subject to recoupment if documentation is missing, incomplete, or incorrect.

A progress note need to be written for each session and documented in Sage or another approved EHR.

- Primary Sage users need to:
  - Select "Field-Based Services" for Method of Service Delivery;
  - Enter the appropriate Place of Service Code within the Location field; **and**
  - Document the location where services were provided (e.g., name of approved FBS location and/or address) within the Field-Based Service Location field.
- Secondary Sage users need to document services with a progress note in their EHR with the following:
  - Services were delivered via field-based services;

- Appropriate Place of Service Code; **and**
- Document the location where the services were delivered (e.g., name of approved FBS location and/or address).

A claim for FBS requires the use of the appropriate Place of Service Code (entered within the Location field of the Fast Service Detail within Sage). The Place of Service Codes need to be entered for their respective locations when billing for FBS, see **Table 12**. Only allowable place of service codes corresponding to the allowable billing may be used. Secondary Sage users need to enter the appropriate Place of Service Code in the SV105 line; see Companion Guide HIPAA 837P (v2.8, June 2024). The Place of Service Code and services provided for a claim need to match the progress note. Claims may only be submitted for allowable service components for FBS.

Table 12: Place of Service Codes for Field-Based Services

Location Name	Description	Place of Service Code
School	A facility whose primary purpose is education.	3
Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).	4
Home	Location, other than a hospital or other facility, where the client receives care in a private residence.	12
Assisted Living Facility	Congregate residential facility with self-contained units providing assessment of each resident's needs and offering on-site services, including some health care.	13
Group Home	A residence with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial services, and minimal services (e.g., medication administration).	14
Mobile Unit	A facility/unit that moves from place to place and equipped to provide preventive screening, diagnostic, and/or treatment services.	15
Temporary Lodging	A short-term accommodation including hotels, campgrounds, or hostels where the client receives care.	16
Urgent Care Facility	A location, distinct from a hospital ER, an office or a clinic, with a purpose to diagnose and treat illness or injury for unscheduled, ambulatory clients seeking immediate medical attention.	20
Emergency Room—Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.	23
Outreach Site/Street	A non-permanent location on the street or found environment, including encampments where services are provided to for PEH.	27
Nursing Facility	A facility that primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons; or, on a regular basis, health-related care services above the level of custodial care to residents other than individuals with intellectual disabilities.	32
Custodial Care Facility	A facility that provides room, board, and other personal assistance services, generally on a long-term basis, and which does not include a medical component.	33

Location Name	Description	Place of Service Code
Federally Qualified Health Center (FQHC)	A facility located in a medically underserved area that provides Medicare members with preventive primary medical care under the general direction of a physician.	50
Community Mental Health Center (CMHC)	A facility that provides mental health services, including DMH provider agencies and other mental health services organizations.	53
Public Health Clinic	A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician.	71
Other Place of Service	Other place of service includes community centers, parks, faith-based organizations, CBOs, and non-profit organizations. *	99

If your FBS location does not correspond with the location types listed in Table 12, email SAPC_ASOC@ph.lacounty.gov for instructions on which code to use. Place of Service Code 99 should not be used for locations outside of the locations described or similar.

When FBS is delivered to the location where a client resides or "in-home FBS", providers need to use the appropriate Place of Service Code, which may include 12 for Home, 4 for Shelter, 13 for Assisted Living, 14 for Group Home, 16 for Temporary Lodging, 27 for Street Outreach or Encampment. These codes ensure accurate documentation and billing aligned with the actual service location.

For services provided at DMC-certified facilities, agencies need to use the appropriate place of service codes, such as: 55 – Residential Substance Abuse Treatment Facility and 57 – Non-residential Substance Abuse Treatment Facility. Since clients can receive services both at a DMC-certified facility and through FBS while in treatment, it is essential that the Place of Service Code correspond to the location where services were delivered.

Mobile Opioid Treatment Programs

A Mobile Opioid Treatment Program (MOTP), also known as a Mobile Narcotic Treatment Program (MNTP), is a mobile component of a primary OTP operating from a motor vehicle under the primary OTP's DEA registration and DHCS license. MOTPs provides OTP treatment at DHCS approved locations in Los Angeles County remote from the primary OTP's registered location. MOTPs are authorized by DHCS to operate under the existing OTP certification, provided that applicable Federal, State, tribal, and local requirements have been met. Pursuant to 21 CFR §1300.01, MOTPs operate as a coincident activity of an existing OTP and, therefore, do not need to obtain a separate DEA registration for the mobile component. A MOTP needs to operate under the license of only one (1) OTP with which it is affiliated and associated. MOTPs need to receive all necessary approvals from DHCS, DEA, and SAMHSA prior to operation. This includes DHCS's route approval and schedule for where and when MOTP services will be delivered. MOTPs require SAPC's approval, as site additions are processed through the contract amendment process outlined in **Table 26**. For additional information, see *Updating Service Provider's Contract* section.

As with OTPs, MOTPs provide treatment for addiction, including buprenorphine, methadone, and naltrexone. In addition to dispensing medications for OUD treatment, a MOTP may provide additional services when approved by DHCS/SAPC: collecting samples for drug testing or analysis (9 CCR §10315), dispensing take-

home medications (9 CCR, Division 4, Chapter 4, Subchapter 5 Article 4), admission into treatment (9 CCR §10270), medical evaluation (9 CCR §10270), and/or counseling. MOTPs function as the same ASAM LOC as standard OTPs, and medical necessity for OTP services need to be established, including a DSM-5 diagnosis of an SUD and an appropriate LOC designation based on an ASAM assessment. The OTP is responsible for ensuring that its MOTP clients have access to any treatment services not provided by a MOTP.

MOTP staff members transporting controlled substances in a MOTP need to retain control over all controlled substances when transferring them between the OTP and the MOTP. MOTPs may not share or transfer controlled substances from one mobile component to another mobile component while deployed away from the registered location. The MOTP may only obtain controlled substances from the OTP under which it is licensed and need to return to the primary licensed location to restock or transfer controlled substances.

MOTP: Service Requirements

An MOTP need to be on a vehicle operating with a minimum of four (4) wheels and follow a predefined and pre-approved route. MOTPs are required to operate a minimum of five (5) days a week, and methadone need to be available seven (7) days a week at the home OTP under which the MOTP operates. This can be fulfilled with take-home meds or courtesy dosing. A MOTP may have different hours than the home OTP site. The home OTP is responsible for ensuring that MOTP clients have access to medically necessary OTP treatment services not provided by the MOTP. The MOTP is required to have a written schedule with days and hours of operation for dispensing medications. For additional information, see BHIN 24-005.

Telehealth and Telephone

In accordance with BHIN 23-018, if a service is provided through telehealth (synchronous audio or video) or telephone, the provider staff need to inform the client prior to initiating applicable health care services (e.g., SUD) and obtain verbal or written consent for the use of telehealth as an acceptable mode of delivering health care services. Providers are required to share additional information regarding:

- Right to in-person services;
- Voluntary and consent for the use of telehealth can be withdrawn at any time without affecting their ability to access covered Medi-Cal or other SUD services in the future;
- Availability of Medi-Cal coverage for transportation services to in-person services when other available resources have been reasonably exhausted;
- Potential limitations or risks related to receiving services through telehealth compared to an in-person visit, if applicable; **and**
- Availability of translation services.

Note: Telehealth and telephone services are meant to supplement, not replace, in-person services. Providers must also offer in-person services or have a documented process to link clients to in-person care within a reasonable time if the services are unavailable from the provider.

The provider staff need to document the provision of this information and the client's verbal or written acknowledgment that the information was received in the client's record.

Note: Consent requirements may be found in California BPC § 2290.5(b) and California WIC § 14132.725(d).

Telehealth

Telehealth is a way to deliver healthcare services remotely. Telehealth allows SUD services to be delivered between a DHCS allowable practitioner type and a client via audio and video communications, even when they are not able to be at the same location. Telehealth services will be available to all populations and allow eligible DMC services to be provided where physical access is a barrier for clients. The type of settings clients can be located at while receiving telehealth services include, but are not limited to, hospitals, medical offices, community clinics, or the client's home. Licensed providers and non-licensed staff may provide services via telehealth as long as the service is within their scope of practice.

Available Telehealth Services

Telehealth services are available to all individuals who meet the eligibility requirements for SUD services and consent to receive these services remotely. The following LOCs are permitted to be conducted via telehealth:

- Outpatient services (ASAM 1.0 & 0.5 LOC)
- Intensive Outpatient services (ASAM 2.1)
- Ambulatory-Withdrawal Management (ASAM 1-WM & ASAM 2-WM)
- Recovery Services

Allowable Telehealth Services within LOCs:

- Care Coordination
- Collateral Services
- Determination of Medical Necessity
- Individual Counseling
- Group Counseling[14]
- Initial Clinical Assessment
- Medication Services (MAT)
- Positive Youth Development
- Care Planning
- Relapse Prevention
- Recovery Monitoring

In-person appointments need to occur whenever client signatures are required. This would include signing initial consents, Treatment Plans, and Treatment Plan Updates in OTP settings. Client signatures are not required on Problem Lists documented in non-OTP settings. If the client is unable to sign, the reason need to be clearly documented in the client's chart.

As noted in the Crisis Intervention, DHCS does not allow for SUD crisis intervention services to be delivered via telephone or telehealth and will not accept the telehealth place of service code or modifiers when claiming. Providers should follow the instructions in the Crisis Intervention section above.

[14] **Group counseling sessions** may be conducted via telehealth if the provider obtains consent from all the clients and takes the necessary security precautions in compliance with HIPAA and 42 CFR Part 2.

Agency Requirements and Responsibilities for Telehealth

Each registered or certified SUD counselor/LPHA delivering Telehealth DMC-covered services need to meet the requirements of California BPC § 2290.5 [a](3), or equivalent requirements under California law. For example, SUD counselors are certified as outlined in the CCR Title 9, Chapter 8: Certification of Alcohol and Other Drug Counselors.

Provider agencies that elect to provide Telehealth services are required to ensure the staff delivering these services have the necessary knowledge, skills, and training to deliver high-quality Telehealth services. Provider agencies need to establish Telehealth policies and procedures that outline how agency staff will abide by the requirements outlined by SAPC in order to deliver telehealth services.
Agencies that provide Telehealth services need to ensure proper technical specifications, system maintenance, security, confidentiality, support, and functioning of associated technologies in accordance with applicable Federal, State, and local policies and regulations.

Services provided via Telehealth are subject to the same privacy and security laws and regulations as services provided by in-person services, and providers need to ensure that they comply with HIPAA, the California Medical Information Act, and, if applicable, 42 CFR Part 2 or California WIC § 5328.

Telehealth Platforms

SAPC does not impose requirements on which live video platforms can be used to provide services via Telehealth, provided they are 42 CFR Part 2 and HIPAA-compliant (rules for telehealth technology in Parts 160 and 164) and conform to DHCS expectations and regulations. Telehealth platforms need to meet security safeguards to PHI confidentiality. Additional information about Telehealth platforms is available through the California Telehealth Resource Center (CTRC) at www.caltrc.org.

For additional claiming requirements or clarification, visit SAPC's Manuals, Bulletins, and Forms – Bulletins Tab webpage for the most current version of the SAPC IN for the Rates and Standards Matrix; and see Companion Guide HIPAA 837P (v2.8, June 2024).

Telephone

SAPC reimburses for eligible telephone services. Telephone services need to be documented in the client's file. Eligible telephone services include:

- Screening
- Individual Counseling
- Collateral Services
- Care Coordination
- Recovery Services

Section 3. CLIENT SERVICE STANDARDS: SPECIAL POPULATIONS

Special Programs Defined

Special programs are designed to support individuals who may face greater barriers to accessing or staying engaged in treatment due to current life circumstances or co-occurring medical and psychosocial conditions. These programs provide tailored approaches to care for people whose needs may not be fully met by standard treatment services.

To participate in these programs, individuals need to meet medical necessity criteria under DMC ODS, as well as any additional eligibility requirements set by the referring entity. Providers delivering services through special programs are encouraged to use EBPs that help individuals explore how substance use may relate to their involvement with the referral source.

The SBAT allows individuals, county partners, and other referral entities (e.g., SASH, CENS, and CORE) to search for contracted SUD treatment provider agencies based on special categories, including those that serve the PPW, families with children, COD, justice-involved, PEH, LGBTQ+, veteran, youth, young adult, adult, and older adult populations.

Pregnant and Parenting Women Population

Substance use while pregnant can result in significant parental, fetal, and neonatal morbidity. Pregnant people who use substances often experience stigma, which may lead them to delay or avoid seeking SUD treatment and prenatal care, increasing the risk of health harms.[15] SUD providers offering services funded by DMC need to address PPW's specific treatment and recovery needs up to 365 calendar days postpartum. Research shows that targeted interventions during this period improve prenatal care attendance, birth outcomes, and overall healthcare costs for both parent and child. Services need to consider the unique needs of this population throughout treatment and recovery.

Motivational therapies are essential to engaging and supporting individuals in their recovery journey. While many treatment approaches overlap with those used for the general population, effective services for this population include elements tailored to pregnancy and parenting, such as bonding with the expected child, reproductive health planning, and care coordination for physical, mental, and material needs. The initial assessment, Problem List (non-OTP settings) or Treatment Plan (OTP settings), and reassessments of progress need to consider the varied needs related to the health and well-being of both the perinatal (pregnant or postpartum) person and fetus/infant.

Federal guidelines prioritize access to SUD treatment in this order: people who are pregnant and inject substances, people who are pregnant and use substances, people who inject substances, and then all others.[16] However, a specific LOC is not prescribed, and thus, the appropriate setting and LOC for this population need to be consistent with the ASAM criteria, with consideration of the ability to accommodate the physical stresses of pregnancy (e.g., climbing stairs, performing chores, bed rest when medically required, etc.) and the need for

[15] Weber, A., Miskle, B., Lynch, A., Arndt, S., & Acion, L. (2021). Substance use in pregnancy: Identifying stigma and improving care. *Substance Abuse and Rehabilitation, 12*, 105–121. https://doi.org/10.2147/SAR.S319180
[16] DHCS. (2024, August). Substance Use Disorder Perinatal Practice Guidelines. https://www.dhcs.ca.gov/services/MH/Documents/Perinatal-Practice-Guidelines-2024.pdf.

safety and support during this period. Depending on clinical need, LOC determinations need to be based on individualized and multidimensional ASAM assessments and may lead to placement recommendations in the residential or OP setting.

Staff working with this population need to be trained in procedures related to prenatal care, labor and delivery, and in responding therapeutically to the range of outcomes that may occur during pregnancy. Services need to be delivered in a respectful, inclusive, and supportive environment.

The use of addiction medications during pregnancy need to be approached with individualized care and informed discussions about potential risks and benefits. Although some risks exist, inadequate treatment also poses significant dangers. For individuals with OUD, medications such as methadone and buprenorphine are considered the standard of care. Providers need to obtain informed consent and discuss expectations, including the possibility of Neonatal Abstinence Syndrome. Detoxification should be carefully considered due to the risk of relapse. Breastfeeding while taking these medications should be evaluated on a case-by-case basis; neither methadone nor buprenorphine is a contraindication to breastfeeding.

Support need to continue after delivery, as individuals in the postpartum period face an increased risk of returning to substance use. Postpartum services should include, but are not limited to:

- Support for parenting a newborn
- Education on breastfeeding
- Integration with other children and family members
- Care Coordination for legal, physical, and mental health needs
- Access to equipment, clothing, and material support
- Coping with the physical and psychosocial changes of the postpartum period
- Reproductive health planning
- Encouragement of the continued pursuit of recovery goals

Perinatal services need to align with the most current version of DHCS's Substance Use Disorder Perinatal Practice Guidelines (August 2024), developed in accordance with DMC and the Substance Use Prevention, Treatment, and Substance Use Block Grant (SUBG or SUPTRS BG; *formerly known as Substance Abuse Prevention and Treatment Block Grant or SABG*) Perinatal Set-Aside from SAMHSA. The SUBG requires specified funds to be used for perinatal clients and is governed by 45 CFR § 96, Subpart L; DMC funds are governed by CCR Title 22.

PPW: Referral Process

PPW who self-identify or are identified by a county department (e.g., DCFS) as needing SUD treatment services are referred to the appropriate LOC by the CENS, SASH, or SUD treatment agency. Referrals need to direct clients to designated PPW providers to ensure they receive the full range of services available to them. Only providers approved by DHCS to deliver PPW services are eligible to bill for this benefit.

PPW: Target Populations

Per DHCS's Substance Use Disorder Perinatal Practice Guidelines (August 2024), individuals eligible for PPW services include:

- Pregnant women
- Women with dependent children
- Women attempting to regain custody of their children
- Postpartum women and their children
- Women with substance-exposed infants

PPW: Treatment Requirements and Care Coordination

Per DHCS's Substance Use Disorder Perinatal Practice Guidelines (August 2024), treatment agencies are required to provide or arrange for case management to ensure that PPW and their children have access to the following services:

- **Primary Medical Care,** including referral for prenatal care.
  Note: Childcare services need to be provided during this specific treatment.
- **Primary Pediatric Care,** including immunization, for the children of PPW receiving treatment services.
- **Gender-Specific Services,** which may address issues of relationships, sexual and physical abuse, DV/IPV, and parenting.
  Note: Childcare services need to be provided during this specific treatment.
- **Therapeutic Interventions for Children** in the custody of PPW receiving SUD treatment services, which should address the child's developmental needs; sexual, physical, and psychological abuse; and neglect.
- **Care Coordination,** including arranging, coordinating, and monitoring services such as primary medical care, prenatal care, and gender-specific treatment.
- **Child Care Coordination** for children age 0-16, including arranging, coordinating, and monitoring services such as primary pediatric care, gender-specific treatment, and therapeutic interventions.
- **Parenting Skills,** including providing education in child development, skill-building training, counseling, modeling, and problem-solving in specific instances of parent-child interactions.
- **Perinatal Transportation**, including providing or arranging transportation for PPW and their child(ren) age 0-16. This benefit may only be used to ensure access to the following services: primary medical care, primary pediatric care, gender-specific treatment, and therapeutic services for children.
  Note: Transportation reimbursement is not available to residential providers, as this benefit is built into the residential rate.
- **Childcare,** including while PPW are receiving primary medical care, prenatal care, and gender-specific services. Childcare need to meet applicable standards of State and local law for licensed and/or licensed-exempt childcare, as defined in CCR Title 22, Division 1, Chapter 1. SAPC will reimburse for the following types of childcare for children aged 0-14 years:
  - **Cooperative (Co-op) Childcare**: Licensed-exempt cooperative childcare is delivered while PPW receive SUD treatment services. Co-op childcare is when one woman, under the supervision of an experienced staff member, watches the children of her fellow group members while they participate in treatment. The client/caregiver watching the children should rotate so that each woman can participate in treatment.

        - Staff-to-caregiver-to-child ratios are one (1) staff and one (1) caregiver to 12 children.
    - **Licensed-Like Childcare:** Licensed-exempt licensed-like childcare is delivered while PPW receive SUD treatment services. Licensed-like childcare is provided by treatment agency staff and includes therapeutic and developmentally appropriate services. Staff-to-child ratios are:
        - Infants (0 to 18 months): one (1) staff to three (3) children
        - Toddlers (18 to 36 months): one (1) staff to four (4) children
        - Preschool Age (36 to 60 months [or 5 years]): one (1) staff to eight (8) children
        - School Age (5 to 14 years): one (1) staff to 14 children

PPW: Expanded Services for Children

In accordance with DHCS's Substance Use Disorder Perinatal Practice Guidelines (August 2024), SAPC expanded SUD treatment services for PPW to include their dependent children (age 0-16), who can receive the following support services while their mother is enrolled in treatment:

- **Residential** room and board for up to five (5) children per parent, accompanying parent in residential treatment services. Contingent on participation in Residential Treatment services by PPW.
- **RBH** bed for up to five (5) children per parent, accompanying parent in RBH. Contingent on participation in RBH by PPW. For additional information on RBH eligibility and benefits, see *Recovery Bridge Housing* section.
- **Child Care Coordination** (as noted above), including arranging, coordinating, and monitoring services such as primary medical care, primary pediatric care, gender-specific treatment, and therapeutic interventions for children.
- **Transportation** (as noted above) to ensure access to the following services: primary medical care, primary pediatric care, gender-specific treatment, and therapeutic services for children.
  Note: Transportation reimbursement is not available to residential providers, as this benefit is built into the residential rate.

For additional information on expanded services for PPW, see SAPC Bulletin 18-11.

DMC Perinatal Eligibility

- The LPHA determines whether SUD services are medically necessary and document approval of the diagnosis performed by the therapist, PA, or NP by signing and dating the Problem List (non-OTP settings) or Treatment Plan (OTP settings).
- Medical documentation to substantiate pregnancy and the last day of pregnancy (if applicable) need to be in the client record.
- PPW agencies need to complete the Women's Health History Form in Sage for all clients who are pregnant or within 365 days postpartum. This form needs to be completed for each pregnancy and updated if the pregnancy ends during treatment. Required fields include the client's last menstrual period, pregnancy start date, expected due date, pregnancy end date (if applicable), and date of initial treatment.
- Eligibility is based on pregnancy and ends on the last day of the month in which the 365th day of the postpartum period occurs.[17]

[17] 22 CCR § 51303 - General Provisions; 22 CCR § 5026 - Answer to Petition.

Mother and Child Habilitative

Under CCR Title 22, DMC perinatal programs are to provide mother/child habilitative services. These services focus on the development of parenting skills and training in child development, and coordinating ancillary services. Services include:

- Education to reduce the harmful effects of SUD on the mother and fetus, or the mother and infant.
- Therapeutic interventions addressing issues such as relationships, sexual and physical abuse, and parenting.

PPW: Discharge Planning

Providers should start discharge planning soon after the client begins treatment services. This planning should include family planning and encouragement of the continued pursuit of recovery goals, education planning, and reunification planning (if applicable).

For additional information regarding services that are required to be provided to the PPW population, see DHCS's Substance Use Disorder Perinatal Practice Guidelines (August 2024).

Women and Children's Residential Treatment Services

WCRTS is a program and funding source used to support Residential Services that are not covered under DMC for PPW clients receiving services in these settings. Covered non-DMC costs include:

- Room and board in residential treatment; and
- Full cost of treatment services for women ineligible for or unenrolled in Medi-Cal who are receiving services in a PPW residential program.

In accordance with California HSC § 11757.65, providers funded by and participating in the WCRTS program need to pursue four (4) primary goals and achieve four (4) outcomes for PPW in residential SUD treatment settings.

The **four (4) primary goals** of the WCRTS Program include:

1. Demonstrate that alcohol and other drug (AOD) treatment services are delivered in a residential setting and coupled with primary health, mental health, and social services for women and children can improve overall treatment outcomes for women, children, and the family unit.
2. Demonstrate the effectiveness of 6- or 12-month stays in a comprehensive residential treatment program.
3. Develop effective, comprehensive service delivery models for women and their children that can be replicated in similar communities.
4. Provide services to promote safe and healthy pregnancies and perinatal outcomes.

The **four (4) outcomes** intended to be achieved through the WCRTS program include:

1. Preserving family unity
2. Promoting healthy pregnancies
3. Enabling children to thrive
4. Reducing or eliminating the distress caused by the symptoms of SUD for women and their families

PPW: Additional Perinatal Services

In addition to providing the expected services, treatment agencies providing PPW services need to incorporate the following into PPW treatment services:

- Promote bonding with the expected child.
- Reproductive health counseling services to provide referrals and support individuals to make informed choices around HIV/STI testing, pregnancy prevention, family planning, sexual health, pregnancy support, pregnancy options counseling, postpartum care, etc.
- Care Coordination to address the material and physical/mental health needs that go with pregnancy.
- Support for newborn parenting, education about breastfeeding, and integration with other children and family members.
- Care Coordination for practical needs such as legal assistance, equipment, and clothing; coordination of physical and mental health services as needed; coping with the physical and psychosocial changes of the postpartum period; family planning and encouragement of the continued pursuit of recovery goals.
- Outreach activities to ensure PPW needing services can access treatment.
- Promote awareness among women who inject drugs about the relationship between injection drug use and communicable diseases, such as HIV, Hepatitis B, Hepatitis C, and TB, and offer referrals to appropriate service providers for appropriate screenings.

Perinatal programs need to notify SAPC and DHCS within seven (7) days once their program reaches 90% capacity. Providers need to submit this notification by sending a notice to SAPCMonitoring@ph.lacounty.gov and DHCSperinatal@dhcs.ca.gov. In accordance with DHCS's Substance Use Disorder Perinatal Practice Guidelines (August 2024), providers need to report this information on the DATAR system for each month by the 10th of the following month.

Sexual and Reproductive Health Services

DHS SRH Health Education Classes

SAPC partners with the Los Angeles County Department of Health Services (DHS) to implement programming on the Sexual and Reproductive Health (SRH) needs of pregnant individuals and other individuals of reproductive age. DHS's health education team offers SRH education classes in English and Spanish to participating PPW provider sites.

These programs integrate SRH counseling and education into the client's treatment goals. Clients are offered referrals to health clinics/hospitals that address their SRH needs, including MAMA's Neighborhood, which is operated by DHS and provides prenatal, postpartum, and other comprehensive healthcare services.

The goal of this collaboration is to better identify and support the SRH needs of receiving treatment at PPW provider sites, improve access to reproductive healthcare through direct linkages, expand clients' SRH knowledge, improve pregnancy and birth outcomes, manage chronic diseases and STIs, and improve recovery management and outcomes.

PPW-CENS and DHS-MAMA's Neighborhood Project

The PPW-CENS Project utilizes dedicated CENS counselors to identify PPW to assess for SUD services and, if appropriate, health services pertaining to their pregnancy or reproductive needs. Upon their consent, individuals are screened and offered a referral to treatment, other health-related services, and/or early intervention services. If SUD services are recommended, the CENS Counselor:

- Refers individuals to the appropriate SAPC SUD treatment providers based on the individual's location, type of services needed, and LOC;
- For pregnant individuals who encounter CENS during the screening, CENS are trained to also refer to DHS clinics/hospitals for prenatal care and/or options counseling.

DHS-MAMA's Neighborhood hospital and clinic staff who encounter a PPW who discloses using a substance can refer to CENS counselors for screening.

SRH Specialist Project

The purpose of the SRH Specialist project is to integrate SRH services for clients in SUD treatment settings to improve their individual and family health outcomes. SRH Specialists have specialized training to address the SRH needs of any client of reproductive age in treatment at a participating PPW site, whether pregnant, postpartum, parenting, or otherwise. They will support clients in their decisions about when, or if, they would like to have children and otherwise integrate clients' SRH care needs into their SUD treatment goals. PPW agencies interested in participating in the SRH Specialist Project can contact SAPC's Treatment Systems of Care Division (SAPC-SOC), Family Services team at SAPC_FamilyServices@ph.lacounty.gov.

SRH Specialists work to ensure SRH programming is developed and available to clients in treatment at PPW programs by implementing four (4) main categories of services:

1. Outreach and Engagement
2. SRH Education Services
3. Client Screening, Appointment Scheduling, Reminders, and Follow-Up
4. Service Navigation, Referral, and Linkages

Note: SRH Specialists are required to complete the PATH (Pregnancy/Parenthood, Attitudes, Timing, and How Important) training, and also serve as their agency's expert on completing the Reproductive Health Screening (RHS) Form.

Pregnancy/Parenthood, Attitudes, Timing, and How Important Training

The PATH training is a pregnancy intentionality training that guides providers on conducting conversations around clients' reproductive health. This specialized training focuses on using standardized client-centered questions about reproductive goals for clients of all demographics and reviews the RHS Form as a tool to document SRH conversations. This training is offered to all PPW providers, and SAPC encourages all PPW sites to have at least one (1) staff member trained.

Note: SRH Specialists are required to complete the PATH training.

Reproductive Health Screening Form

PPW treatment providers who have completed PATH training will use the standardized RHS Form to screen for reproductive health needs and identify appropriate services. PPW providers will:

- Access the RHS form in Sage to screen individuals during intake or later in treatment to identify what, if any, reproductive health needs the individual may have based on their reproductive preferences.
- Follow the prompts on the RHS form to connect the individual with the most appropriate service. This could include their PCP, local clinic, or the nearest DHS clinic or hospital.

For individuals who are currently pregnant, planning to become pregnant, seeking to prevent pregnancy, or working toward preferred birth spacing, providers need to support appointment scheduling and make referrals for relevant services based on the individual's reproductive goals. These may include contraception, pre- or inter-conception care, prenatal and postpartum care, pregnancy options counseling, and related services.

Family Programs

DPSS - CalWORKs

CalWORKs: Referral Process

CalWORKs Welfare to Work (WtW) clients are screened for SUDs by their Greater Avenues for Independence (GAIN) Services Worker (GSW) during their GAIN Orientation and Vocational Assessment. Clients who screen positive and self-identify a need for services will be referred for an assessment in one (1) of three (3) ways:

1. Referral to the CENS Area Office nearest to the individual, where the CENS will:
    a. Schedule the screening appointment within three (3) business days after receiving the GN 6006A, CalWORKs Clinical Assessment Provider Referral Form (see Appendix K);
    b. Screen the individual using the ASAM CO-Triage® Tool for Adults (age 21 and over);
    c. Secure intake appointment with an SUD treatment agency selected from the SBAT within three (3) business days of screening; **and**
    d. Forward a copy of the GN 6006A to the selected treatment provider agency.
2. Referral directly to a contracted provider agency. Clients can present directly at a provider agency of their choosing (based on location or other preferences).
3. Referral to the SASH. The GSW will provide the client with the SASH number for screening and referral to treatment.

Provider agencies may also admit existing clients who identify as having CalWORKs without a formal GSW referral. This is called a "Reverse Referral." When this occurs, the provider agency need to initiate notice to DPSS via a CalWorks Treatment/Services Verification Form (PA 1923 Form), which states that the client is in treatment and requests that their case be expedited to GAIN. The PA 1923 Form need to be faxed or emailed via encrypted email to the Los Angeles County DPSS, Centralized Unit (DPSS-CU) for processing within ten (10) business days of completion of the PA 1923 Form.

CalWORKs: Intake

Once the provider agency receives the referral either directly from the GSW or the CENS, they are to:

- Schedule the assessment appointment within three (3) business days of receiving either the GN 6006A or GN 6006B, CalWORKs Specialized Supportive Services Provider Referral (see Appendix K), forms;
- Conduct the full ASAM CONTINUUM™ Assessment or Assessment Tool - Youth (Paper Version) found on the SAPC website;
- Complete page two (2), section B, of the GN 6006B; **and**
- Submit the GN 6006B to the GSW within five (5) business days of assessment to report the date services began (or failure to appear for services), expected duration of hours per week, and, if less than 32-35 hours per week, whether the number of hours is considered full-time by the service provider.

If the agency receives GN 6006A from CENS, it should be filed in the client's records, as CENS has already sent a copy to the DPSS GSW.

Note: Clients should be admitted to treatment based on the appropriate LOC and their preferences. If a transfer to another agency is necessary, a copy of the GN 6006B must be sent via fax or encrypted email to the GSW to notify them of the new treatment location. A copy must also be sent to the new treatment provider agency.

CalWORKs: Treatment Requirements and Care Coordination

Treatment services are administered based on medical necessity. Services may be a combination of various treatment service modalities as outlined in the *Early Intervention and Treatment Service Components* section.

The Treatment Progress Report (Form ABP 132) is generated by LRS and mailed directly to the receiving provider agency every 60 days for completion. It is then returned to DPSS, which monitors the individual's participation. LRS resets this date to generate a new Treatment Provider Progress Report form.

Provider agencies are required to notify DPSS of all changes in clients' status within five (5) days of the actual change, including transfers to other sites or treatment modalities, dropouts, and completions.

Provider agencies need to notify DPSS of any changes in clients' treatment hours within three (3) days using the Report of Changes form. These updates should align with modifications in the client's Problem List (for non-OTP settings) or Treatment Plan (for OTP settings). Treatment Extensions are requested when it is determined that a client requires continued treatment beyond the initial six (6) months due to medical necessity.

If an extension is required, the provider agency will submit a reauthorization request to SAPC-UM for evaluation and approval or denial. Once the request is evaluated, the provider agency needs to forward the form to DPSS for final approval or denial, which will then update the LRS. DPSS is responsible for notifying the provider agency of the extension status and providing a copy of this status.

Additionally, provider agencies need to inform the CENS Area Office and their dedicated GR CENS of any changes in GR client status. The CENS is responsible for updating client information in LRS through the CalSAWS website, using the login instructions provided by DPSS.

CalWORKs: Status Reports

Contracted SUD treatment agencies are required to communicate the status of the client's progress and treatment/services to DPSS using the appropriate forms noted below:

- Complete GN 6008, Service Provider Progress Report (see Appendix K), every 90 days, or as required, to indicate whether the client is complying with program requirements and maintaining satisfactory progress, has successfully completed treatment, or has dropped out of treatment.
- After treatment for 90 days, complete the CW 61, Authorization to Release Medical Information form. This form is used to evaluate a client's ability to participate in a work/training program. The clinician completing the form will determine the length of time the person should be exempt from work requirements. At the end of that timeframe, the GSW will contact the client to determine if they are able to participate in a work-related activity.
- Complete GN 6007B, Enrollment Termination Notice, within three (3) business days of termination to report if the client has successfully completed treatment services or treatment services were terminated and the reason for termination.
- Complete GN 6007A, Notification of Change from Specialized Supportive Services Provider, within five (5) business days of a service change and include changes in LOC, start date, treatment hours, and other service information.
- Provider agencies need to retain copies of all documentation and communications with DPSS, in the client's chart, including: completed DPSS forms, confirmation of faxing, and any letters/correspondence to and from DPSS regarding the client. This includes any written notice of eligibility/acceptance by the Centralized PA 1923 unit for reverse referrals. Provider agencies need to obtain and keep on file a Provider Notification Letter for clients entering treatment through the reverse referral process.

CalWORKs: Asian Pacific Islander Targeted Outreach Program

The purpose of targeted outreach to the Asian Pacific Islander (API) population is to provide SUD information and education for CalWORKs clients who may have an SUD and/or co-occurring mental health issues in the API communities. The outreach seeks to identify individuals with SUD needs and connect them with culturally and linguistically appropriate staff and treatment services. The program serves CalWORKs clients in API communities in LA County, including those who are experiencing homelessness.

The program also provides intensive, family-centered pre-treatment outreach, education, and supportive services to affected API families in LA County. This is both to encourage clients with SUDs and family members to enter treatment and to ensure that a supportive family network is in place to support those individuals who choose to enter treatment.

The duties of the API Outreach Worker include, but are not limited to:

- Assist clients in self-exploration of the consequences of SUDs.
- Educate on how self-help (i.e., Alcoholics Anonymous, Al-Anon, and Narcotics Anonymous) complements SUD treatment and the unique role of each in the recovery process.
- Connect clients with culturally and linguistically appropriate treatment agencies.

CalWORKs: Adult At-Risk Program

The CalWORKs AAR Program is designed to provide individuals receiving DPSS CalWORKs benefits an opportunity to learn about and be aware of SUD through interactive educational sessions. This initiative provides educational courses about the effects of substances and their impact on an individual's life. These courses are designed for individuals whose screening results indicate they might be at risk of developing an SUD based on reports of experimental or early-phase substance use. The sessions are designed to teach ways to prevent adults from developing SUDs and maintain a healthy and SUD-free lifestyle.

AAR: Target Population

The target population is any DPSS CalWORKs client whom DPSS's GSW has referred to the CENS due to suspected substance use and:

- Has been screened by the CENS for ASAM 0.5 Early Intervention, or does not meet medical necessity for SUD treatment, and would benefit from Early Intervention services.
- Has engaged in or is engaging in SUD high-risk behaviors.

AAR: Referral Process

DPSS refers the CalWORKs recipient deemed at-risk for SUD to the CENS Area Office for screening. The designated CalWORKs CENS counselor screens using the ASAM CO-Triage® Tool for Adults (age 21 and over). If the screening result indicates 0.5 Early Intervention LOC, CENS offers a referral to the AAR Program, which is voluntary. The dedicated CalWORKs CENS Counselor provides a referral and arranges an appointment for enrollment and services with the CENS At-Risk Counselor. The client enrolls and completes the program, or may refuse to enroll. If the client consents, the CalWORKs At-Risk CENS Counselor informs the DPSS worker via email.

CalWORKs LACOE GAIN Focus 360

A partnership between DPSS and Los Angeles County Office of Education (LACOE), GAIN Focus 360 (formerly known as Job Club) is an educational program for DPSS CalWORKs GAIN clients. Services include job readiness and career planning as well as assisting clients in overcoming employment barriers, such as SUD and mental health, through goal setting, building self-esteem, SUD education, and providing job search and placement activities that enable clients to obtain gainful employment.

CENS Area Office – CalWORKs Dedicated CENS Responsibilities

The Contracted CENS Area Office has a dedicated CENS Counselor who will schedule and conduct presentations on the topic of SUD 101 using the specified PowerPoint presentation created by SAPC. The schedule is submitted to the CENS Area Office on a quarterly basis. Upon receipt:

- CENS staff/managers will schedule a time for their presentation and return the schedule to their SAPC liaison within five (5) business days.
- SAPC liaison will forward the schedule back to LACOE and DPSS.
- CENS Counselor will conduct presentations at the scheduled time they selected and document the number of CalWORKs recipients who participated.

DCFS Programs

Substance Use Disorder Trauma-Informed Parent Support (SUD-TIPS)

The SUD-TIPS program provides access to SUD screening and referrals to treatment for parents/guardians with open DCFS referrals and cases. Designated CENS Counselors work with the DCFS Regional Office aligned to their SPA to receive SUD-TIPS referrals from the DCFS social worker via email or by the DCFS-involved parent walking into the CENS Area Office.

The designated SUD-TIPS CENS counselors apply MI techniques to provide:

- Outreach to, and engagement with, the target population
- On-site or virtual evidence-based SUD screenings for parents with substance use challenges using the ASAM CO-Triage® Tool for Adults (age 21 and over)
- Medi-Cal eligibility assessment and enrollment
- Referral to SUD treatment services
- Client education
- Referrals to early intervention SUD or mental health services, as appropriate
- Linkages and warm hand-off to the appropriate community SUD treatment resources

SUD-TIPS: Referral Process

Any DCFS staff member may refer a parent/guardian with an open DCFS case to the SUD-TIPS program. Steps in the referral process are as follows:

- DCFS staff members complete sections A and B of the SUD-TIPS Referral Form and send via encrypted email to their aligned CENS Area Office.
- Upon receipt, CENS staff will contact the DCFS Children's Social Worker (CSW) for any missing information or questions regarding contacting the parent.
- The CENS staff will contact the parent to schedule the screening appointment within 48 hours of receipt of the referral.
- If the parent does not show up to the screening appointment, the CENS staff will attempt to contact the parent to reschedule an appointment for a total of three (3) attempts. After two (2) attempts, the CENS staff will update the DCFS Staff by email or phone.

- If the parent refuses to be screened, does not show up for a scheduled screening appointment, or is not reached for an appointment after a third attempt, the CENS staff will note the Screening as either "not completed," "no show," "refusal or unable to reach" by completing Section D of the SUD-TIPS Referral Form. CENS will then forward the Referral Form via encrypted email to the referring DCFS staff.
- If the parent completes the screening, CENS staff will refer screened clients to the appropriate SAPC DMC contracted treatment providers based on the client's proximity, type, and level of service(s) needed.
- CENS staff will request the client's consent to release information to share their care planning and progress information with DCFS, the treatment provider agency, and the CENS provider agency. Such releases need to adhere to all confidentiality laws, including 42 CFR Part 2 and HIPAA.
- By the 10th of each month, CENS staff will submit copies of the prior month's referral forms by sending an encrypted email to SAPC-SOC at SAPC_FamilyServices@ph.lacounty.gov.

Recovery Support Court

RSC: Referral Process

Parents who are 18 years or older and have active cases with both DCFS and the Juvenile Dependency Court may qualify for treatment services through the RSC program (formerly known as Family Dependency Drug Court [FDDC]). While the program is designed to support family reunification, participation is voluntary. Parents who enroll receive court supervision throughout the course of their treatment.

Candidates for the RSC program are identified by the nearest DCFS office, dependency attorneys for parents and children, County Counsel, or judicial officers. Referrals to the program need to be initiated by the assigned DCFS CSW; treatment providers do not initiate referrals. Once eligibility is confirmed by DCFS, the following steps are taken:

- DCFS CSW or Program Manager contacts the contracted SUD treatment agency nearest to the parent to complete the initial screening/assessment and schedule an intake appointment.
- DCFS CSW completes section A of the RSC Referral Form (see Appendix L) and sends via encrypted email to the contracted SUD treatment provider.
- The SUD treatment agency will schedule an ASAM assessment appointment within three (3) business days of receipt of the RSC Referral Form.
- The treatment agency will make best efforts to complete the ASAM CONTINUUM™ Assessment within five (5) business days of appointment.
- With the client's signed consent, notify the DCFS CSW by completing sections B and C of the RSC Referral Form. Ensuring the client has completed section D, and returning it via encrypted email to the DCFS CSW within five (5) business days of the intake appointment.
- The treatment agency will notify the DCFS CSW of any appointments a parent misses within 48 hours of the missed appointment date.
- The treatment agency will follow up with DCFS clients who fail to keep their initial assessment appointment and reschedule a missed appointment once.

RSC: Treatment Requirements

Treatment services are provided based on medical necessity and may include a combination of various modalities as specified in the *Early Intervention and Treatment Service Components* section.

Provider agencies are advised that family counseling sessions should be an integral part of the care planning and services for these clients.

RSC: Client Progress Reports

Contracted RSC provider agencies serving RSC clients are required to:

- Submit an initial report to the DCFS CSW within five (5) business days of the treatment admission.
- Submit a client progress report to the DCFS CSW within five (5) business days prior to the client's scheduled Court appearance.
- Submit a client progress report to the DCFS CSW immediately upon discharge (expected or unplanned).
- Submit progress reports for each court hearing that reflect client progress since the last court hearing, pertaining only to SUD treatment services.

Note: Recommendations and/or comments on visitation rights are not permitted.

RSC: Treatment Completion/Reunification

- Contracted provider agencies need to work closely with the DCFS CSW on family reunifications. Discharge planning should begin shortly after the client enters treatment and should focus on aftercare preparation.
- Within five (5) working days of program completion, the provider agency needs to enter the information on a client progress report to confirm completion and notify DCFS and/or the court of client discharge. The client will deliver a copy of the completion report to the CSW and the court in a sealed envelope.
- When clients are terminated from treatment due to non-compliance, the provider agency needs to forward a termination report to the CSW and the court within five (5) business days of program termination.
- Graduations are conducted to acknowledge the completion of the RSC program and may take place at a later date designated by the provider agency and/or court. Graduation marks the end of the SUD treatment episode.

Co-Occurring Disorder Population

In this document, CODs are defined as when an individual has a combination of any SUD or any mental health condition, though individuals with COD can have physical health conditions as well. The significant co-morbidity of SUDs and mental illness (typically reported as 40-80%, depending on study characteristics and population) and the growing body of research associating poorer outcomes with a lack of targeted treatment efforts have highlighted the importance of addressing the unique needs of this population.

Integrated treatment coordinates substance use and mental health interventions to treat the whole person more effectively. As such, integrated care broadly refers to ensuring that COD treatment interventions are combined within a primary treatment relationship or service setting.

According to SAMHSA's Treatment Improvement Protocol (TIP) series titled "TIP 42: Substance Use Treatment for Persons With Co-Occurring Disorders" consensus panel members recommend the following guiding principles in the treatment of clients with CODs:

- **Employ a recovery approach:** The recovery perspective essentially acknowledges that recovery is a long-term process of internal change that requires continuity of care over time and recognizes that these internal changes proceed through various stages and that treatment approaches need to be specific to the goals and challenges of each stage of the COD recovery process.
- **Adopt a multi-problem viewpoint:** Treatment comprehensively addresses the immediate and long-term needs of the multidimensional problems typically presented by clients with COD (e.g., housing, work, health care, a supportive network).
- **Develop a phased approach to treatment:** Treatment phases generally include engagement, stabilization, treatment, and continuing care, which are consistent with and parallel to the various stages of recovery. Treatment through these phases allows providers to develop and use effective, stage-appropriate treatment interventions.
- **Address specific real-life problems early in treatment:** Given that CODs often arise in the context of social and personal problems, addressing such problems is often an important first step toward achieving client engagement in continuing treatment.
- **Plan for the client's cognitive and functional impairments:** Clients with a COD often display cognitive and functional impairments that affect their ability to comprehend information or complete tasks. As a result, services need to be tailored to and compatible with the needs and functional level of COD clients.
- **Use support systems to maintain and extend treatment effectiveness:** Given that many clients with COD have strained support systems and the central importance of supportive people and environments in the recovery process, ensuring that clients are aware of available support systems and motivated to use them effectively is a vital element of effective treatment of the COD population.

Optimal Treatment of COD Population

Research generally supports addressing through integrated care, rather than treating SUDs and mental health conditions separately. When staff are trained and skilled in managing CODs, integrated care should be provided in-house. If a provider cannot offer the necessary services, clients with CODs should be referred to appropriate external providers who can deliver the required care.

Developing a therapeutic alliance with clients who have CODs relies heavily on the counselor or clinician's comfort level in working with this population. Some SUD counselors or mental health clinicians might find clients with significant mental health conditions or SUDs intimidating. It's crucial for professionals to recognize these feelings and employ strategies to prevent them from impacting client care. Often, these challenges can be addressed through further experience, training, supervision, and consultation.

While SUD counselors are not expected to diagnose mental health disorders, they should be familiar with relevant terminology and criteria to identify potential mental health concerns that may require referral. Training that enhances understanding of mental disorders and guidance on accessing appropriate medical or mental health support are essential.

Importantly, agencies should not be screening out clients with COD based on a mental health diagnosis or prior psychiatric hospitalization history. Simply because a client has a prior diagnosis of schizophrenia or bipolar disorder does not mean that he/she is inappropriate for the SUD system, as people can be stable and have a mental health diagnosis or may have also been incorrectly diagnosed previously as a result of symptoms resulting from their SUD. Similarly, a prior psychiatric hospitalization history indicates prior acute psychiatric needs but does not necessarily mean that someone has acute psychiatric needs presently. The key determination for appropriateness of admission to SUD treatment for COD populations should be if an individual is psychiatrically stable enough to benefit from SUD treatment in his/her present state, and not be based on a prior history of specific diagnoses or prior psychiatric hospitalization history.

Appropriate staffing is another key element in effectively addressing the needs of the COD population. An organizational commitment to professional development, skills acquisition, values clarification, and competency attainment is necessary to successfully implement integrated care programs and maintain a motivated and effective staff. Ideally, enhanced staffing for clients with a COD at SUD treatment sites would include mental health professionals, and vice versa at mental health treatment sites. Alternatively, establishing appropriate referral relationships, referral processes, and protocols can also help to ensure comprehensive and necessary care for individuals with a COD.

Psychosocial interventions that have been demonstrated to be effective for the COD population include motivational enhancement, CM, relapse prevention, and cognitive–behavioral techniques. These strategies need to be tailored to the client’s unique stage of recovery and can be helpful even for clients whose mental disorder is severe. For clients with functional and cognitive deficits in areas such as understanding instructions, repetition, and skill-building strategies can aid progress. Additionally, 12-Step and other dual recovery mutual self-help groups may be valuable as a means of supporting individuals with COD, and counselors and clinicians often play an important role in facilitating participation in such groups.

The use of appropriate psychotropic medications and addiction medications is an essential component of the treatment of individuals with CODs. Oftentimes, the appropriate use of medications can help clients with a COD stabilize and control their symptoms so that they can better focus on their recovery for either their SUD or mental health condition. Research has clearly demonstrated that medications used in conjunction with psychosocial interventions for both SUDs and mental illness are preferable and lead to better outcomes than either intervention alone. An important component of the treatment of clients with CODs is thus ensuring a recovery environment that is supportive of the various and individualized paths to recovery that many clients with CODs take. This includes ensuring that staff are prepared to facilitate the client’s treatment with medications for SUDs and mental health conditions when necessary and appropriate by counselors and clinicians practicing within their scope of practice.

In summary, treating clients with COD requires a comprehensive and flexible approach and coordination with other systems of care.

Justice-Involved Population

SUD often directly or indirectly results in interaction with law enforcement and the criminal justice system. As a result, most people in carceral settings have an active SUD, and overdose is a leading cause of death in the two (2) weeks after an individual is released from incarceration. SUD treatment can help break this cycle by supporting alternatives to incarceration, a safer pathway to community reentry, and ultimately by treating the SUD and its root causes.

Optimal Treatment of the Justice-Involved Population

Effective clinical strategies for working with justice-involved clients should include interventions that address criminal thinking and develop basic problem-solving skills. Providers need to utilize EBPs tailored to managing SUDs, mental health issues, and criminogenic needs. For example, approaches like MI and CBT target both substance use and antisocial behaviors that contribute to criminal recidivism. Additionally, trauma-informed care and CM therapies play a crucial role.

As with other populations, the treatment of justice-involved clients should be viewed as a dynamic, longitudinal process aligned with the chronic disease model of addiction. Consequently, effective treatment should persist even after the legal issues of justice-involved clients are resolved.

Adult Justice-Involved Population

While justice-involved clients may have similar clinical needs to other clients in SUD treatment, they often require that treatment providers communicate with justice partners, such as court and probation professionals, to support the client's legal obligations and keep them in the community and recovery.

- Court-Based Diversion Programs,
- Jail-Release/Community-Reentry Programs, **and**
- Community-Supervision Programs through probation or parole.

Justice System Entryway Programs

Court-Based Diversion Programs

Courts have an important opportunity to recognize alleged criminal activity due to underlying problems, such as SUD, and offer treatment as an alternative to incarceration or further legal action. Court-based diversion is often the earliest opportunity to refer justice-impacted clients to treatment and can prevent the consequences of being charged or extended jail time. Court-based diversion is often conditional on the client being enrolled and engaged in treatment, and judges expect regular updates to assure them that the client is continuing to receive care. For this reason, timely communication with court partners is critical to support clients in continuing treatment and avoiding legal consequences. Expected communication includes:

- Being responsive to requests for progress reports, **and**
- Notifying court partners if the client leaves AMA or is at risk of administrative discharge.

Jail-Release/Community-Reentry Programs

People re-entering the community after incarceration have significant physical and behavioral health needs and are at high risk of injury and death, especially immediately after release. Compared to the general population, people who have been released from jail within the past two (2) weeks are 12 times more likely to die, and the risk of overdose is 129 times that of the general population.[18]

California has developed local and statewide initiatives for justice-involved individuals with behavioral health issues to support their transition from custody to the community and promote health outcomes. These steps include mandating Medi-Cal application process while in custody and, under AB 133 in 2021, to implement a process requiring CFs to facilitate referrals to counties' DMC, DMC-ODC, SMHS, and/or Medi-Cal MCPs for incarcerated members who received behavioral health services and want to treatment upon release to the community.

As of October 1, 2024, under the CalAIM Justice-Involved Initiative, DHCS required SAPC and all California county behavioral health agencies to launch a behavioral health link process to accommodate the post-release requests from CFs. These post-release linkages include referrals and appointments to SUD and/or mental health services to ensure continuity of behavioral health or other health services received while in custody.

For additional information on SAPC's CalAIM post-release linkage process, see SAPC IN 25-05.

Community-Supervision Programs – Probation & Parole

Most justice-involved individuals are on probation or parole, roughly twice (2x) as many as those who are incarcerated. This "community-supervision" allows people to remain in the community, maintaining their relationships and employment instead of incarceration. However, people under community supervision need to satisfy any number of conditions, including SUD treatment, to maintain good standing and avoid legal consequences and possible incarceration. **For this reason, timely communication with LAC-Probation partners is critical to support clients remaining in the community and avoid legal consequences.** Expected communication includes:

- Being responsive to requests for progress reports,
- Notifying LAC-Probation partners if the client leaves against medical or is at risk of administrative discharge, **and**
- Discharge date and final report.

The community supervision model in California today is the result of several pieces of legislation enacted over the past two decades. In 2000, Proposition 36 (now known as California PEN § 1210) mandated that certain non-violent drug offenders be sentenced to probation and receive SUD treatment rather than be incarcerated. In 2011, AB 109 redirected certain Non-violent, Non-serious, and Non-sexual (N3) offenses away from state prisons and towards county jails or community supervision. In 2014, Proposition 47 further reclassified certain non-violent offenses from felonies to misdemeanors. In 2016, Proposition 57 created new parole considerations for non-violent offenses. In 2024, Proposition 36 (not to be confused with the 2000 proposition)

[18] California Health Care Foundation. (2023). CalAIM Explained: Caring for Californians Leaving Incarceration. https://www.chcf.org/publication/calaim-explained-caring-californians-leaving-incarceration/.

repealed some of Proposition 47's reduced sentencing measures and classified certain drug offenses as "treatment-mandated felonies." Taken all together, many offenders who would previously be incarcerated now serve their sentence in the community and often in partnership with SUD treatment providers. **Importantly, Proposition 36/PEN 1210, Proposition 47, and Proposition 57 clients can have SUD treatment services supported by AB 109 funds**. SUD treatment providers should identify "AB 109" as a secondary guarantor in Sage to cover expenses not covered by Medi-Cal. Notably, funding for **Proposition 36 (2000) clients** has not yet been identified.

Communication with Justice Partners

Justice-involved clients – whether referred from LA Superior Courts, LAC-Probation, or other justice partners – rely on treatment providers communicating with justice partners when necessary to stay in good standing and remain in treatment. While the specifics of what needs to be communicated and when it needs to be shared can vary, overall, there are general expectations that treatment providers should keep in mind.

- **Initial Confirmation of Treatment:** Some partners may request simple confirmation that the client was successfully admitted and is currently in treatment.
- **Progress Reports:** For clients who are receiving treatment as part of a court-diversion or community-supervision-based program, regular progress reports inform justice partners that the client is engaged in treatment as expected. Partners who require this information will typically reach out around every 30 days. However, this may vary depending on scheduled court dates, etc.
- **Discharge/Exiting Treatment:** For clients who are receiving treatment as part of a court-diversion or community-supervision based program, justice partners should be notified when the client exits treatment, whether it be a self-discharge, administrative discharge, or planned discharge. This allows justice partners to help plan and work to bring the client into compliance with their program and, ideally, avoid unnecessary legal consequences.

Treatment Requirements and Care Coordination

A qualified counselor or clinician should determine the appropriate LOC and interventions, and these are not to be determined by justice partners. Provider agencies need to be individualized and based on medical necessity. For clients who are incarcerated, SUD screening should be based on the client's substance use status 30 days prior to incarceration. Contracted provider agencies delivering services to justice-involved clients will be expected to inform the court of the client's treatment progress (with informed consent), including other care coordination activities as outlined in the *Overview of Care Coordination and Services* and *Justice-Involved* sections.

Specialty Programs

Substance Treatment and Re-Entry Transition – Community

LASD utilizes Alternatives to Custody (ATC) to allow inmates to serve the remainder of their jail sentence in the community at a residential facility. All individuals need to receive clearance from the LASD Community-Based ATC Division for electronic monitoring in a therapeutic SUD residential treatment community in lieu of incarceration. ATC provides individuals with a foundation to promote successful reentry post-incarceration, and under DMC-ODS, individuals will have access to additional services to assist with successful reintegration.

Clients participating in the Substance Treatment and Re-Entry Transition – Community (START-Community) program will remain under the supervision of LASD using a Global Positioning Satellite (GPS) ankle monitor worn for the duration of their 90-day residential treatment episode. Although clients need to initially meet medical necessity to participate in the program, they may remain in residential treatment for days 61-90 even if medical necessity is not met to prevent their return to custody.

Treatment providers are expected to collaborate with the justice system to transition clients to more appropriate LOCs (e.g., residential to OP with RBH) when an agreement can be met without jail time. Upon completion of their sentence, other treatment modalities are available to the client on a voluntary basis if the client meets medical necessity.

Target Population

Eligibility for the START-Community program is limited to those N3 individuals referred through LASD who meet the following general criteria:

- History of drug and/or alcohol usage and/or drug-related charges for eligibility
- N3 classification
- No past violent, sexual, or arson charges
- Age 18 or older
- No medical or psychiatric conditions that require medications prior to release
- Have a maximum of 90 days left on their sentence and no pending court dates. Individuals who have more than 90 days may be considered for admission on a case-by-case basis, as determined by SAPC

Screening and Referral Process

Eligible inmates are identified and assessed by LASD using the Correctional Client Management Profiling for Alternative Sanctions. Then, the overall criminal history and other determinants are reviewed to make an appropriate recommendation for placement in the START-Community program. LASD will provide a referral list of potential inmates to the designated CENS staff. CENS staff will coordinate with LASD to conduct the SUD screening and make the appropriate referral to a community-based residential treatment facility.

Treatment Requirements and Care Coordination

Treatment services are administered based on medical necessity. SUD treatment services for clients referred by LASD may consist of a combination of various treatment service modalities, as outlined in the *Service Benefit and LOC* section. Care Coordinators may perform additional Care Coordination activities for justice-involved clients as outlined in the *Overview of Care Coordination and Services* and *Justice-Involved* sections.

Electronic Monitoring Requirements

LASD requires clients participating in the program to wear GPS equipment at all times. Failure to adhere to this requirement will result in an immediate return to custody. LASD contracts with a dedicated service provider for 24/7 technical support for GPS equipment. Should provider agencies encounter any concerns with GPS equipment, they need to contact the assigned Representative to report these concerns. The most common concerns reported include, but are not limited to: battery life diminishing, client wandering out of bounds, **and/or** notify clients when they are being transported to off-site appointments.

Compliance Check Procedures

LASD will conduct periodic compliance checks for all clients receiving SUD treatment services and who are under electronic monitoring. Compliance checks and investigations are conducted randomly and may occur in person or via telephone. They require a status report on the client's progress in treatment and/or verification of physical presence at the treatment program.

For contracted provider agencies serving START-Community clients to remain in compliance with LASD supervision requirements, agency staff need to supervise clients at all times. Any scheduled recreation activities or off-site appointments need to be cleared with LASD one (1) week in advance by contacting **(213) 893-5345** (during business hours) for approval on a case-by-case basis. LASD will arrange GPS clearance for **approved** off-site activities. Clients are to be escorted by staff at all times while off-site.

START-Community clients need to remain in-custody while participating in residential treatment. Therefore, should a client abscond from the residential treatment facility, contracted provider agencies need to:

- Immediately contact LASD at (213) 453-4528 (24-hour line) and LASD Community-Based Alternative to Custody at (213) 893-5345 (during business hours) to report that the client has absconded.
- Allow LASD designated personnel limited access into the relevant treatment facility and/or room to verify client location and/or locate the GPS monitoring device, and to gather relevant information from the Supervisor and/or designated staff on duty for the LASD investigative report on the client

Early Termination

Termination of any justice-involved referred client can occur if the client violates any facility rules, engages in violent behavior, utilizes alcohol and/or drugs, or makes threats to another client. Contracted provider agencies need to notify LASD and SAPC within 24 hours and document the termination reason in the appropriate data tracking system (e.g., CalOMS/LACPRS).

In addition, provider agencies need to complete the *Program Incident Form (see Appendix G)* describing the incident being reported and maintain a copy of the form in the client's file. Completed forms should be submitted within 24 hours to SAPC-SOC at SAPC_ASOC@ph.lacounty.gov.

Termination can occur for the following reasons:

- Absconding or willful violations of program requirements,
- Client poses a safety risk for self or others, **or**
- Client opts out of the project.

Note: Termination of START-Community will require the client to be returned to jail to complete the remainder of their sentence.

In-Custody to Community Referral Program

In-Custody to Community Referral Program (ICRP) is an SUD collaborative designed to provide a warm handoff for individuals transitioning from incarceration to SUD services in the community upon release from custody. The ICRP is a partnership among SAPC, its contracted provider agencies, and the Los Angeles County Department of Health Services, Correctional Health Services (DHS-CHS).

Rapid Diversion Program

Rapid Diversion Program (RDP) is a pre-plea diversion program targeting individuals with a mental health diagnosis or SUD. Individuals participate in programming, receive housing resources, and are case managed for a period of time recommended by the service provider and approved by the court. Cases are dismissed for individuals who successfully complete the program. RDP is run through the Los Angeles County Justice Care and Opportunities Department (JCOD), and case managers are contracted through Project 180 and Exodus.

Los Angeles Law Enforcement Assisted Diversion

Los Angeles Law Enforcement Assisted Diversion (LEAD) is a pre-arrest community-based diversion model that diverts individuals with repeated low-level drug-related offenses at the earliest contact with law enforcement to harm reduction-based Care Coordination and social services as an alternative to jail and prosecution. LEAD is run through the Los Angeles County Department of Health Services, Office of Diversion and Reentry (DHS-ODR), with case management contracted through Alma Family Services and the LA Community Health Project.

Reentry Intensive Case Management Services

Reentry Intensive Case Management Services (RICMS) improves the health and well-being of justice-involved individuals by providing care management and service navigation. Community Health Workers with lived experience of justice system involvement support individuals by identifying their needs and making connections to relevant organizations and services, including social services, physical and mental health, housing support, employment and education, cognitive behavioral interventions, arts and entrepreneurship programming, and SUD treatment.

Community Reentry and Resource Center

The CRRC is a hub station that operates as a one-stop shop for male inmates transitioning back to the community. CENS provides on-site SUD screening to clients being released from the county jail or for LAC-Probation to refer AB 109 clients with a potential need for SUD treatment.

Developing Opportunities Offering Reentry Solution (D.O.O.R.S)

The Developing Opportunities Offering Reentry Solutions (D.O.O.R.S) center is an initiative of LAC-Probation's Adult Services Division and DHS-ODR, which operates countywide under JCOD. The D.O.O.R.S center offers an array of comprehensive supportive services to address the barriers to reentry for justice-involved individuals, particularly those on adult felony supervision, their families, and the community. County department staff (DMH, DPSS, LAC-Probation) and community agencies are co-located in the center,

providing and or arranging linkage(s) to a range of rehabilitative services that assist with SUD, mental health care, employment, education, housing, legal issues, family reunification, and other social support.

Co-Occurring Integrated Care Network

The Co-Occurring Integrated Care Network (COIN) program addresses the needs of adult AB 109 clients who have co-occurring chronic SUD and severe and persistent mental illness. COIN provides integrated SUD and mental health treatment. Treatment is for clients who are at high risk for relapse and are referred through the AB 109 Revocation Court.

Division of Adult Parole Operations

The California Department of Correction and Rehabilitation, Division of Adult Parole Operations (DAPO) supervises the adult parole population. DAPO's headquarters provides statewide oversight, while the Regional Administrators are responsible for the day-to-day operations related to the supervision of adult parolees. The field parole units supervise the adult offenders subject to state-supervised parole, as well as those currently serving their sentences in an alternative custody program and adult offenders released on medical parole.

The parole population can access the County's DMC-ODS SUD treatment system of care through the CENS, SASH, or direct-to-provider. In addition, Contracted provider agencies are encouraged to participate in Parole and Community Team (PACT) resource fairs for parolees. Resource fairs offer the parole population information for various community resources (e.g., housing, legal counsel, etc.). At these PACT Meetings, provider agencies can educate and inform the parole population about their respective SUD treatment services and the services offered under the County's DMC-ODS SUD treatment system of care.

Juvenile Justice-Involved Population

The County's juvenile justice system governs the legal (i.e., LA Superior Courts) oversight and LAC-Probation detention (i.e., juvenile halls/camps) of youth and young adults pre- and post-adjudication. The system's objectives – in addition to maintaining public safety – are skill development, habilitation, rehabilitation, addressing treatment needs, and successful reintegration of youth and young adults into the community. The County is currently expanding diversion efforts to deter in-custody placements; however, clients dispositioned to the County's juvenile justice system may be placed in-custody for short periods of time and should be prepared for rapid reentry transition. Additionally, youth and young adults serving sentences in State juvenile justice facilities have been transferred to the County's Secure Youth Treatment Facilities (SYTF), which will result in longer periods of custody at County facilities.

Given the nature of in-custody settings, delivery of services need to consider security protocols and limited access to youth throughout the day-to-day settings. SAPC and its providers will work with LAC-Probation to understand security protocols and advocate for appropriate youth SUD services.

Juvenile Justice Crime Prevention Act

The JJCPA funds collaborative projects between SAPC and LAC-Probation. The goals of this collaboration are to:

- Provide youth with skills to resist continued substance use and the associated negative behaviors.
- Demonstrate reductions in subsequent arrests, incarceration, and probation violations.
- Increase completion of probation, restitution, and community service requirements.

JJCPA Target Population

JJCPA services are for at-risk youth and probation-involved youth, either in-custody or under community LAC-Probation supervision.

Referral Process for In-Custody Juvenile Population

- In-custody, pre-adjudicated youth are typically referred when probation case workers have identified an individual in need of SUD screening, intervention, and treatment linkage in preparation for release from custody. However, any entity providing in-custody services to the youth may refer to CENS (i.e., DMH, DHS, LACOE, Courts) for the appropriate screening and services. JJCPA funds co-located CENS services at the Los Padrinos Juvenile Hall (LPJH).
- All referrals for JJCPA CENS services need to be submitted utilizing the *Juvenile Justice SUD Screening Referral Form for CENS (see Appendix I)*. For additional details on CENS services for this population, see CENS Standards and Practices.

Referral Process for Juvenile Population in the Community

- LAC-Probation's Prospective Authorization and Utilization Review Unit (PAUR) makes/approves all JJCPA referrals to youth providers, including those from school-based and other LAC-Probation Officers.
- Within five (5) business days of receiving a referral, the youth provider agency needs to notify PAUR of family contact via email and the CBO tracking system. Request an extension via email to PAUR if needed.
- After the first in-person (intake) session, return the referral form with the "Agency Response" section completed (including the start date) to PAUR. If an intake appointment is rescheduled, hold the referral until the intake is complete. If reasonable attempts to schedule an intake are made, including contacting the referring (DPO), and the family is unresponsive, please note in the JJCPA tracking system within one (1) working day of missed or rescheduled appointment.
- If the service is incomplete, return the referral form to PAUR with the Did Not Complete (DNC), date, and reason.
- Upon discharge and service completion, return the referral form to PAUR with the completion date to SAPC by the 10th of the month following the reporting month. All JJCPA admissions need to also be entered in CalOMS/LACPRS.

Staffing and Fingerprint Clearance

SAPC and LAC-Probation ensure ongoing compliance with background and security investigations applicable to each department's contracts and contract employees.

Secure Youth Treatment Facilities

SB 823, the Juvenile Justice Realignment Bill, resulted in the closure of the State of California Division of Juvenile Justice (DJJ), effective June 20, 2023, and the transfer of individuals aged 15-25 who were convicted of crimes as juveniles back to the County. The Board of Supervisors has identified three (3) site locations as SYTFs to house these high-risk detainees. SAPC has received SB 823 funding via a Direct Service Order with LAC-Probation to implement SUD services for this population.

SYTF Target Population

The target population includes Youth (age 17 and under) and Young Adults (age 18-20) referred for JJ-SUD and housed at one of three (3) sites identified as SYTF by the Board of Supervisors to house high-risk detainees diverted from DJJ to the County in response to SB 823. The three (3) current SYTF sites are:

1. Barry J. Nidorf Juvenile Hall,
2. Camp Vernon Kilpatrick, and
3. Dorothy Kirby Center.

Contracted provider agencies co-located at these SYTF sites offer Early Intervention/AAR and OP Services for suitable clients (see more information about these services below). SYTF Probation case workers and any entity providing in-custody services to the youth may refer (i.e., DMH, DHS, LACOE, Courts) potential clients for these SUD services by completing the *Juvenile Justice SUD Screening Referral Form for SYTFs (see Appendix J)*. In addition, post-adjudicated clients sentenced to SYTF sites from LPJH and screened by the co-located CENS at LPJH to be suitable for SUD services can also receive Early Intervention/AAR or OP services.

SYTF Provided Services

Early Intervention and Adult At-Risk Services

Services are available for clients whose screenings show no need for SUD treatment but who would benefit from intervention due to high-risk behaviors, including those leading to incarceration. These services, which use evidence-based and County-approved materials (e.g., "*Healthy Youth: An Early Intervention Service Model for Addressing Substance Use Risk and Promoting Wellness Among At Risk Youth*" for Youth [age 17 and under] and Young Adults [age 18-20], and AAR materials developed by SAPC-CST), can be delivered individually or in groups and focus on:

- Understanding SUD signs, risks, and associated consequences
- Minimizing harm related to SUD
- Preventing overdose, dependence, and relapse
- Promoting sobriety
- Delivering the curriculum within a timeframe appropriate for individual comprehension

SUD Treatment Services (ASAM 1.0)

OP treatment services are available to individuals who meet the medical necessity criteria for this LOC. Providers receive referrals from on-site LAC-Probation staff and may also get information from other providers when individuals are transitioning from other probation facilities. Barry J. Nidorf offers an SUD housing unit for a small group, but placement in this unit is not required to receive SUD treatment services.

If individuals are transitioning to another probation facility or would benefit from ongoing community-based care upon release, the provider will facilitate a warm handoff.

Reporting Requirements and Procedures

- **Reporting to LAC-Probation (Community)**: A CBO Note needs to be entered into LAC-Probation's web-based reporting system (www.probjjcpa.lacounty.gov/cbo/) for each JJCPA referral, regardless of admission status, and at least once every 30 days for youth admitted into treatment. For all admissions, the "Enter Service Data" screen in LAC-Probation's web-based reporting system need to be completed monthly and updated as necessary.
- **Reporting to LAC-Probation and other referring departments (In-Custody)**: Upon completion of the appropriate ROI, the screening results need to be communicated to the referring department (LAC-Probation, DMH, DHS, LACOE, Los Angeles County Department of Youth Development [DYD]) for reporting and documentation purposes, as well as to the court, as needed. For clients accessing ongoing intervention services, monthly progress reports need to be reported to the case worker and the referring department.
- **Reporting to SAPC**: Provider agencies need to electronically submit a Client Data Report that lists all new referrals, youth in treatment, and closed cases, by using the Sage Juvenile Justice reporting form.

People Experiencing Homelessness Population

Homelessness significantly affects many individuals with SUDs, often due to the socioeconomic decline associated with addiction. Estimates suggest that 20-35% of PEH have substance use issues. PEH generally require more intensive treatment and face greater and more diverse needs compared to those with stable housing. They encounter numerous barriers to accessing care, including, but not limited to, social isolation, distrust of authorities, and lack of transportation.

Stable housing is crucial for achieving treatment goals and is a key component of effective services. Early linkage to secure housing in treatment often leads to better outcomes, highlighting the importance of Care Coordination to address the diverse needs of PEH.

Psychosocial interventions and addiction medications for PEH should adapt successful strategies used with other populations to address their unique needs. Mobile outreach services and motivational enhancement interventions are particularly effective in encouraging ongoing treatment engagement, as PEH generally respond better to supportive rather than confrontational approaches.

Optimal Treatment of PEH Populations

Research indicates that effective programs for PEH should address both their substance use and practical needs, such as housing, employment, food, clothing, and finances. These programs should be flexible, non-demanding, and tailored to the specific needs of different subpopulations, such as by gender, age, or COD. They should also offer long-term, continuous interventions. Therefore, substance use treatment for PEH must integrate a holistic approach that considers the individual's overall needs and environment.

A comprehensive range of services is required to meet the safety, health, social, and material needs of PEH. Common services include food and clothing assistance, shelter/housing, identification papers, financial aid, legal support, medical and mental health care, dental care, job training, and employment services. These services can be provided directly within the SUD program or through connections with community resources. Proactive outreach in a non-judgmental and supportive manner, and addressing identified needs early in treatment, can enhance engagement with this population.

Counselors and clinicians need to address the physical and mental health needs of PEH, considering their high rates of co-morbidity. Medications should be used when clinically indicated, with prescribing practices that consider the environment in which medications will be used and stored (e.g., ensure that medications that require refrigeration are not prescribed when the client has no way to store such medications). Integrated interventions that concurrently address the multitude of medical, psychiatric, substance use, and psychosocial needs of PEH tend to produce improved outcomes compared to interventions that are provided sequentially or in parallel with other services.

Effective counselors and clinicians often have a particular interest and comfort level in working with this challenging and rewarding population. Staff should be skilled in managing the diverse needs of PEH and knowledgeable about community resources to make appropriate referrals and linkages. Ideally, care teams are interdisciplinary, including medical, mental health, substance use, and social service professionals, working collaboratively.

While treating PEH with SUDs is challenging, successful outcomes are achievable by focusing on access to suitable housing and providing comprehensive, client-centered services with skilled staff.

Services for PEH

PEH have greater and more varied needs than housed individuals and, therefore, typically require more intense treatment that addresses the needs of the whole person in the context of their environment. A full continuum of comprehensive services is necessary to treat the whole client and fully address their needs.

PEH: Target Population

All single adults, youth, and families who meet the homeless or chronic homeless definition set by the HUD, LA County agencies, and other local housing organizations.

PEH: Determination of Appropriate LOC and Linkage to Treatment

- Client is enrolled in treatment:
  - If the client is enrolled in treatment, the provider agency needs to complete the steps noted in PEH under Care Coordination Considerations for People in Vulnerable Groups.
- Client is not enrolled in treatment:
  - If the client is not enrolled in treatment services, the provider staff needs to conduct the ASAM CO-Triage® Tool for Adults (age 21 and over) or the Youth and Young Adult Screener to determine the appropriate LOC needed.
  - If the client requires residential treatment, the provider agency needs to place the client in residential treatment the same day, if available.
  - If the provider agency does not have an available residential treatment bed or does not offer residential treatment, the provider agency needs to contact the residential provider with available beds to schedule an appointment on behalf of the client on the same day.
  - If the LOC for the client is OP, IOP, OP-WM, or OTP services, then the provider agency needs to connect the client to RBH as follows:
    - Contact an RBH provider agency with available beds for the client's placement on the same day.
    - If there are no available RBH beds, the provider agency needs to contact shelters and other interim housing providers with available beds and arrange for the client's housing placement on the same day.

PEH: Assessment

Trained SUD care coordinators with access to the HMIS will:

- Obtain the client's consent to share information in the HMIS to coordinate housing resources. Administer the CES Survey Packet, including the Los Angeles–Housing Assessment Tool (LA-HAT) for homeless adults, families, and the Next Step Tool for Youth (age 17 and under) and Young Adults (age 18-20);
- Enter or update the homeless clients' information into HMIS; **and**
- Coordinate with the CES agency for the clients' housing within 14 calendar days of the first treatment service or intake appointment; see CES Access Point Directory.

Treatment providers who have not been trained on the CES adult and youth tools and have not received access to HMIS:

- Will need to refer PEH directly to the CES agency within the same SPA within 14 calendar days of the first service or intake appointment.
- To get access to HMIS, email SAPC-SOC at SAPC_ASOC@ph.lacounty.gov.

For PEH with their families, the SUD care coordinator will call "211" or refer them to any of the CES for Families agencies countywide to schedule a housing screening appointment. Depending on the availability of resources, adult and young adult clients, and PPW may be offered SAPC's RBH benefit if they prefer a temporary recovery-focused environment prior to securing more permanent housing.

PEH: Care Coordination

The SUD counselor or care coordinator will work with the CES Housing Navigator to ensure all required documents and forms are uploaded into HMIS and that the client is Match Ready (i.e., all necessary documentation is collected and entered into HMIS). They will also assist the client in completing the required application forms and ensure eligibility for permanent housing vacancies listed in the CES.

Housing Assessment and Intervention Options[19]

Within three (3) calendar days of admission for clients identifying as homeless, SUD counselors/care coordinators need to initiate the following:

1. **Develop a Housing Plan:** The client-focused housing plan documents all the steps both the client and the SUD counselor/care coordinator will take to support the client in moving toward stable housing. The housing plan serves as a road map of needed services, actions that need to be taken by both the SUD counselor/care coordinator and the client, and referrals that need to be made to address the client's housing barriers. The SUD counselor/care coordinator need to develop a housing plan for every client identified as homeless or unstably housed and work together to identify the housing barriers and challenges that prevent the client from achieving housing stability. Once the barriers and challenges are identified, the care coordinator and client will work to identify:
    a. Steps needed to mitigate those barriers to housing,
    b. The client's strengths and the steps to build on those strengths,
    c. The services and resources available and the paths to access them.

    While the long-term objective is to achieve and maintain stable, permanent housing, this may not always be possible within the timeframe the client receives SUD services. Therefore, the SUD counselor/care coordinator need to propose interim housing options, including emergency housing, so the client does not return to homelessness upon discharge.

    The housing plan should include both short-term and long-term goals and objectives with reasonable timeframes to achieve them. The goals can address housing, income through benefits and/or employment, money management and budgeting, and improving physical, mental, and/or SUD health.

    At a minimum, the SUD counselor/care coordinator need to collaborate with the client every 15 days to review any changes in status and regularly update the housing plan until the client transitions to stable housing. The housing plan, relevant notes, and updates should be entered in Progress Notes in Sage.

2. **Connect Client to the CES:** LA CES works to connect the highest need, most vulnerable persons in the community to available housing and supportive services equitably. All providers should ensure that care coordinators are familiar with CES and the CES Access Centers within each of the eight (8) SPAs.

[19] SAPC. (2024, January). Recovery-Oriented Housing Assessment and Intervention Workflow. http://publichealth.lacounty.gov/sapc/docs/providers/trainings/Recovery-Oriented-Housing-Assessment-Intervention-Workflow.pdf.

In LA County, HMIS is used in the coordinated entry process by homeless assistance providers to coordinate care, manage operations, and enhance service delivery. This secure online database allows organizations to gather and manage client-level and system-wide information on services for PEH and those at risk. SUD treatment providers will utilize HMIS to collect accurate client information, facilitating the best match to available services in the CES. The care coordinator need to check if the client has a profile in the HMIS system:

a. If there is no record of an existing profile, providers will initiate a client record in HMIS and complete the appropriate and most recent version of the CES Triage Tools.
b. If the PEH has a client profile in HMIS, a completed CES Triage Tool score in HMIS, and an additional CES Survey Packet does not need to be administered unless the care coordinator believes the result of the score does not accurately reflect their vulnerability, because:
    i. Their life circumstances have changed,
    ii. Their triage tool result contains errors, **or**
    iii. Because their condition limits their ability to respond to the questions on the triage tool.
c. The SUD provider agency needs to use the CES Triage Tool Score Revision Worksheet to update the client's assessment. This document can be found on LAHSA's Document webpage.
d. If the provider staff is not trained to administer the CES Triage Tools and does not have access to HMIS, the care coordinator need to refer and set up an appointment with the adult or youth CES Access Centers within the same SPA and within 14 calendar days of admission. Homeless families should contact 211 and be referred to the Family Solution Centers within each of the eight (8) SPAs countywide within 14 calendar days of admission.

3. **Enter or update the Point of Contact:** SUD counselors/Care coordinators need to enter and update the client's information and Point of Contact every 90 days in HMIS to ensure that the client remains in the queue so the housing client can be reached in the event of a potential match to a housing resource. Points of Contact work to:
    a. Connect clients to services and resources in support of a successful housing placement,
    b. Provide document collection support, and
    c. Provide a warm handoff to any services and resources made available.

The Point of Contact may change while the client is on the path to permanent housing. The current Point of Contact should ensure that the client has a new designated Point of Contact and that the client profile is updated in HMIS. For example, a client's transition from Residential to OP treatment would necessitate a change in the Point of Contact.

For additional information about identifying a Point of Contact, see **Table 13**.

Table 13: Designing or Updating a CES Client's Point of Contact

Designating a Point of Contact	The care coordinator will serve as the Point of Contact for clients on their caseload. To enter a Point of Contact, complete the following steps: • Open HMIS and go to the Client Profile Page • Add Point of Contact fields (Date, Name, Phone, Email, Agency, Program)
Reviewing a Point of Contact Before 90 Days	The Point of Contact for CES clients need to be confirmed when there is a change or update at least 90 days before to remain active in the Community Queue for resource matching. After 90 days without an update, the client will become inactive in HMIS. Records can be made active again when the Point of Contact is updated. • Open HMIS and go to Client Profile • Revise Date
Updating a Point of Contact After Loss of Communication	When the Point of Contact can no longer contact the CES client and/or perform the roles and responsibilities of a Point of Contact, the contact fields should be deleted. • Open HMIS and go to Client Profile • Delete Point of Contact fields (Date, Name, Phone, Email, Agency, Program)
Updating a Point of Contact During an Extended Leave	When the Point of Contact plans an extended absence, they should work to ensure coverage for any of their CES clients by adding a secondary point of contact within their agency, when there is not already a second Point of Contact recorded. • Open HMIS and go to Client Profile • Add Point of Contact fields for secondary Point of Contact (Date, Name, Phone, Email, Agency, Program) • Delete Point of Contact fields for original Point of Contact (Date, Name, Phone, Email, Agency, Program)
Updating Points of Contact When There are Two (2)	• Open HMIS and go to Client Profile • If two (2) Points of Contact are already recorded, confirm that both contacts are still working with the client. • Delete any Points of Contact that are out of date. • If both are still active, delete the oldest record and replace it with the new Point of Contact's information (Date, Name, Phone, Email, Agency, Program)

PEH: Discharge

When the CES Housing Navigator notifies the SUD counselor/care coordinator when a housing resource has been identified, the SUD counselor/ care coordinator will coordinate the appointments between the Housing Provider and the client, verifying eligibility information and assisting the client with the housing application process. The SUD counselor/care coordinator will link the client to the appropriate supportive services for securing and maintaining appropriate housing, including income/benefits/employment and transportation.

SAPC aims to prevent situations where clients are discharged into unsheltered homelessness. Requests for continued residential admission for PEH without stable housing will be considered if:

- The client's homelessness status is documented in CalOMS, a current finalized Problem List/Care Plan (updated every 30 days), or the client's EHR.
- The client agrees to ongoing residential admission and treatment.
- The provider has documented efforts to develop a post-discharge housing plan.
- These details are included in a Progress Note submitted with the request for residential LOC reauthorization.

Interim Housing Outreach Program

The Interim Housing Outreach Program (IHOP) addresses current gaps in behavioral and physical health services in interim housing settings to support stability, facilitate transitions to permanent housing, and prevent recurrence of homelessness. CENS counselors join Interim Housing Multi-Disciplinary Teams (MDTs) across LA County, collaborating with staff from DMH and the Los Angeles County Department of Health Services, Housing for Health (DHS-HFH) to meet clients' comprehensive behavioral and physical health needs.

CENS counselors will deliver on-site substance use outreach, engagement, educational sessions (both individual and group), screening, and referrals to SUD services. This includes connecting clients with SAPC treatment providers that offer addiction medications at interim housing sites.

Additionally, CENS counselors will implement harm reduction strategies, coordinate referrals to harm reduction services like syringe programs, and provide overdose prevention training and kits to residents and staff. For residents needing traditional SUD treatment but unable or unwilling to attend a treatment facility, OP services can be offered on-site through SAPC's network of FBS treatment providers.

Measure A

Effective April 1, 2025, the half-cent sales tax repealed and replaced the quarter-cent sales tax for County homeless services that was set to expire in 2027 (formerly known as Measure H).

As part of LA County's agenda to combat homelessness and effectively serve PEH, Measure A funding was allocated to support RBH for PEH who are exiting from institutions such as jails, prisons, other CFs, hospitals, UCCs, SUD residential treatment centers, mental health treatment facilities, and foster care and probation camps for young adults aging out of these settings. For full benefit details, see *Recovery Bridge Housing* section.

Measure A also supports SUD screening and referral services at PSH sites throughout the county. For full benefit details, see *Client Engagement and Navigation Services* section.

Lesbian, Gay, Bisexual, Transgender, Queer, Gender Expansive, Queer Population

LGBTQ+ individuals often experience higher rates of substance use compared to the general population. The stigma and discrimination associated with being part of a marginalized community can lead some LGBTQ+ people to use substances as a coping mechanism. Furthermore, research has also shown that once LGBTQ+ clients do meet the criteria for a diagnosable SUD, they are less likely to seek help. These findings may be due to the various barriers the LGBTQ+ population faces in seeking treatment and the unique needs that SUD programs may not address.

Despite protections intended to shield people in recovery from discrimination, LGBTQ+ individuals frequently face inadequate safeguards. Homophobia, heterosexism, and transphobia can make it challenging for them to

access treatment and discuss their sexual orientation or gender identity openly. Internalized negative societal attitudes can lead to feelings of sadness, doubt, and fear, further complicating their trust in healthcare systems.

SAPC offers the "Ensuring Affirming and Culturally Responsive Care for Transgender Clients Toolkit" as a resource to support providers in offering affirming care to transgender clients.

Important Considerations in the Treatment of the LGBTQ+ Population

Providers need to be aware of some unique aspects of treating LGBTQ+ clients. While group therapies should be as inclusive as possible and encourage each member to discuss relevant treatment issues or concerns, some group members may have negative attitudes toward LGBTQ+ clients. It is crucial for staff to ensure that LGBTQ+ clients are treated with respect, and group rules should foster an inclusive and welcoming environment.

LGBTQ+ clients should have control over whether they discuss their sexual orientation or gender identity in mixed groups, and this decision should not be influenced by other group members. While individual services can reduce the risk of heterosexism, homophobia, or transphobia in group settings, group therapy also offers valuable healing opportunities when LGBTQ+ clients receive acceptance and support from non-LGBTQ+ peers.

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

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

The methods of best practice outlined in the counseling competency model are applicable to all populations, particularly when working with LGBTQ+ clients. In this model, a counselor:

- Respects the client's frame of reference;
- Recognizes the importance of cooperation and collaboration with the client;
- Maintains professional objectivity;
- Recognizes the need for flexibility and is willing to adjust strategies in accordance with client characteristics;
- Appreciates the role and power of a counselor as a group facilitator;
- Appreciates the appropriate use of content and processes for therapeutic interventions; **and**
- Is non-judgmental and respectfully accepting of the client's cultural, behavioral, and value differences.

Family dynamics play a crucial role in treating LGBTQ+ individuals, and SUD providers should recognize that family therapy may be challenging due to potential alienation related to the client's sexual or gender identity. Nonetheless, involving family in the treatment process can lead to more positive outcomes. Attention should be given to discharge planning, considering factors such as living environments (for recovery and safety), social isolation, employment, finances, and ongoing issues related to homophobia and transphobia.

Successful treatment for LGBTQ+ clients involves cultural sensitivity, understanding the effects of cultural victimization, and addressing internalized shame and negative self-acceptance. CBTs can help challenge negative beliefs and enhance emotional regulation, which aids in relapse prevention. Motivational enhancement techniques can also boost treatment engagement among LGBTQ+ individuals.

Understanding each client's unique history and background enhances respectful treatment and increases the chances of positive outcomes. SUD treatment staff may sometimes be unaware or insensitive to LGBTQ+ issues, harbor biases, or mistakenly believe that sexual or gender identity causes substance use or can be altered through therapy. In these cases, providers need to be aware of these beliefs in order to prevent them from becoming barriers to the effective treatment of LGBTQ+ clients. An SUD treatment facility's commitment to providing sensitive care for LGBTQ+ clients can be included in its mission statement, administrative policies, and procedures. Providing staff training and education are oftentimes valuable and include sexual orientation sensitivity training to promote a better understanding of LGBTQ+ issues, trainings that assist staff in better understanding the needs of transgender individuals and the role that acknowledging gender identity plays in culturally competent treatment services, and other educational areas to ensure that quality care is provided. Providers who understand and are sensitive to the issues surrounding LGBTQ+ issues, such as culture, homophobia, heterosexism, and sexual and gender identity, can help LGBTQ+ clients feel comfortable and safe while they start their recovery journey.

Veterans

According to the 2018-2022 United States Census, LA County is home to 230,028 veterans. While many share similar experiences, their backgrounds and needs are highly diverse. Some may have seen combat in one or more wars, while others may have served in non-combat roles. Likewise, some veterans may have experienced injury, including traumatic brain injuries (TBI), loss of limb or other physical injuries, while others may have emotional trauma. Gender is also a factor, as more female veterans report experiences of harassment, trauma, and Military Sexual Trauma (MST).

These varied experiences can lead to SUDs and present unique treatment challenges. Some veterans may not qualify for Veterans Affairs (VA) benefits due to a dishonorable discharge or "other-than-honorable" discharge. Additionally, some veterans and family members may attempt to secure services from SUD treatment programs due to the long wait times at the VA. Providers agencies need to ensure that their services are tailored to meet the diverse and specific needs of veterans and their families.

Important Considerations in Treating the Veteran Population

Given the high rates of trauma and complex physical and behavioral health issues among veterans, SUD providers should conduct comprehensive assessments that explore trauma, combat or war experiences, and injuries that may impact SUD treatment. When such issues are identified, coordinated care with medical and mental health providers is essential.

Stigma presents an additional challenge. Veterans may experience stigma related to substance use as well as seeking help for any health condition. In addition, anger and personality disorders can make it more challenging to engage in treatment. EBPs, such as MI, can help address these challenges and support more effective care.

A key time to engage veterans in substance use treatment is right after their military discharge. Veterans may begin using substances due to mental health conditions, difficulty adjusting to civilian life, loss of social support, or pain from injuries sustained during service. While substance use varies, some may turn to sedating drugs, including prescription medications, to cope with untreated or under-treated mental health issues. Physical health conditions and injuries can also lead to higher use of prescription drugs, opioids, or heroin, putting some veterans at greater risk for fatal overdose. These individuals may benefit from addiction medications.

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

Youth Population

In this document, the term “Youth” refers to individuals under the age of 17. Adolescence presents a critical period for influencing risk factors related to substance use, offering an opportunity to address these issues earlier than with adult clients. In accordance with DHCS's Adolescent Substance Use Disorder Best Practices Guide (October 2020), youth SUD treatment is approached differently from adult treatment due to differences in psychological, emotional, cognitive, physical, social, and moral development. Examples of these developmental issues include their newly formed independent living skills, the powerful influence of interactions between youth and family/peers, and the fact that a certain degree of limit-testing is a normal feature of adolescence.

These developmental differences are reflected in clinical practices and the ASAM criteria, which often necessitate more intensive LOCs for youth compared to adults. Consequently, the client-to-counselor ratio for youth cases should be lower than for adults to manage this increased treatment intensity effectively.

Given the rapid progression of substance use among youth, it is crucial to streamline the treatment admission process to promptly identify and address their needs. Engaging youth effectively, maintaining their attention, and retaining them in treatment are essential. Youth treatment should also address their higher rates of CODs, emphasizing the need for coordinated care with mental health services as clinically indicated.

Optimal Treatment of the Youth Population

Generally, optimal treatment of the youth population requires more significant amounts of external assistance and support compared to adults, and more intensive treatment and/or higher LOCs for a given degree of severity or functional impairment, when compared with adults.

Although most youth do not develop classic physical dependence, physical deterioration, or well-defined withdrawal symptoms as is common for adults who have longer durations of substance use, youth may be more susceptible to the functional impact of SUDs. For youth, casual substance use can quickly escalate to highly problematic use. Subsequently, youth often exhibit higher rates of CODs, such as anxiety and depression, because of the negative impact that substance use has on normal youth social and psychological development.

Care planning needs to begin with a comprehensive assessment based on the ASAM criteria or, for youth receiving Early Intervention services, with an ASAM Screener for Youth and Young Adults. The assessment includes all the dimensions and biopsychosocial components of the complete adult assessment, the nuances of the youth experience, and their unique needs and developmental issues. Strengths and weaknesses need to be identified and youth need to be involved in setting their treatment objectives. Comprehensive youth assessments include information obtained from family, and when the appropriate releases are obtained, members of the community who are important to the youth client, such as school counselors, peers, and mentors. The support of family members is important for youth‘s recovery, and research has shown improved outcomes for interventions that seek to strengthen family relationships by improving communication and improving family members’ ability to support abstinence from drugs.

During treatment, it is important to address the youth’s broader life needs, such as medical, psychological, and social well-being, as well as housing, school, transportation, legal services, cultural and ethnic factors, and any special physical or behavioral issues. Flexibility in treatment schedules, such as offering weekend and evening hours, helps accommodate ongoing school and social activities, thereby supporting treatment success.

Behavioral therapies, delivered by trained counselors and clinicians practicing within their scope of practice, need to be employed to help youth clients strengthen their motivation to change. Effective psychosocial interventions may provide incentives for abstinence, build skills to resist and refuse substances and deal with triggers or cravings, replace drug use with constructive and rewarding activities, improve problem-solving skills, and facilitate better interpersonal relationships.

Addiction medications for youth should be considered and used when deemed clinically appropriate by a licensed prescribing clinician. Research and clinical experience have not identified any age-specific safety concerns for addiction medications, and all treatment options should be considered for clients of all ages.

The ASAM LOC criteria for youth differ from those for adults, as they are specifically designed to address the unique needs of younger individuals. Generally, the ASAM criteria often assign youth to more intensive LOC compared to adults.

Youth treatment services should occur in a clinically appropriate and comfortable setting for this population. The environment should be physically separate from that of adult clients. Staff need to also be familiar with and

appropriately trained to address the developmental nuances of caring for this unique population. Programming activities and treatment services for youth need to be in alignment with DHCS's most current version of the DHCS's Adolescent Substance Use Disorder Best Practices Guide (October 2020).

Similar to other groups, treatment of the youth population is regarded as a dynamic, longitudinal process that is consistent with the chronic disease model of addiction. As such, effective treatment is expected to continue into adulthood, with a gradual transition to adult SUD services.

Youth clients should be referred to a qualified youth OP treatment agency where they will receive a full assessment and referral to an appropriate LOC, as necessary. If the individual initially presents at an SUD treatment provider that does not offer the appropriate provisional LOC, that agency will identify alternate referral options and assist the individual in connecting with the selected agency, or the individual may elect to remain with the initial provider if clinically appropriate. All Medi-Cal eligible members will be referred to and/or served by a DMC-certified agency for DMC-reimbursable services.

Building Relationship, Inspiring Development, and Growing Engagement Program

Family involvement in SUD treatment services provides youth with the greatest chance for long-term recovery from the harmful effects of substance use and/or misuse. The Building Relationship, Inspiring Development, and Growing Engagement (BRIDGE) program is aimed to enhance youth treatment providers' capacity to deliver supportive services for parents, caregivers, and families of Youth (age 17 and under) who are receiving SUD treatment services, inclusive of youth with complex needs, juvenile justice-involved youth, and those released from detention or secured facilities.

To strengthen services for parents and caregivers, SAPC will fund a BRIDGE Family Support Specialist (BFSS) position dedicated to enhancing family-focused support for youth in SUD treatment. The BFSS will coordinate and deliver services for parents and caregivers, which may include one-on-one consultations to help them navigate the treatment process, educational sessions, family support groups, and programs that promote positive family relationships to support youth in recovery.

The BFSS role may be filled by an LPHA, a license-eligible LPHA, a Certified Peer, a Registered SUD Counselor, or a Certified SUD Counselor. Candidates need to have at least one (1) year of experience providing and/or coordinating family supportive services to youth and/or families.

The BFSS will collaborate with the SUD treatment team to develop, implement, coordinate, and integrate family supportive services provided to parents and caregivers of youth who are seeking or receiving SUD services. For a list of services to be provided under this program and for additional information, see SAPC 24-06.

Note: The BRIDGE program is effective October 1, 2024, and will renew each subsequent FY contingent upon the availability of funds and the program's success in achieving its goals and objectives.

Young Adult Population

In this document, “Young Adult” refers to individuals between the ages of 18 and 20. This group includes young people transitioning into adulthood, some of whom may have received services through the youth system and may now need continued support from the adult system.

Age definitions should be applied flexibly, as developmental maturity does not always align with chronological age. This population presents unique challenges because they are often too old for youth services but may not yet be ready for adult services. Young adults are navigating independence while still depending on parents or caregivers, which creates complexities related to confidentiality, financial support, and shared living arrangements.

Optimal Treatment of the Young Adult Population

The treatment needs of young adults are typically more intensive than those of the average adult but less intensive than those of most youth. Addressing these needs often requires blending elements of youth and adult treatment programs. Ideally, this care would be provided within programs that have specific experience and expertise working with young adults. Treatment approaches should be flexible and adapted to each individual, taking into account their history with the treatment system and their unique clinical needs.

For young adults who previously received services through the youth system of care for substance use or other health-related issues, it is important to coordinate with their prior providers to determine the most appropriate treatment strategy. Early responses to treatment interventions should help shape and guide future care, with the understanding that the treatment approach must remain adaptable as young adults continue their transition into adulthood.

Multidimensional assessments should identify the developmental stage of each individual and help determine whether a youth-based, adult-based, or blended treatment approach is most appropriate. Treatment planning needs to be individualized, taking into account the young adult’s strengths, goals, and needs. Young adults need to be involved in their own care planning. When the appropriate authorizations are obtained, family involvement should be included in the information-gathering and treatment process. Care planning begins with the ASAM full assessment or, for young adults receiving Early Intervention Services, the ASAM Screener for Youth and Young Adults.

Similar to youth, young adults often have broader life needs that have to be addressed to support positive outcomes. These needs may relate to medical, psychological, and social well-being, as well as housing, education, transportation, legal services, cultural and ethnic factors, and any special physical or behavioral issues.

Behavioral therapies and addiction medications should be offered based on clinical need and delivered by trained counselors and clinicians practicing within their scope of practice. As outlined in the *Medication for Addiction Treatment* section, there are various medications used for addictions that have been FDA-approved for individuals over the age of 18 (and some for those over the age of 16) and should be available to young

adults as part of a comprehensive treatment plan that includes psychosocial support. Effective psychosocial interventions may support abstinence, increase motivation for change and recovery, build skills to resist and refuse substances, help manage triggers and cravings, encourage constructive and rewarding activities, improve problem-solving skills, and support stronger interpersonal relationships.

Ideally, staff working with the young adult population would be familiar with and interested in meeting their unique needs. They should have experience treating Youth (age 17 and under) and Adults (age 21 and over) populations to best blend necessary treatment approaches.

While the ASAM criteria do not specifically explore the specialized considerations of young adults, they recognize the possibility of establishing an intermediate developmental stage in the future. This would support the creation of individualized treatment approaches tailored to the unique strengths, needs, and vulnerabilities of this group.

Adult Programs

DPSS – General Relief

GR Referral Process

As a condition of eligibility, all adult GR applicants need to undergo a pre-screening interview for an SUD by their DPSS EW. If there is a reasonable suspicion of an SUD, the GR applicants need to be referred to the DPSS Mandatory Substance Use Disorder Recovery Program (MSUDRP). GR applicants with a positive SUD pre-screen are referred to:

- The CENS area office nearest to the client;
- Directly to a contracted provider agency; **or**
- SASH for a clinical screening and/or assessment.

Treatment Requirements and Care Coordination

Treatment services are administered based on medical necessity. Services may be a combination of various treatment service modalities as outlined in the *Early Intervention and Treatment Service Components* section.

The Treatment Progress Report (Form ABP 132) is generated by the LEADER Replacement System (LRS) and mailed directly to the receiving contracted provider agency every 60 days for completion. It is then returned to DPSS, which monitors the individual's participation. LRS resets this date to generate a new Treatment Progress Report Form.

Contracted provider agencies are required to notify DPSS of all changes in client's status within five (5) days of the actual change, including:

- Transfers to other sites or treatment modalities
- Dropouts
- Completions

SUD provider agencies are required to notify DPSS within three (3) days of changes in the number of hours clients are in treatment using the Report of Changes form. These changes should correspond to changes in the client's Problem List (non-OTP settings) or Treatment Plan (OTP settings). Treatment Extensions are initiated when agencies determine the client's need for treatment proceeds beyond the initial six (6) months based on medical necessity.

If a treatment extension is needed, the contracted provider agency will submit a reauthorization request to SAPC-UM, which will evaluate and approve/deny the request. The contracted provider agency will forward the form to DPSS for final approval/denial, which then updates LRS. DPSS is responsible for notifying and sending a copy of the extension status back to the provider agency.

In addition, provider agencies are to contact the CENS Area office and notify their dedicated GR CENS of any GR client changes as the CENS need to update client data in LRS via the CalSAWS website, accessed according to login instructions given by DPSS.

Older Adults Population

As the number of older adults increases and the long-term nature of SUDs becomes clearer, treatment approaches need to adapt to meet their unique needs. While "older adults" typically refers to those over 65, some under 65 may require similar care due to cognitive decline, medical issues, or social challenges.

Specialized approaches are necessary when treating older adults. Factors such as slower metabolism, changes in brain function, use of multiple medications, and common age-related health conditions can make it difficult to recognize the effects of substance use. Retirement often reduces visible signs like work-related or social impairment. Even small amounts of alcohol or other substances may have a stronger impact on older adults compared to younger individuals. Treatment providers may misattribute symptoms to dementia, depression, or other aging-related conditions rather than substance use.

Older adults may also face unique barriers to care. Limited mobility, social isolation, lack of transportation, and feelings of shame or guilt can make it harder to seek treatment. Those who serve as caregivers for spouses with complex needs may find it especially difficult to access services.

Optimal Treatment of the Older Adult Population

SAMHSA panelists recommend the following best practices when treating older adults:

- Use age-specific settings whenever possible, with treatment administered at an appropriate pace.
- Maintain a respectful, supportive, and non-confrontational approach.
- Address age- and gender-specific issues, including depression, loneliness, and loss, while building coping skills and support networks.
- Ensure staff are trained, experienced, and genuinely interested in working with older adults.

Research has demonstrated that age-specific assessment and treatment lead to better outcomes than mixed-age approaches. Assessments should be multidimensional and tailored to the physical, mental, and social needs of older adults. Treatment needs to be paced to fit each individual's cognitive and physical abilities. Program schedules and timelines should reflect the slower pace of progress often seen in older adults.

Studies have generally indicated that cognitive-behavioral techniques are generally effective for older populations, especially those focused on managing depression, grief, and loneliness. In general, confrontational therapy should be avoided. Educational treatment approaches should be geared toward the specific needs of older adults (e.g., coping strategies for dealing with loneliness and general problem-solving). Educational sessions work best when they include a clear explanation of goals, an outline of the content, and repeated exposure to information using both visual and audio formats. Instruction should also include coping and problem-solving strategies.

Since social isolation is common among older adults, group therapy and skills to build support networks are important. Family therapy can also be helpful. According to SAMHSA's TIP series titled "TIP 26: Treating Substance Use Disorder in Older Adults" consensus panel members recommend that family involvement should be limited to one (1) or two (2) close members to avoid overwhelming the client. Involvement of grandchildren may hinder open discussion, as older adults might hesitate to share personal issues in front of younger relatives.

Medications, including addiction medications, should be prescribed judiciously due to age-related physiological changes. Dosages may need to be adjusted when co-occurring medical conditions are present. When used for WM, medication dosages for older adults should adjusted in light of age-related changed in medication distribution and metabolism. Concerns or questions about medication safety in the older adult population should be directed toward appropriately trained medical professionals.

Staff working with older adults should ideally have training in aging and geriatric care. Staff need both the interest and skills to offer age-appropriate services. The most effective care comes from staff who understand the physical, emotional, social, and spiritual issues specific to older adults. Ongoing training on EBPs is essential to maintain quality of care.

Section 4. CLINICAL PROCESS STANDARDS

Utilization Management Components

The UM program analyzes how the SAPC provider network delivers services and utilizes resources for eligible clients. The various responsibilities of the UM program include:

- Ensuring adherence to established DMC eligibility verification and medical necessity criteria.
- Ensuring that clinical care and ASAM LOC guidelines are followed.
- Monitoring both under- and over-utilization of services.
- Assessing the quality and appropriateness of care furnished to enrollees with special health care needs.
- Conducting clinical case reviews (prospective/concurrent/retrospective) of requests for select services.
- Authorization of select services.
- Random and retrospective monitoring of a portion of provider caseloads.
- Ongoing monitoring and analysis of provider network service utilization trends.

In summary, the purpose of the UM program is to achieve the following objectives for clients and providers:

- To assure effective and efficient utilization of facilities and services through an ongoing monitoring program designed to identify patterns in under-utilization, over-utilization, and inappropriate utilization of services across the service continuum.
- To ensure fair and consistent UM decision-making.
- To focus resources on a timely resolution of identified problems.
- To assist in promoting and maintaining the optimally achievable quality of care.
- To educate healthcare professionals on appropriate and cost-effective use of healthcare resources.

SAPC follows Federal and State decisions and notification timeframes for UM determinations. SAPC will make every effort to complete UM determinations expeditiously, facilitating timely treatment for clients served in the specialty SUD system in LA County, and ensuring compliance with all requirements.

Eligibility Verification

Initial DMC eligibility verification occurs at the point of first contact between a client and the specialty SUD system and includes considerations outlined in **Table 2**. Medical necessity determinations will be made at the provider's site. The initial DMC eligibility verification may be performed by trained support staff and/or registered or certified SUD counselors.

However, medical necessity determinations need to be performed by an LPHA who is able to render an SUD Diagnosis as part of their scope of practice (see *Workforce* section) and need to be established regardless of the client's insurance and funding status. Providers are required to confirm DMC eligibility on a monthly basis to ensure clients are actively enrolled in the DMC program.

Specialty SUD benefits are available to all clients who meet the requirements of the DMC eligibility verification and medical necessity. Legal status (e.g., parole, probation) is not a barrier to accessing substance use services.

All clients eligible for specialty SUD services (e.g., clients in qualified County-funded programs/projects) will have access to the same benefit package as DMC members and will be required to follow the same eligibility and medical necessity verification processes. For additional information, see Eligibility Verification and Member Authorizations on SAPC's website.

Re-Verification Period for DMC Eligibility

- Non-OTP settings: At least every six (6) months
- OTP settings: At least every twelve (12) months

During the re-verification process for DMC eligibility, the LPHA (who has the ability to render diagnoses as part of their scope of practice) at the provider agency will be required to justify ongoing eligibility for services by verifying DMC eligibility, submitting applicable request forms (e.g., Financial Eligibility Form; Discharge and Transfer Form, etc.), and submitting clinical documentation including current Problem List (non-OTP settings) or Treatment Plan (OTP settings), full ASAM CONTINUUM™ Assessment or Assessment Tool - Youth (Paper Version) found on the SAPC website (if client's condition has changed), Medical Necessity Justification Progress Note, and laboratory test results (if available).

Sources of information may include, but are not limited to, information from the client or responsible family member, client record, substance use providers, physical/mental health providers, etc. UM staff will use this information, along with clinical judgment, departmental policies and procedures, client needs, recommendations from providers, and characteristics of the system of care, to decide whether SUD services are provided, as needed.

If UM staff determines that DMC eligibility verification and medical necessity criteria have been met, and the proposed or provided services are deemed clinically appropriate, service authorizations will be approved, and the applying treatment provider will be notified in accordance with the notification timeframes outlined in **Table 14.**

Adverse DMC eligibility and medical necessity determinations result in denial of reimbursement for services rendered. Denial notifications contain information including, but not limited to:

- Reason(s), including specific plan provisions and clinical judgment used.
- Any additional information needed to improve or complete the authorization.
- Descriptions of the appeal or grievance process.

Clients or providers acting on behalf of the client can review and respond to the evidence and rationale outlined in the initial denial and may challenge a denial of DMC eligibility, coverage of services, or denial of payment for services. For additional information, see *Complaints/Grievances and Appeals Processes* section.

Table 14: Utilization Management Notification Timeframes

Review Type	Written Decision Notification
Initial Pre-Authorizations, Authorizations, and Verifications	
Initial Pre-Authorization: Residential Services (ASAM 3.1, 3.3, 3.5)	24 hours after receipt of the request for services per BHIN 24-001.
Initial Authorization: Residential Services (ASAM 3.1, 3.3, 3.5)	**Approvals:** Within seven (7) calendar days of receipt of request. **Other Decisions:** See timeframes outlined in *Complaints/Grievances and Appeals Processes* section.
Initial Verification: Non-Residential Services (ASAM 0.5, 1.0, 2.1, 2.5, OTP, and the Recovery Incentive Program)	**Approvals:** Within 14 calendar days of receipt of request. **Other Decisions:** See timeframes outlined in *Complaints/Grievances and Appeals Processes* section.
Initial Verification: Withdrawal Management (ASAM 1.0WM, 3.2WM, 3.7WM and 4.0WM)	**Approvals:** Within seven (7) calendar days of receipt of request. **Other Decisions:** See timeframes outlined in *Complaints/Grievances and Appeals Processes* section.
Initial Authorization: RBH *Only for Young Adults (age 18-20) and Adults (age 21 and over)*	Within 14 calendar days of receipt of request.
Reauthorizations and Reverifications	
Reauthorization for ongoing Residential Services (ASAM 3.1, 3.3, 3.5)	**Approvals:** Within seven (7) calendar days of receipt of request. **Other Decisions:** See timeframes outlined in *Complaints/Grievances and Appeals Processes* section.
Reverification for Non-Residential Services (ASAM 0.5, 1.0, 2.1, 2.5, OTP, and the Recovery Incentive Program) *Need to submit ongoing verification requests at least 21 calendar days but no earlier than 30 days in advance of the end date of current authorization or verification.*	Within 14 calendar days of receipt of request.
Recovery Bridge Housing *Young Adults (age 18-20) and Adults (age 21 and over) may be authorized for 90 days of RBH and reauthorized for additional 90-day durations of RBH if needed, for a potential maximum stay of 360 days per calendar year, based on concurrent enrollment in non-residential treatment services.* *Need to submit residential and RBH reauthorization requests no earlier than seven (7) calendar days in advance of the end date of current authorization*	Within 14 calendar days of receipt of request.

Note:

- ***Timeframes begin only after all required components have been submitted for SAPC's review. An authorization request is not considered complete until both medical necessity and financial eligibility documentation have been submitted in Sage PCNX.***
- ***If a provider chooses to deliver services before receiving SAPC authorization, they assume the financial risk if the request is ultimately denied.***

- ***SAPC may deny authorization requests that are submitted more than 30 days after the initial date of service or after the date the client's financial eligibility was established (whichever comes later).***
- ***If a client enters treatment for an authorized service but leaves AMA, the provider must still obtain SAPC authorization to be reimbursed for any services delivered while the client was in treatment. SAPC will deny reimbursement if financial eligibility is not verified, required information is missing, or medical necessity was not established according to the timeframes outlined in Table 3 before the client left AMA.***
- ***SAPC conducts a financial eligibility check at time of Member Authorization Request review. SAPC is not responsible, nor does SAPC have control over, eligibility changes in the DPSS system or the DPSS system being misaligned with the effective date on the NOA or the effective date on the CRS. These potential mismatches may result in billing denials. If you encounter a billing denial after authorization has been approved, please contact Netsmart for help with troubleshooting and/or contact DPSS. Provider can only bill if the client is still eligible to receive the requested services with an appropriate funding source. Approved authorizations do not guarantee payment for rendered services.***

QI and UM staff will review clinical cases from SUD treatment providers. The purpose of these case reviews is to establish an ongoing monitoring program to ensure appropriate and quality care and appropriate utilization of services across the SUD service continuum. In some instances, these reviews are related to service reimbursement, while in others, they aim to ensure the quality and appropriateness of the services provided.

SUD treatment providers are required to cooperate with all case reviews conducted by SAPC-QI and SAPC-UM. These reviews are independent of but complementary to, SAPC contract monitoring activities.

The following methods of review are utilized by QI and UM staff:

- **Prospective Review:** A prospective review occurs prior to the delivery of the services and applies to an initial request or for services that require authorization. QI and UM staff perform a prospective review, applying pre-established medical necessity and appropriateness criteria, and render a decision of approval or denial of authorization and/or reimbursement.
    - Prospective reviews allow for the opportunity to assure the efficient and appropriate provision of care and utilization of resources, and to continually assess and improve access and quality of care.
    - Example of prospective review: Pre-authorization of residential services.
- **Concurrent Review:** A concurrent review examines ongoing care to evaluate medical necessity and the quality and appropriateness of care. As previously mentioned, this review is conducted by QI and UM staff in accordance with pre-established criteria.
    - The main objectives of the concurrent review process are to ensure that care is appropriate and in accordance with generally accepted standards of practice, to continually monitor client progress, and to anticipate treatment needs and transitions that promote recovery.
    - Examples of concurrent review: Authorization of RBH, Initial authorization of residential services received following admission, Reauthorization of ongoing residential services
- **Retrospective Review:** Retrospective reviews examine various aspects of previously provided services. These reviews provide information on the quality of verification of DMC eligibility, service authorization decisions, and other aspects related to client services. This information is used to evaluate the quality and appropriateness of the services the provider is contracted to deliver. Open and closed cases may be identified for retrospective review through numerous mechanisms.
    - Retrospective reviews allow for the opportunity to identify service under- and overutilization, utilization patterns and trends, the consistency of the QI and UM review and decision-making

process, and areas of improvement.
- Example of retrospective review: Random, focused chart review of services that have already been rendered to ensure fidelity to verification of DMC eligibility, medical necessity criteria, and quality of care.

The QI and UM programs utilize a variety of review methods when performing case reviews to monitor care quality and appropriateness and inform decisions regarding verification of DMC eligibility, coverage of services, and authorizing reimbursements. The timely submission of Sage authorization requests by providers is essential in minimizing the potential complications and financial impact of retrospective review denials and is, therefore, beneficial to the submitting provider.

Timeliness of Authorization Submissions

Member authorizations and reauthorizations need to be submitted to SAPC-QI and SAPC-UM within 30 calendar days of admission or within 30 calendar days of reauthorization start date.

Five (5) exceptions to the 30 days rule – authorization submissions should be held pending the establishment of financial eligibility in the following circumstances:

1. An individual who applied for Medi-Cal but has not established DMC benefits yet.
2. Awaiting receipt of an OHC denial.
3. Pending resolution of Sage technical issue that prevented authorization submission (providers need to document Sage Help Desk Ticket Number related to the technical issue).
4. Pending ICT of Medi-Cal benefit.
5. Authorizations for RI-CM

All SARs, including those delayed due to the establishment of financial eligibility, need to adhere to and meet Medi-Cal standards and requirements for timelines of clinical assessment.

Transitions in Care

When a client steps up or down in LOC, the Discharge and Transfer Form in Sage needs to be completed.

To verify eligibility for SUD services, providers treating clients in non-residential LOCs need to either document that there has been no change in the client's SUD and any associated medical or mental health conditions every six (6) months in non-OTP settings and every 12 months in OTP settings or complete the documentation for verification of medical necessity for the LOC the client is receiving.

Required documentation for re-verification of medical necessity may be found in the Checklist of Required Documentation for Utilization Management on SAPC's website. For information about when a new ASAM assessment is required, see ASAM Assessment Requirements for LOC Transitions on SAPC's website.

Pre-Authorized Services

Services requiring pre-authorization are those for which the treating provider agency needs to request approval before initiating treatment. In these instances, UM staff will conduct prospective reviews of care to determine the medical necessity of the proposed services that have yet to be provided, as well as concurrent reviews of extensions of previous authorizations, as needed. Provider agencies seeking pre-authorization of services should email SAPC.QI.UM@ph.lacounty.gov.

Authorized Services

To support the prompt review of member authorizations, providers are required to submit member authorization requests within 30 calendar days, along with relevant clinical documentation, of admitting a client into a treatment or SUD-related benefit program, or within 30 calendar days of initiating continued services. For a list of exemptions to the 30-day authorization submission deadline policy, see Timeliness of Authorization Submissions.

Member authorizations and reauthorizations submitted 30 calendar days after the admission date or reauthorization start date may result in partial approval based on delayed establishment of medical necessity. In this scenario, only those services provided after medical necessity is established will be authorized for reimbursement. In addition, providers who submit member authorizations outside of the 30-calendar day requirement will be subject to partial approval for the service dates based on the authorization submission date.

SAPC-QI and SAPC-UM are notified via Sage whenever a provider submits an electronic member SAR. Member SARs from providers need to be submitted. For a list of required documents to be included with member SARs, see the Checklist of Required Documentation for Utilization Management on SAPC's website. Approval for initial member authorization requests is based on medical necessity and ASAM LOC guidelines, as well as generally accepted standards of clinical practice. Consideration for ongoing authorization is based on the same criteria, as well as documented progress and engagement in treatment. For services that require authorization, notifications will occur within the review timeframes specified in **Table 14**.

If a decision determination cannot be made due to insufficient documentation, SAPC-QI and/or SAPC-UM will notify the provider and offer an opportunity for the provider to submit additional information in order to continue the authorization review accurately and, if appropriate, before issuing an authorization denial. prior to authorization denial.

If SAPC-QI and/or SAPC-UM determine that the proposed and provided services are necessary, appropriate, and in accordance with standards of clinical practice outlined in the clinical service standard of this Provider Manual, the authorization will be approved. Reimbursements for services will be retroactive to the start date of the authorization if all required documentation and authorization submissions are complete and submitted in a timely manner.

Denials of authorization will result in denial of reimbursement for services, and the applying treatment provider will be notified of the decision of denial within the timeframes outlined in **Table 14**.

Denial notifications will include, but will not be limited to:

- The action SAPC has taken or intends to take.
- The reasons for the action.
- The client's or the provider's right to file an appeal or grievance.
- The client's right to a State fair hearing.
- The procedures for exercising the client's rights.
- The circumstances under which expedited resolution is available and how to request it.

Table 15: Residential Authorization and Reauthorization Service Limits

	Youth (age 17 and under)	Young Adults (age 18-20)	Adults (age 21 and over)	Justice-Involved Adults	Pregnant and Perinatal Adults
Initial Residential Authorizations	Initial authorization of 30 calendar days	Initial authorization of 60 calendar days			
Residential Reauthorizations	Reauthorizations required every 30 calendar days, based on medical necessity				
Initial and Reauthorization Outpatient	End of the 6th month, or in case of initial authorization with existing eligibility verification align with eligibility verification if more than 30 days are left from authorization start date				
Initial and Reauthorization OTP	See *MAT Services for Youth (age 17 and under)* section.	End of the 12th month, or in case of initial authorization with existing eligibility verification, align with eligibility verification if more than 30 days left from the authorization start date.			
Initial and Reauthorization RBH	N/A	90 calendar days			
DMC Service Limits	DMC service limits are determined by an LPHA, based on medical necessity, and align with EPSD requirements	DMC service limits are determined by an LPHA, based on medical necessity. Limits on the residential length of stay have been removed.	DMC reimbursable residential length of stay is based on medical necessity. Extensions may be granted based on the clients' continued medical necessity for residential services and take legal requirements into consideration.	DMC reimbursable PPW residential length of stay extends from pregnancy through 365 days postpartum period based on medical necessity for perinatal clients receiving services at contracted PPW sites.	

Residential Treatment

Residential services require authorization before reimbursement can be made. This authorization is required for ALL clients needing residential treatment, with the following considerations:

- Provider agencies need to submit a member authorization request to the SAPC-QI and SAPC-UM, which will conduct a review and then respond with an approval, denial, or request for additional documentation in accordance with the notification timeframes outlined in **Table 14**.
- Authorization will only be reviewed when all required elements are received.
- UM requests that are missing or incomplete will result in authorization review time reset and may be denied due to insufficient information if requested materials are not provided in a timely manner.
- If relapse risk is deemed to be significant without immediate placement in residential care, a residential treatment provider may admit an individual prior to receiving an approved residential authorization.. However, the provider accepts financial risk if the request is later denied due to lack of medical necessity. If approved, reimbursement will be retroactive to the earliest eligible date. For example, a residential treatment provider may choose to accept the financial risk of admitting residential cases over the weekend, knowing that SAPC-QI and SAPC-UM will render an authorization decision within seven (7) calendar days of receiving the completed request.
- Requests for continuation of residential services need to be submitted at least seven (7) calendar days in advance of the end date of the current authorization.
- Authorizations are required when initiating residential care, transitioning from a lower to a higher level of residential care (e.g., ASAM LOC 3.1 to 3.5), transitioning from non-residential to residential LOCs, or transitioning from one residential location to another.
- For additional information regarding residential lengths of stay, see **Table 15**.

Youth (age 17 and under)

- Youth (as defined by EPSDT) – In general, youth clients typically require shorter lengths of residential stay than adult clients and should be stabilized and then moved down to a less intensive LOC. However, care should be individualized to the needs of the client. While youth typically require shorter lengths of stay in residential settings than adults, it is also true that they require more external assistance and support and, at times, more intensive treatment and/or higher LOCs. Higher intensity of service and longer duration of services are not necessarily correlated.
    - Residential authorizations for youth are approved every 30 days.
    - Parental/guardian consent is required for services delivered to youth under the age of 12.

Young Adults (age 18-20) and Adults (age 21 and over)

- Residential reauthorizations beyond the initial 60 calendar days will occur every 30 calendar days, with extensions granted based on medical necessity.
    - Justice-Involved Individuals
        - Clients with in-custody status participating in the START – Community program can serve the final 90 days of their in-custody sentence in a community residential SUD treatment facility while wearing a GPS ankle monitor. START– Community clients may be authorized for 90 calendar days of residential SUD treatment (ASAM 3.1, 3.3, or 3.5) if providers include documentation from LASD or CEN that identifies the client as a START – Community client.

- PEH
  - PEH at the time of admission to residential treatment are at increased risk of returning to problem substance use if they do not have a place to stay following discharge. Providers should establish a housing plan for PEH during the client's residential admission, ensuring they are discharged with a place to stay. SAPC recognizes that successful housing plans are more feasible for clients who complete residential treatment than for clients who leave AMA.
  - SAPC considerations for approval of reauthorization requests for continued residential services for PEH include the following:
    - The client's homelessness status is appropriately documented in CalOMS, on a current Problem List finalized/signed by an LPHA (required every 30 days) and documented within the clinical record.
    - The client agrees to ongoing residential services and treatment.
    - The provider has documented their efforts to establish a post-discharge housing plan for the client.
    - The above is documented within a Progress Note that is submitted alongside the request for residential LOC reauthorization.
  - To meet the ''chronically homeless'' definition, an individual needs to be living in a place not meant for human habitation for at least 12 months continuously or on at least four (4) separate occasions in the last three (3) years, totaling 12 months of homelessness. If an individual resides in an institutional care facility, such as an SUD residential treatment facility, for more than 90 days, they will no longer meet the designation for chronically homeless even if they were homeless prior to entering the facility. This is important to keep in mind when applying for residential treatment reauthorizations and identifying available and appropriate housing placements during discharge planning, as certain PEH resources require the chronically homeless status.

- For a list of required documents to be included with member authorization requests, see the Checklist of Required Documentation for Utilization Management on SAPC's website.
- Given the fluid nature of clinical progression, it is expected that the Problem List and Progress Notes will reflect progress regularly during residential treatment, as clinically warranted. Additionally, it is anticipated that certain clients will not require the full period of authorized residential services. In these instances, clients need to be transitioned to a lower LOC as soon as clinically indicated. Providers are required to update problem lists every 30 days to facilitate an accurate UM authorization review and to ensure that clients receive care in the least restrictive setting that is clinically appropriate.
- If a residential treatment case is determined to be unnecessary based on the aforementioned considerations upon clinical review, provider may receive recommendation to consider an alternative LOC. UM staff will have the authority to terminate/modify the current authorization, deny ongoing reimbursement for residential services, and recommend a transition to an appropriate lower LOC. In these instances, reimbursement for previously approved residential services will be maintained, but future reimbursement for the identified episode will be denied.
- SUD treatment providers will be responsible for ensuring successful Care Coordination during all LOC transitions.
- Providers will be required to notify UM staff of residential discharges by submitting a completed Discharge and Transfer Form within 24 hours.

Authorized services require approval from SAPC but do not require authorization prior to being provided. In these instances, UM staff will perform concurrent reviews of care and extensions of previous authorizations when pertinent. The provider will be required to notify UM staff of the recommended services within 30 calendar days to begin the authorization review process. Any authorization request may be denied due to untimely submission.

Campus-Like Setting Facilities

Providers identified and approved by SAPC as operating campus-like settings should request member authorizations for the client in the usual and customary manner. These authorizations will also be reviewed and processed by SAPC-UM in the usual and customary manner.

Once these authorizations are approved by SAPC UM, **the specific location will be automatically removed from the approved authorization**, which will enable any of the campus programs to submit claims under those authorizations. Any pending or denied authorizations will still show a location.

Important: Only campus programs that are licensed and contracted to provide services at the approved LOC will have those claims approved. If a program submits a service that they are not licensed or contracted to provide, the claim will be denied with a reason code of "Procedure not on fee schedule".

RBH Authorizations

- If RBH is determined to be appropriate, RBH provider agencies need to submit a member authorization request. For a list of required documents to be included with member authorization requests, see the Checklist of Required Documentation for Utilization Management on SAPC's website.
- Referring OP provider agencies need to document the need for RBH in the client's Problem List (non-OTP settings) or Treatment Plan (OTP settings).
- Young Adults (age 18-20) and Adults (age 21 and over) are eligible for RBH services if the following criteria are met: they are homeless and are currently enrolled in OP services (e.g., ASAM 1.0, ASAM 2.1, OTP). RBH is authorized in 90-day increments. For additional details, see *Recovery Bridge Housing* section. Clients do not need to use these days continuously.
- SAPC will not reimburse providers for RBH if criteria are not met and/or client is no longer concurrently enrolled in OP services. RS does not meet the criteria for RBH will make client ineligible for RBH.

Sage Outage Procedure

Although every effort will be made to conduct maintenance procedures during low-activity periods, unforeseen circumstances may require the system to be unavailable. Effective communication, planning, and training for these events through written processes and staff preparations can mitigate the impact on the organization, staff, clients, and their ability to provide or receive treatment.

In the event of a planned outage, providers will receive a notice from SAPC.

If you are experiencing technical issues and are unable to chart in real-time, contact the Netsmart Helpdesk and document the Helpdesk ticket in Progress Note.

To prepare for such events, SUD provider agencies need to maintain the following documents in hard copies or other formats that would not be impacted by their inability to access Sage:

- Current Client Roster
- ASAM Assessment Tool or ASAM Screener for Youth and Young Adults
- Care Plan Template
- Problem List Template
- Progress Note Template
- Discharge and Transfer Form Template (for all LOCs)
- Recovery Bridge Housing Authorization Request Form
- Recovery Bridge Housing Discharge Form
- Billing-related documents
- All required consents
- Admission/Discharge Forms
- Any other documents required by the County or the organization

Approved forms are available on SAPC's Manuals, Bulletins, and Forms – Clinical Tab webpage.

Once the Sage outage is resolved, the above forms should be uploaded as attachments via Provider File Attach in Sage. Documents should be labeled according to the Standardized Naming Convention.

Workforce

Health systems are increasingly adopting a chronic disease and public health approach to SUD care, necessitating a diverse, skilled, and well-trained workforce.

SAPC values the contributions of contract providers across all sizes and capacities, recognizing that a successful SUD system needs to reflect the varied needs of the population it serves. Traditionally staffed primarily by SUD counselors, the specialty SUD system now includes a broader range of disciplines. Increasing the diversification of the SUD workforce is crucial. This diversification is particularly important for meeting the requirements of diagnosing LPHAs to verify medical necessity and eligibility for DMC services, as well as sign Problem Lists (non-OTP settings) or Treatment Plans (OTP settings).

A robust workforce in SUD treatment requires not only proper provider credentials but also comprehensive training to meet the needs of a diverse population. Professional development should include mandatory trainings and CEs on ASAM criteria and EBPs for clinical staff. For additional information, see *Evidence-Based Practices* section.

Providers should develop a business plan with a clear hiring and training strategy to ensure their staff has the necessary background and skills to deliver high-quality SUD services. Additionally, DHCS has specified the types of providers qualified to deliver each DMC-ODS service under the CalAIM 1115 Demonstration & 1915(b) Waiver, California State Plan, and SPA 23-0026.

Recommended Responsibilities for Medical Directors and Physicians

- Provide MAT
- Provide WM
- Provide clinical supervision for staff
- Refer/treat co-occurring physical and mental health conditions
- Assist other professional staff with challenging cases
- Lead QI functions/projects
- Conduct clinical trainings on issues relevant to professional staff
- Provide physical exams, when necessary

Clinicians in SAPC's network who prescribe medications (MDs, DOs, APRNs, PAs, RNs) should practice at the highest level of their license and receive adequate training in addiction medications to enhance client access to this essential SUD treatment component.

Medical Director

Each SUD treatment site needs to have a DMC Medical Director who has been approved by DHCS by submitting Form 6010. The State contract requires an agreement with the Medical Director that includes:

- Ensure that medical care provided meets the appropriate standard of care and is not influenced by fiscal considerations;
- Duties and responsibilities and state these duties may not be delegated to non-physician staff;
- Develop and implement medical policies and standards;
- Lines of supervision; **and**
- Education, training, work experience, and other qualifications for the position.

An agreement and Code of Conduct for the Medical Director needs to be clearly documented, signed, and dated by a provider representative and the physician. The Medical Director, or their designated physician, needs to be present on-site for **a minimum of two (2) hours per month.** If a physician cannot fulfill this requirement, the provider agency needs to develop a plan or identify an on-call physician to comply with this contractual obligation. Provider agencies should determine the most effective approach to meet this requirement while addressing their specific needs. For instance, agencies may establish agreements with other SUD providers to cover gaps as needed.

Given their advanced education and training, it is beneficial to employ staff at the highest level of their licensure and expertise. Medical Directors at SUD provider agencies should ideally undertake responsibilities that cannot be performed as effectively by other staff members (e.g., different types of LPHAs) within the agency.

Minimum expectations of Medical Directors of treatment sites within the specialty SUD system:

- Comply with clinical standards of best practice, licensing, accreditation standards, and other Federal/State/local regulatory and reporting requirements. Interpret and support the agency's standards of care by leading the development of the agency's treatment workflows that incorporate best practices.
- Research and maintain knowledge of EBPs and updates regarding the treatment of SUDs and recovery-based services.
- Participate in SAPC-related meetings (e.g., Medical Director meetings, Provider meetings).

Recommended Responsibilities of Medical Directors

The following are recommended responsibilities for medical directors and physicians under the DMC-ODS system of care, including, but not limited to, ways to enhance their contributions to maximize their roles:

- Provide addiction medications, when clinically necessary
- Medication management of intoxication and/or withdrawal, when clinically necessary
- Provide clinical supervision for staff
- Refer/treat co-occurring physical and mental health conditions
- Assist other staff with challenging cases (e.g., refractory SUD, CODs, certain special populations)
- Lead QI functions/projects (e.g., QIPs, leading clinical team meetings, etc.)
- Conduct clinical trainings on issues relevant to professional staff (e.g., documentation, ASAM Criteria, DSM5-TR, addiction medications, co-occurring mental health conditions)
- Provide physical exams, when necessary and appropriate, at their facility

Licensed Practitioners of the Healing Arts

DHCS identifies the following professional categories as LPHAs:

- Physician (MD or DO)
- Advanced Practice Nurse (APRN)
- Physician Assistant (PA)
- Registered Nurse (RN)
- Registered Pharmacist (RP)
- Licensed Clinical Psychologist (LCP)
- Licensed Clinical Social Worker (LCSW)
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Vocational Nurse (LVN)
- Licensed Psychiatric Technician (LPT)
- Licensed Occupational Therapist (LOT)
- Licensed-eligible LPHA working under the supervision of licensed clinicians

LPHAs are professional staff who provide or oversee services within their scope of practice. SAPC further classifies them as Diagnosing or Non-Diagnosing LPHAs. Diagnosing LPHAs have final signatory authority on documentation requiring an LPHA signature, including the Problem List, Treatment Plan, full ASAM, and Medical Necessity Progress Notes. Other LPHA-required documentation may be completed by any LPHA, as long as it falls within their scope of practice.

Table 16: Types of Licensed Practitioners of the Healing Arts

Diagnosing LPHAs	Non-Diagnosing LPHAs
Physician (MD or DO)	Registered Nurse (RN)*
Nurse Practitioner (NP)	Registered Pharmacist (RP)
Physician Assistant (PA)	Licensed Vocational Nurse (LVN)
Licensed Clinical Psychologist (LCP)	Licensed Psychiatric Technician (LPT)
Licensed Clinical Social Worker (LCSW)	Licensed Occupational Therapist (LOT)
Licensed Professional Clinical Counselor (LPCC)	
Licensed Marriage and Family Therapist (LMFT)	

RNs may serve as the final signatory on Problem Lists; however, other non-diagnosing LPHAs may not.

Licensed-eligible LPHAs are persons who have already earned their advanced degree (e.g., Master of Science [M.S.], Master of Arts [M.A.], Master of Social Work [MSW], Doctor of Philosophy [PhD], Doctor of Psychology [PsyD], etc.), who are properly registered with their respective state board (e.g., California Board of Behavioral Sciences [BBS], California Board of Psychology [BOP], etc.) and are authorized to practice under the license of a fully licensed practitioner with proper supervision as required by the state board with which they are registered. Providers will need to demonstrate compliance with the required supervision and oversight. Within the specialty SUD system, licensed-eligible LPHAs can fulfill the functions of independently licensed LPHAs (e.g., finalize ASAM assessments, make diagnoses[20] (aligned with the scope of practice for making diagnoses as regulated by the relevant licensing board), and sign Problem Lists (non-OTP settings) or Treatment Plans (OTP settings).

Clinical Trainees

Previously referred to as students, interns, or trainees, Clinical Trainees are now credentialed under state plan amendment SPA 23-0026 to provide billable services under DMC-ODS. Additionally, AB 1860 and BHIN 23-008 exempt graduate student trainees from registration or certification requirements as SUD counselors for the purpose of providing reimbursable services. According to AB 1860:

- A graduate student providing counseling services in an AOD program needs to:
  - Be enrolled as a university graduate student in psychology, social work, marriage and family therapy, or counseling.
  - Be completing their supervised practicum hours to meet graduate school requirements; **and**
  - Provide proof of enrollment as a graduate student in the AOD program on an annual basis.
- A graduate student who is no longer enrolled in a university program identified above needs to notify the AOD program in writing of their withdrawal within one working day. An AOD program needs to immediately remove the former graduate student from providing counseling services.

[20] Per DHCS, although LVNs, LPTs, LOTs, RNs and RPs are classified as LPHAs, they are not allowed to diagnose.

A Clinical Trainee is an unlicensed individual currently enrolled in an educational/training program or a post-secondary educational program in California that is required to obtain licensure as a Licensed Mental Health Professional or LPHA. This person is involved in a practicum, clerkship, or internship approved by their educational program and meets all relevant program and licensing board requirements to participate in these activities. Clinical Trainees provide rehabilitative mental health or SUD treatment services, including fulfilling coursework and supervised practice requirements. However, they are not authorized to perform administrative duties reserved for LPHAs, such as signing off on Problem Lists (non-OTP settings), Treatment Plans (OTP settings), or finalizing ASAM assessments. They are, however, permitted to deliver clinical services within the scope outlined in the most current version of the SAPC IN for the Rates and Standards Matrix and BHIN 24-023 Standards for Specific Behavioral Health Provider Types and Services; Amends Relevant Sections Within Title 9 and Title 22 of the California CCR.

Clinical Trainees, as determined by DHCS, include the following:

- Nurse Practitioner Clinical Trainee
- Clinical Social Worker Clinical Trainee
- Marriage and Family Therapist Clinical Trainee
- Medical Student in Clerkship (Physician Clinical Trainee)
- Occupational Therapist Clinical Trainee
- Pharmacist Clinical Trainee
- Physician Assistant Clinical Trainee
- Professional Clinical Counselor Clinical Trainee
- Psychiatric Technician Clinical Trainee
- Psychologist Clinical Trainee
- Registered Nurse Clinical Trainee
- Vocational Nurse Clinical Trainee

Retroactive to July 1, 2023, Clinical Trainees can submit claims for services provided on or after this date. Claims for Clinical Trainee services will be reimbursed at the same rate as the licensed supervisor's discipline rate. Clinical trainees still need to be credentialed within the Sage system. Provider agencies need to notify the Sage Helpdesk of the primary supervisor's name, National Provider Identification Number (NPI), and credentials to configure the information in Sage during the credentialing process. The supervisor's NPI need to be active as it will be validated against the National Plan and Provider Enumeration System (NPPES) and need to be included on the claim to DMC. Claims need to include the taxonomy code for their discipline and the appropriate provider type modifier.

The sponsoring provider agency provides adequate clinical supervision and oversight of the trainees' clinical activities. These trainee providers are required to have co-signatures on all of their clinical documentation and receive weekly supervision at a minimum. This supervision requirement consists of one (1) hour of individual supervision or two (2) hours of group supervision for every ten (10) hours of direct clinical service provided by the clinical students, interns, or trainees.

Note: Clinical trainees cannot perform the duties of an LPHA (e.g., sign-off on a Problem List (non-OTP settings) or Treatment Plan (OTP settings) or ASAM assessment).

Certified Peers

Training Requirements

In addition to completing their state certification, all Certified Peers need to also complete the training module entitled “ASAM Multidimensional Assessment" (ASAM A). This module provides an overview of the ASAM LOCs that the Certified Peers will assist clients in navigating. Given that this is not a standardized part of the Peer Support Specialist certification training, this singularly required training has been deemed critical for Certified Peers to assist clients within the specialty SUD system.

Certification Renewal

To maintain certification, Certified Peers need to renew their certification every two (2) years. If a certification is not renewed by its expiration date, it is considered expired. State standards mandate that applicants fulfill renewal requirements, which include completing 20 hours of CE. This education needs to include six (6) hours of law and ethics training. For a comprehensive list of the renewal certification requirements, see CalMHSA’s Guidelines, Standards, and Procedures Manual.

Once these requirements are met, applicants can submit a renewal application and pay associated fees. It is important to note that applications for renewal can only be submitted up to 90 days prior to the expiration date. Any applications submitted after the certification has expired will incur additional fees and may cause delays in the renewal process. For additional information, visit CalMHSA’s Certification Renewal and Continuing Education webpage.

If an individual’s certification lapses within four (4) years of when the certification renewal was due, the individual needs to meet all Certified Peer Requirements, complete 40 hours of training, and pass the certification exam to reinstate certification. Applicants with a lapsed certification greater than four (4) years from the date the renewal was due do not qualify for recertification. If these applicants are interested in recertification, they need to reapply for initial certification.

Resources to Support the Integration of Certified Peers in SUD Treatment

As Certified Peers enter the workforce, it is important to understand how these services can enrich substance use treatment. SAPC-CST developed the “Enriching Substance Use Treatment with Certified Medi-Cal Peer Support Specialist Services” training to support provider agencies in achieving a greater understanding of Certified Peer roles. For available trainings, visit the SAPC Trainings and Events webpage on SAPC’s website and refer to the training calendar to register for upcoming sessions.

CalMHSA provides Best Practice Guidelines for Employing Certified Medi-Cal Peer Support Specialists. These guidelines offer valuable insights and recommendations to help organizations optimize their integration of Certified Peers and enhance the quality of care they provide.

For additional information and resources, visit SAPC's Certified Medi-Cal Peer Support Specialist webpage. If you have any questions or need additional support, email SAPC-SOC at SAPC_ASOC@ph.lacounty.gov.

Minimum Staffing Requirements

Professional staff need to be licensed, registered, certified, or recognized under the California State scope of practice statutes. Professional staff need to provide services within their discipline's scope of practice and receive supervision required under their respective scope of practice laws.

Registered and Certified SUD counselors need to adhere to all requirements in the CCR Title 9, Division 4, Chapter 8 and need to be registered with or certified by one of the National Commission for Certifying Agencies (NCCA) accredited organizations recognized by DHCS: Addiction Counselor Certification Board of California (ACCBC) – which is affiliated with California Association of DUI Treatment Programs (CADTP); California Association for Alcohol and Drug Educators (CAADE); and CCAPP.

To be able to conduct contracted treatment services, Registered SUD counselors need to:

- Complete the State-required ASAM A and ASAM B trainings prior to delivering DMC-reimbursable treatment services. The only exception to this requirement is Certified Peers, who are only required to complete their certification as PSS providers and complete ASAM A;
- Complete training on CBT, MI, clinical documentation, and Treatment Planning either through a qualified Continuing Education Unit (CEU) agency such as SAPC-CST, UCLA-ISAP, and CIBHS, or a qualified trainer funded by a provider agency or through their training program;
- Complete one (1) classroom course equaling a minimum of 45 hours of formal instruction in a CAADE, CCAPP, or CADTP-approved SUD education program on relevant SUD-related topics within 12 months of the counselor's first day of employment and annually thereafter until certified. Typically, one (1) academic course is equal to three (3) hours of classroom instruction per week for one academic semester; **and**
- Complete the Certification process within five (5) years unless qualified for a hardship extension, which can extend registered status for an additional one (1) year.

Proof of completion needs to be documented in staff files and shared with SAPC staff upon request. Proof of completion may include letters from school administrators, certificates, and school transcripts. **If required education/training is not completed within the required timeframes, SAPC will not pay for the services and will be eligible for recoupment.**

Note: Registered counselors who have completed all necessary education hours for certification but have not taken the examination to become certified needs to complete 45 hours of SUD education or approved CEUs of training on an annual basis until certified. Additionally, it is important to note that registered counselors are required to become certified within five (5) years of registration unless qualified for a hardship extension, which can extend registered status for an additional one (1) year, after which time they will no longer be eligible for registered counselor status.

Services in the WM setting may be provided by registered or certified SUD counselors or LPHAs, depending on the nature of the service and its scope of practice. Where noted, physician involvement in evaluating and assessing the severity of WM is required.

All counselors and clinicians (including LPHAs and licensed-eligible LPHAs), whether full-time, part-time, or on-call, have the same training requirements. The training requirements are:

- All provider staff need to be trained in the ASAM Criteria prior to providing DMC billable services; **and**
- Staff conducting ASAM assessments need to complete the two (2) training modules entitled “ASAM Multidimensional Assessment" (ASAM A) and “From Assessment to Service Planning and Level of Care” (ASAM B). *Titles for ASAM A & ASAM B (aka Module I & Module II) may vary depending on where these courses are taken.

In addition, LPHAs (including the Medical Director) need to complete a minimum of five (5) hours of CE related to addiction every renewal cycle. Registered and certified SUD counselors need to adhere to all requirements in CCR Title 9, Division 4, Chapter 8.

The providing agency is responsible for ensuring that their staff are competent, capable, and appropriately credentialed to provide SUD services, including the ASAM Criteria. Similarly, staff who are unfamiliar with MI and/or CBT are unlikely to be able to utilize one (1) of these required evidence-based approaches effectively. As such, it is highly recommended that provider agencies ensure their staff is adequately prepared prior to providing treatment.

Provider agencies can and should provide workforce development training to their specialty SUD workforce within their agency. SAPC does not maintain a list of authorized trainers. Therefore, in addition to the requirements for initial trainings, provider agencies retain responsibility for all further training and development of their staff.

Provider agencies are responsible for ensuring that their staff are appropriately trained on Sage prior to being given access to the Sage EHR system. Staff who are not trained on Sage will be unable to access the system. SAPC has developed a series of role-specific Sage training modules that are available on the SAPC-LNC platform.

Provider agencies are also responsible for ensuring that their staff are appropriately trained on CalAIM requirements, including documentation requirements, initiating treatment during the assessment period, and treating clients with CODs. SAPC requires providers to send at least one (1) representative per contracted provider agency to all designated trainings.

For available SAPC trainings, including applicable CalAIM trainings, visit the SAPC Trainings and Events webpage on SAPC’s website and refer to the training calendar to register for upcoming sessions.

Non-professional staff, including clerical, billing, and facility management support, require appropriate on-site orientation and training prior to performing their assigned duties. Non-professional staff require supervision by professional and/or administrative leadership. Both professional and non-professional staff are required to have appropriate experience and the necessary training at the time of hiring.

For a full list of services available by provider type, visit SAPC's Manuals, Bulletins, and Forms – Bulletins Tab webpage for the most current version of the SAPC IN for the Rates and Standards Matrix. Codes with associated rates reflect services that can be provided by that provider type under DMC-ODS.

Personnel File Requirements

All provider agencies need to maintain a personnel file for staff funded under their SAPC service contract. All personnel files need to include, but are not limited to, the following documents:

1. Signed employment confirmation statement/duty statement
2. Job description
3. Performance evaluations
4. Health records/status as required by the provider, AOD Certification, or CCR Title 9
5. Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries)
6. Training documentation relative to SUDs and treatment (e.g., staff participation in trainings delivered or contracted through SAPC)
7. Current registration, certification, intern status, or licensure
8. Proof of CEs is required by the licensing or certifying agency and program
9. Provider's Code of Conduct

Data Exchange & Release of Information

Data exchange and ROI are structured processes that support the secure transfer of information between individuals, providers, entities, or information systems. These processes are key to supporting care coordination by allowing information to be shared among SUD providers, physical health providers, mental health providers, MCPs, and other service providers supporting a client's unique needs. Care coordination relies on the principle that the appropriate and authorized sharing of health information enables providers to deliver more effective care, which leads to better health outcomes. A critical part of data exchange includes obtaining informed client consent, responding to ROI requests in a timely manner, and tracking all authorized ROI requests. Providers are expected to continue receiving and processing ROI requests for both current and former clients. The Health Information Management (SAPC-HIM) Unit within SAPC supports the management of authorized ROI requests and develop data exchange strategies with other health systems.

SAPC-HIM reviews all ROI requests SAPC receives. To fulfill certain requests, SAPC may need support from contracted provider agencies to supply records that are not available in the Sage system, particularly those maintained by Secondary Sage Users. In an effort to protect the privacy and confidentiality of SAPC's clients, all requests and exchanges of information will be completed using SAPC's secure file transfer protocol (SFTP). Similar to other business processes that use the SFTP, SAPC Provider Agencies will receive an email notification to the designated email addresses when a file is shared through the SFTP. Provider agencies must ensure that at least two (2) authorized staff members maintain access to their SAPC SFTP folders. If an authorized staff member departs from the agency, the agency must notify SAPC within one (1) business day of the staff member's notice of departure and identify another authorized staff member to gain access.

Secondary Sage users are responsible for responding to all authorized ROI requests sent by SAPC-HIM within seven (7) calendar days of receiving the request in their SFTP folder. All responses must be returned to SAPC-HIM using the SAPC SFTP folder. When transferring files to SAPC through the SFTP system, Secondary Sage users must follow the required file naming convention for records requests. This ensures that the automated file transfer program can detect and process the files successfully. Files that are not properly named may not

be detected by the system, which will result in the request being considered incomplete and processed accordingly.

SFTP Authorized Release of Information Naming Convention
File Naming convention: Name of Org File type- Client Last Name First Name MRN/PATID or DOB_Date of document_Copy number (if applicable)

- Example: SoCalHC RR- DoeJohn 12.31.1999_01.01.2025

Secondary Sage Users are required to respond under the following scenarios:

- **Member Not Found –** The request is for a client that was not found in your EHR records. Please upload the original ROI request with your response to the Member Not Found response SFTP folder.
- **Common Member Found –** The request is for a client found in your EHR. Please upload the original ROI request and the full requested client records authorized for release to the *Common Member* response SFTP folder. Secondary Sage Users are responsible for ensuring the records being disclosed are complete and consistent with the authorization for disclosure as indicated on the authorized ROI request. Any information not authorized to be released per the ROI form needs to be redacted from the record prior to uploading to the SFTP folder.
    - Example of client record to be included, but not limited to, are: Admission/Discharge information, Assessments (ASAM CONTINUUM™ Assessment, ASAM CO-Triage® Tool, or other clinical assessments), Drug tests, Medication lists, Problem List or Treatment Plans, Diagnosis, Progress Notes, and Referrals.

SAPC-HIM will provide the requestor with the agency's contact information to facilitate continued care coordination, or to follow up if the agency did not respond to the ROI request, or if the response provided was incomplete. For additional information about ROI requests or if you have any questions, email SAPC-HIM at SAPC-HIM@ph.lacounty.gov.

Quality Assurance – Regulations

In healthcare, quality assurance refers to activities and programs intended to achieve improvement and maintain quality of care. Oftentimes, these activities involve ensuring compliance with regulations established by governmental and/or administrative entities. In all cases, key components of quality assurance involve:

- Assessing quality
- Identifying problems with care delivery and designing QI activities to overcome them
- Follow-up monitoring to make sure activities achieve their intended aims

In addition to the requirements outlined in this manual, all SUD treatment programs need to operate in accordance with Federal and State laws and regulations, including those identified below, as well as those outlined in BHINs and relevant SAPC All Providers Letters, INs, and Bulletins.

Confidentiality

Maintaining appropriate confidentiality is of paramount importance. All provider agencies are required by contract to establish confidentiality policies and procedures and need to comply with 42 CFR Part 2, HIPAA, and California State law regarding confidentiality for information disclosure of SUD, and other medical records.

Health Insurance Portability and Accountability Act

HIPAA establishes federal standards to protect the privacy and security of individuals' medical information.

- HIPAA for Professionals: https://www.hhs.gov/hipaa/for-professionals/index.html
  - Summary of the HIPAA Rule: www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html
- HIPAA for Individuals: https://www.hhs.gov/hipaa/for-individuals/index.html

HIPAA should not be viewed as a barrier to delivering coordinated, integrated care. Provided that the appropriate client releases and/or consents for treatment are obtained, every effort should be made to share clinical information with relevant providers across the continuum of SUD care and systems of care (physical and mental health, etc.).

Under the requirements of the laws and regulations governing confidentiality in the provision of health services, all providers within the specialty SUD system need to cooperate with system-wide efforts to facilitate the sharing of pertinent clinical information to improve the effectiveness, integration, and quality of health services.

42 CFR Part 2 - Confidentiality of SUD Client Records

Covers all records relating to the identity, diagnosis, and/or treatment of any client in an SUD program that is conducted, regulated, and/or assisted in any way by any Federal agency. On February 8, 2024, the U.S. Department of Health & Human Services (HHS) announced a final rule modifying the Confidentiality of SUD Client Records regulations at 42 CFR part 2 ("Part 2 Final Rule 2024").

- Part 2 Final Rule 2024 has a compliance date (enforcement may formally begin) of February 16, 2026. All organizations have until this date to comply by updating consent forms, required notices, revise organizational policies and procedures and ensure staff knowledge by providing training.
- For a summary of 42 CFR Part 2 Final Rule 2024 modifications, visit: https://www.hhs.gov/hipaa/for-professionals/regulatory-initiatives/fact-sheet-42-cfr-part-2-final-rule/index.html
- Subpart A covers introduction to the statute (e.g., purpose, criminal penalty, reports of violations, etc.).
- Subpart B covers general provisions (e.g., definitions, confidentiality restrictions, minor clients, etc.).
- Subpart C covers disclosures allowed with the client's consent (e.g., consent requirements, notice and copy of consent to accompany disclosure, disclosures permitted with written consent, use and disclosures to prevent multiple enrollments, etc.).
- Subpart D covers disclosures that do not require client consent (e.g., medical emergencies, scientific research, evaluation, and audit activities, disclosures for public health).
- Subpart E includes information on court orders around disclosure (e.g., legal effects of order confidential communications, etc.).

42 CFR Part 438 – Managed Care

As a member in LA County's DMC-ODS Waiver, the administrative entity that is SAPC becomes a specialty MCP responsible for overseeing the specialty SUD system. As a component of becoming a managed care entity, SAPC and its specialty SUD network need to abide by the 42 CFR Part 438 requirements.

The primary aim of 42 CFR Part 438 is to achieve delivery system and payment reforms by focusing on the following priorities:

- Network adequacy and access to care standards (e.g., timeliness of services, distance standards)
- Client/consumer protections
- Quality of care

Title 9 – Certification of Alcohol and Other Drug Counselors

CCR Title 9, a section titled Certification of Alcohol and Other Drug Counselors, provides minimum requirements on the level of credentials counseling staff need to secure prior to conducting services. The minimum standards are designed to ensure baseline quality and effectiveness of treatment services. The County has built on these requirements and established minimum staffing standards specific to LA County.

For additional information, visit SAPC's Manuals, Bulletins, and Forms – Bulletins Tab webpage for the most current version of the Provider Staffing Guidelines.

Evidence-Based Practices

EBPs are interventions that have been shown to be effective and are supported by evidence. In LA County, although other psychosocial approaches may be used (e.g., relapse prevention, trauma-informed treatment, and psychoeducation), provider agencies need to, at a minimum, implement MI and CBT and ensure their staff are appropriately trained to deliver both MI and CBT. Providers are also expected to present and support the use of addiction medications as an evidence-based intervention when clinically appropriate.

Motivational Interviewing

MI is a client-centered and empathic counseling strategy designed to explore and reduce a person's ambivalence toward treatment by paying particular attention to the language of change. This approach frequently includes other problem-solving or solution-focused strategies that build on clients' past successes. According to *Motivational Interviewing: Helping People Change and Grow, 4th Edition* (Miller & Rollnick, 2023), MI "is designed to strengthen an individual's motivation for and movement toward a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion."

Cognitive Behavioral Therapy

CBT is among the most extensively studied psychotherapy treatments for substance use. The CBT model of relapse prevention focuses on cognitive, affective, and situational triggers for substance use and provides skills training specific to coping alternatives. CBT treatment often includes the following strategies: (1) identifying

intrapersonal and interpersonal triggers for relapse, (2) coping-skills training, (3) drug-refusal skills training, (4) functional analysis of substance use, and (5) increasing nonuse-related activities.[21] The Matrix Model is an example of an integrated therapeutic approach that incorporates CBT techniques and has been empirically shown to be effective for the treatment of stimulant use.[22]

Other Contractor Selected Practices

Relapse Prevention

According to SAMHSA's National Registry of Evidence-Based Programs and Practices[23], relapse prevention is "a behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment. Coping skills training strategies include both cognitive and behavioral techniques. Cognitive techniques provide clients with ways to reframe the habit change process as a learning experience with errors and setbacks expected as mastery develops. Behavioral techniques include the use of lifestyle modifications such as meditation, exercise, and spiritual practices to strengthen a client's overall coping capacity."

Trauma-Informed Treatment

According to SAMHSA's concept of a trauma-informed approach[24], "a program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization." Seeking Safety is an example of evidence-based trauma-informed practice.[25]

Psychoeducation

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

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[21] Magill, M., & Ray, L. A. (2009). Cognitive-behavioral treatment with adult alcohol and illicit drug users: A meta-analysis of randomized controlled trials. Journal of Studies on Alcohol and Drugs, 70(4), 516–527. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2696292.

[22] SAMHSA. (2023, October). Matrix Intensive Outpatient Treatment for People with Stimulant Use Disorders: Counselor's Treatment Manual. http://store.samhsa.gov/product/matrix-intensive-outpatient-treatment-people-stimulant-use-disorders-counselors-treatment.

[23] SAMHSA. (n.d.). Evidence-Based Practices Resource Center. https://www.samhsa.gov/resource-search/ebp.

[24] SAMHSA. (2014, October). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. https://library.samhsa.gov/product/samhsas-concept-trauma-and-guidance-trauma-informed-approach/sma14-4884.

[25] SAMHSA. (2023, August 23). Seeking Safety. http://www.samhsa.gov/resource/dbhis/seeking-safety.

Documentation

Clinical documentation includes any part of the client's health record that describes the care provided and the reasoning behind it. It is observational and narrative in nature, and it is written by counselors, clinicians, and Certified Peers to analyze both the process and content of client encounters. Clinical documentation is a vital part of delivering quality healthcare and serves multiple important purposes, including the following:

1. **Ensure comprehensive and quality care:** The process of writing initial assessments and progress notes requires thought and reflection. Preparing accurate and thorough clinical documentation is essential to ensuring quality client care. It allows practitioners to think critically about their clients, review and reflect on therapeutic interventions, consider the effectiveness of their clinical work, and explore alternative approaches to care. Good documentation organizes clinical details into a case formulation that guides care planning, and it is a fundamental part of professional practice and the delivery of quality services. It also promotes the effective use of team members from different disciplines by drawing on their unique strengths and enhancing the overall quality of services provided.
2. **Ensure efficient organization and communication with other providers:** Clinical documentation helps organize care and facilitates clear communication with other providers involved in a client's treatment. This promotes coordinated care and reduces the risk of fragmented service delivery.
3. **Protect against risk and minimize liability:** Accurate and comprehensive clinical documentation is essential for delivering quality care and effective risk management. Detailing and justifying thought processes that contributed to the clinical decision-making process helps to support the adequacy of the clinical assessment, the appropriateness of the treatment/service plan, and demonstrates the application of professional skills and knowledge toward providing professional services.
4. **Comply with legal, regulatory, and institutional requirements:** Good documentation practices help ensure compliance with requirements imposed by Federal and State (including licensing boards) laws, regulations, and rules. It also helps ensure that documentation meets the standards set by specific accreditation programs (e.g., Commission on Accreditation of Rehabilitation Facilities [CARF], The Joint Commission), when applicable, and by healthcare institutions, facilities, and agencies.
5. **Facilitate QI and UM:** Clinical documentation plays a key role in explaining the processes and content of assessments, treatment, and service planning, as well as in informing clinical decision-making, medical necessity, and the effectiveness of services provided. It is essential to the utilization review process, as it supports the need for further assessment, testing, treatment, or additional services, and it also helps justify changes to or the termination of treatment. From a quality improvement perspective, documentation supports supervision, consultation, and professional development. It helps identify service delivery issues and provides the information needed to implement effective preventive or corrective actions. Accurate recordkeeping also contributes valuable data for staff training, policy development, program planning, and research within agency settings.
6. **Clinical documentation needs to be credible, complete, and protected under HIPAA and 42 CFR Part 2.** It encompasses all aspects of clinical care, including initial assessments, progress notes, and relevant client encounters that occur outside of scheduled appointments. Documentation of initial assessments follows the same format as the multidimensional ASAM assessment, reflecting a comprehensive biopsychosocial approach. Progress Notes are written during/after follow-up appointments to gauge clinical progress and assess whether the client's needs have changed and if modifications to the treatment approach/plan are required. The documentation style need to be consistent and standardized throughout the agency/institution.

In general, clinical documentation includes the following characteristics:

- Assessment and Progress Notes include the typed or legibly printed name, signature of the service provider, and date of signature (requirement is met via Sage electronic signature)
- Client name and identifier are included
- Client's race, ethnicity, and primary language, as recorded at admission and on demographic forms
- Referral information
- Sources of information are clearly documented
- The type(s) of service(s) being offered as described within the clinical record
- Duration of the service(s) being provided, including travel and documentation time
- The date that the service was provided to the client
- Documentation of any changes in the client's status (e.g., change in LOC provided or discharge status)
- Description of how services provided reduced impairment, restored functioning, and prevented significant deterioration
- For clients with LEP, documentation indicating whether interpreter services were offered and provided, along with the client's response

Documentation, including forms and assessments within Sage, need to be completed and signed on the date indicated on the documentation. Providers may NOT back- or forward-date documentation so that it appears to have been completed and signed on a different date than was the case.

Assessment

An ASAM Criteria® assessment is required. The assessment includes the LPHA's determination of medical necessity and service recommendation. The Problem List and Progress Note requirements identified below support the medical necessity of each service provided.

Problem Lists and Treatment Plan for Non-OTP and OTP Settings

Client-centered care is critical and requires that clients be provided the opportunity to actively shape their treatment.

As clients advance through treatment, the corresponding Problem List (Non-OTP) and Treatment Plan (OTP) is reviewed and updated on an ongoing basis to reflect the client's current presentation, including stability and the likelihood of rapid changes in client condition. Problem Lists and Treatment Plans are updated more frequently if an individual is unstable, or a notable event requires a change in the Plan of Care. For additional details regarding minimum requirements for Problem Lists (non-OTP settings) and Treatment Plan (OTP settings) reviews and updates, see **Table 17** and **Table 18**.

Note: These are maximum allowable timeframes. Ideally, the Problem List (in non-OTP settings) or Treatment Plan (in OTP settings) should be completed and signed as promptly as possible, preferably close to the client's treatment admission date.

Table 17: Problem List Minimum Requirements for non-OTP Settings

Problem List Activity	LOC	Minimum Requirement*
Initial Problem List *Note: Initial Problem Lists need to be performed as instructed by SAPC on standardized Sage templates in Sage or Problem List or Treatment Plan forms approved by SAPC.*	All WM LOCs	• Need to be completed upon intake and signed by an LPHA within the treatment episode.
	• Outpatient • Intensive Outpatient • Recovery Services	• Need to be completed 30 calendar days of the first service or first intake appointment for Adults (age 21 and over), including signature by LPHA; **or** • Within 60 calendar days of first service or first intake appointment for Youth (age 17 and under) and Young Adults (age 18-20), and for Adults (age 21 and over) who are documented as a PEH* including signature by LPHA. • *Documentation of homelessness status need to be indicated in a Medical Necessity Justification Progress Note.
	• Residential	• Need to be completed upon intake within seven (7) calendar days of first service or first intake appointment for Young Adults (age 18-20) and Adults (age 21 and over), including signature by LPHA; **or** • Within 14 calendar days of first service or first intake appointment for Youth (age 17 and under) including signature by LPHA.
Problem List Review *Note: If the review of the Problem List results in a determination that changes to the Problem List are not necessary, a Progress. Note: (with Problem List-Treatment Plan Development Review Service Type) stating that a Problem List Review was completed need to be included in the client's record. When Problem Lists require modification, an updated Problem List should be documented.*	• Outpatient • Intensive Outpatient • Recovery Services	Every 30 calendar days, at minimum.
	• Residential	Every 15 calendar days, at minimum.
Problem List Update *Note: Problem List updates involve a review, documenting any updates, and the LPHA signing the updated Problem List at the required intervals. Problem List updates need to be completed as instructed by SAPC on LPHA, certified or registered counselor standardized SAGE templates on Sage or Problem List or Care Plan forms approved by SAPC.*	• Outpatient • Intensive Outpatient • Recovery Services	No later than 90 calendar days after the signing of the initial care plan, and no later than 90 calendar days thereafter, or when there is a change in treatment modality or a significant event, whichever occurs first.
	• Residential	No later than 30 calendar days after the signing of the initial care plan, and no later than 30 calendar days thereafter, or when there is a significant event, whichever occurs first.

DHCS does not require the Problem List to be updated within a specific timeframe or have a requirement about how frequently it should be updated after a problem has initially been added. However, DHCS requires that providers update the Problem List within a reasonable time and in accordance with generally accepted standards of practice, which for LA County are those outlined in the Table 17.

If a client's condition does not show improvement at a given LOC or with a particular intervention, a review, abbreviated assessment, and update of the Problem List should be conducted to enhance therapeutic outcomes. Any change in LOC or intervention should be guided by a reassessment and adjustment of the Plan of Care to achieve better results.

The Problem List, maintained by the practitioners responsible for the client's care, includes symptoms, conditions, diagnoses, and risk factors identified through assessments, diagnostic evaluations, and other service interactions. If a new problem is identified during a service encounter, it may be addressed by the documenting practitioner (within their scope of practice) and added to the Problem List. This list should be updated regularly to accurately reflect the client's current condition.

The Problem List needs to include, but is not limited to, the following:

- Diagnoses identified by a provider acting within their scope of practice
- Applicable diagnosis-specific specifiers from the current DSM
- Problems identified by a provider acting within their scope of practice, if any
- Problems or illnesses identified by the member and significant support person, if any
- The name and title of the provider who identified, added, or removed the problem and the date the problem was identified, added, or removed
- Providers need to add to or remove problems when there is a relevant change to a member's condition

Table 18: Treatment Plan Minimum Requirements for OTPs

Treatment Plan Activity	Minimum Requirement
Initial Treatment Plan *Note: Initial Treatment Plans need to be performed using standardized Treatment Plan templates approved by SAPC.*	Need to be completed and signed by the client and LPHA within 28 calendar days of admission.
Treatment Plan Review *Note: If the Treatment Plan Review results in a determination that changes to the Treatment Plan are unnecessary, a Progress Note stating that a Treatment Plan Review was completed need to be included in the client's record. If Treatment Plans require modification, a Treatment Plan Update should be performed.*	Not less frequently than every 30 calendar days following completion of the initial Treatment Plan.
Treatment Plan Update *Note: Treatment Plan Updates involve reviewing a Treatment Plan. If the review results in a determination, changes to the Treatment Plan are needed. Treatment Plan Updates need to be performed on standardized templates on Sage or approved by SAPC.*	Whenever necessary, and not less than every three months from the day of admission.

Suppose a client's condition does not show improvement at a given LOC or with a particular intervention. In that case, a review, abbreviated assessment, and Treatment Plan Update should be made to improve therapeutic outcomes. Changing the LOC or intervention should be based on a reassessment and modification of the Treatment Plan to achieve an improved therapeutic response.

Treatment Plans need to meet the requirements specified in Title 9 CCR § 10305 and Title 22 CCR § 51341.1(h)(2)(B).

At a minimum, Treatment Plans should include:

- Thorough documentation of case details, including a diagnosis and statement of problems to be addressed.
- Goals that are mutually established between client and provider for each identified problem.
- Action steps to be taken by the provider and/or client to achieve the identified goals.
- Target dates for the achievement of identified action steps and goals.
- Description of the type(s) and frequency of services to be provided. If the frequency changes, a Treatment Plan update need to be completed to prevent disallowances.
- Required documentation, as specified in Title 9 and Title 22, including documentation of physical examinations.
- The client needs to review, approve, type, or legibly print their name, sign, and date the initial Treatment Plan and Treatment Plan Update, indicating whether they participated in the preparation of the plan, within seven (7) calendar days for Young Adults (age 18-20) and Adults (age 21 and over) **or** 14 calendar days for Youth (age 17 and under) of the first service or first intake appointment. Suppose the client refuses to sign the Treatment Plan. In that case, the provider staff needs to document the reason for refusal and the provider staff's strategy to engage the client to participate in treatment; see **Table 4**.
- If the LPHA determines the services in the Treatment Plan Update are medically necessary, the LPHA needs to type or legibly print their name, sign, and date the Treatment Plan Update within 15 calendar days of signature by the SUD counselor.
- LPHAs who sign off on Treatment Plans in OTP settings need to be licensed prescribers.

Progress Notes

Provider agencies/staff need to document the care provided to clients with SUDs in Progress Notes. Each Progress Note needs to provide sufficient detail to support the services being billed (as indicated by service code descriptions) during each treatment episode. All Progress Note documentation would be entered directly into the Progress Note form within Sage or an approved Progress Note template in a provider's own EHR if a secondary provider.

Progress Notes need to include:

- The type of service rendered.
- A narrative describing the service, including how the service addressed the client's SUD and/or mental health need (e.g., symptom, condition, diagnosis, and/or risk factors) in accordance with the ASAM Criteria.
- The date that the service was provided to the client.
- Duration of the service, including travel time.
- Location of the client at the time of receiving the service.
- Justification of discrepancy if the LOC suggested by ASAM criteria is not recommended by the counselor/clinician (if applicable).
- Justification of discrepancy if the discussed LOC is not agreeable to the client (if applicable)
- Justification of discrepancy if the LOC the client was referred to does not match the LOC suggested by the ASAM criteria (if applicable).

- A typed or legibly printed name, service provider signature, and signature date (electronic signatures are acceptable).
- An appropriate ICD-10 and HCPCS/CPT code(s) need to appear in the clinical record, associated with each encounter, and consistent with the description in the Progress Note, as this is a requirement for Medi-Cal claims to be valid. This requirement is managed in Sage by linking the various items during the claiming process.
- Next steps including, but are not limited to, planned action steps by the provider or by the client, collaboration with the client, collaboration with another provider (s), and any update to the Problem List (non-OTP settings) or Treatment Plan (OTP settings) as appropriate.

Provider staff need to complete Progress Notes within three (3) business days (excluding weekends and LA County holidays) of providing a service, except for crisis services, which need to be completed within one (1) calendar day. The day the service is provided counts as day 0.

For services billed daily, such as residential treatment, at least one Progress Note daily is required. For. services provided in residential services that are not included in the bundled rate and can be claimed separately, a separate progress note is required to support the unbundled service.

When documenting group services, providers need to keep a list of clients. If multiple practitioners are involved in a group session, one Progress Note per client, signed by one practitioner is acceptable. This note needs to detail the involvement and time of each practitioner during the session. All other Progress Note requirements listed above need to also be met for group service Progress Notes.

Group Session Progress Notes

When documenting group services, provider agencies need to keep a list or sign in sheet of all clients attending the group session. If multiple practitioners are involved in a group session, a Progress Note for each client attending the group need to be completed and signed by one (1) practitioner is acceptable. The Progress Note need to detail the involvement and time of each practitioner during the session.

Group Session Progress Notes need to include:

- The type of service rendered.
- A narrative describing the service, including the title of the group session and how the service addressed the client's SUD and/or mental health need (e.g., symptom, condition, diagnosis, and/or risk factors) in accordance with the ASAM Criteria.
- The date that the service was provided to the client.
- Duration of the service, including travel time.
- Location of the client at the time of receiving the service.
- Justification of discrepancy if the LOC suggested by ASAM criteria is not recommended by the counselor/clinician (if applicable).
- Justification of discrepancy if the discussed LOC is not agreeable to the client (if applicable)
- Justification of discrepancy if the LOC the client was referred to does not match the LOC suggested by the ASAM criteria (if applicable).
- A typed or legibly printed name, service provider signature, and signature date (electronic signatures are acceptable).

Providers should document the appropriate ICD-10 codes in the Diagnosis Form in Sage and use the applicable HCPCS code for billing, as outlined in the *Finance Management* section. This ensures that claims associated with Progress Notes include the necessary diagnostic and procedure code elements for DMC-ODS.

Progress Notes need to be documented for all client encounters and services in all settings. Documentation is necessary for providers to demonstrate that services have been delivered in accordance with the service hour requirements associated with the LOC the client is receiving and with the client's clinical needs.

Standardized documentation by SUD counselors and clinicians assists with increasing treatment consistency and quality of care and reducing reimbursement disallowances. As such, SAPC requires that the multidimensional components of the ASAM criteria be incorporated into the initial documentation of the first complete assessment. Progress Notes for both individual and group sessions do not require a specific format under CalAIM; however, SAPC recognizes that providers with other accreditations, such as CARF, may still need to use one of four (4) formats: SOAP, GIRP, SIRP, or BIRP.

SOAP (Subjective, Objective, Assessment, and Plan) is an acronym that describes the structure of a specific style of Progress Note documentation. The SOAP format is widely used and improves the quality and continuity of client services by providing a consistent and organized framework of clinical documentation to enhance communication among healthcare professionals and better recall the details of each client's case. This format allows providers to identify, prioritize, and track client problems so they can attend to them promptly and systematically. It also provides an ongoing assessment of both the client's progress and the treatment interventions. While a full review of the SOAP note format is beyond the scope of this document, **Table 19** outlines a summary of its components, and providers should refer to additional resources for additional information.

Table 19: SOAP Progress Note Format

S	**Subjective –** Client statements that capture the theme of the session. Brief statements as quoted by the client may be used, as well as paraphrased summaries.
O	**Objective –** Observable data or information supporting the subjective statement. This may include the client's physical appearance (e.g., sweaty, shaky, comfortable, disheveled, well-groomed, and well-nourished), vital signs, results of completed lab/diagnostics tests, and medications the client is currently taking or being prescribed.
A	**Assessment –** The counselor's or clinician's assessment of the situation, the session, and the client's condition, prognosis, response to intervention, and progress in achieving clinical goals/objectives. This should also include the list of problems documented on the Problem List (non-OTP settings) or Treatment Plan (OTP settings), including a diagnosis and/or a list of symptoms and information around a differential diagnosis.
P	**Plan –** The Plan of Care is based on the assessment and clinical information acquired.

The ***GIRP***, ***SIRP***, and ***BIRP*** Progress Note formats also record similar clinical information in a structured format. The information included in these Progress Note formats includes client goals/situation/ behavior, staff interventions used during the session, client response to the session, and the plan for future sessions or progress made toward resolving the problems documented in the Problem List (non-OTP settings) or the Treatment Plan (OTP settings). Like the SOAP note format, GIRP, SIRP, and BIRP notes provide a standardized structure for documentation that better ensures a comprehensive and consistent quality of care.

Table 20, Table 21, and Table 22 summarize the key components of GIRP, SIRP, and BIRP Progress Notes, although a full review of these standardized formats is beyond the scope of this document. Providers should refer to additional resources for detailed information.

For clients with multiple health problems, the problems can be numerically prioritized according to severity and treatment need in the plan section for the respective Progress Note format.

Table 20: GIRP Progress Note Format

G	**Goal –** Client's current focus and/or short-term goal, based on the assessment and Problem List (non-OTP settings) or Treatment Plan (OTP settings).
I	**Intervention –** Provider's methods used to address the client's statements, the provider's observations, and the treatment goals and objectives.
R	**Response –** The client's response to intervention and progress toward individual plan goals and objectives.
P	**Plan –** The Plan of Care moving forward, based on clinical information acquired and assessment.

Table 21: SIRP Progress Note Format

S	**Situation –** Client's presenting situation at the beginning of the intervention. It may include counselor/clinician observations, the client's subjective report, and the intervention setting.
I	**Intervention –** Provider's methods used to address the client's statements, the provider's observations, and the treatment goals and objectives.
R	**Response –** The client's response to intervention and progress toward individual plan goals and objectives.
P	**Progress –** The progress made toward treatment goals and objectives and the plan for future interventions as determined by the clinical picture.

Table 22: BIRP Progress Note Format

B	**Behavior –** Client statements that capture the theme of the session and provider observations of the client. Brief statements as quoted by the client may be used, as well as summaries that closely adhere to client statements. Provider observations may include the physical appearance of the client (e.g., sweaty, shaky, comfortable, disheveled, well-groomed, well-nourished, etc.), vital signs, results of completed lab/diagnostics tests, and medications the client is currently taking or being prescribed.
I	**Intervention –** Provider's methods used to address the client's statements, the provider's observations, and the treatment goals and objectives.
R	**Response –** The client's response to intervention and progress toward individual plan goals and objectives.
P	**Plan –** The Plan of Care moving forward, based on clinical information acquired and assessment.

Residential Progress Notes

Residential Progress Notes can be documented either by individual encounter or as daily summaries. Documenting by encounter involves recording each service or activity a client participates in as it occurs within the residential setting. Alternatively, daily documentation entails summarizing all services and activities the client engages in over the course of a day.
Regardless of the method used, Residential Progress Notes need to include details about the service or

activity, how it supports the client's progress toward care goals, attendees, the start and end times of both the service/activity, and any relevant information about the client's response. Progress Notes need to be signed or initialed by the LPHA or counselor responsible for the service, with signatures placed adjacent to each other when both are required.

SAPC recommends documenting by encounter due to the difficulty of capturing all services and activities within a day, especially with multiple staff members involved. Encounter-based documentation can be more efficient than daily summaries, which often require extensive tracking. However, the minimum requirement is daily documentation of Residential Progress Notes in residential settings. If notes are written for each encounter, a daily summary is not necessary.

A Medical Necessity Justification Progress Note is essential for documenting medical necessity. This note should concisely explain how the client meets the criteria for the requested LOC, including details about the client's SUD history, current clinical condition, and treatment progress. Progress Notes need to be finalized by a diagnosing LPHA or LE-LPHA staff.

Discharge Summary and Transfer

Provider agencies need to submit discharge or transfer summaries to SAPC when clients are discharged or transition care. These summaries document the treatment episode, discharge reason, overall prognosis, follow-up plans, and other essential details for effective Care Coordination and high-quality SUD service delivery. In Sage, the Discharge and Transfer Form need to be submitted by all treatment providers, both Primary and Secondary Sage Users, when:

- A client is stepping up or stepping down between residential LOC **or** between OP LOC (e.g., ASAM level 2.1 to level 1.0); **or**
- A client is being discharged from any LOC (e.g., they are not stepping up or down to other LOCs).

The Recovery Bridge Discharge form is required to be completed in Sage by all providers on the same day of discharge from the client's RBH stay.

Both the Discharge and Transfer Form and the Recovery Bridge Discharge form need to be completed within Sage, as it is used in reports to calculate current active clients and length of stay.

Complaints/Grievances and Appeals Processes

The complaint/grievance and appeals processes are available for clients, their authorized representative, or providers acting on behalf of the client ("involved parties"). A complaint is the same as a grievance.

An "appeal" refers to a request to review an "action," which may include:

- Denial or limited authorization of a requested service, such as the type or level of services;
- Denial, suspension, or termination of a previously authorized service; **or**
- Denial, in whole or in part, of payment for a service.

A “grievance” or complaint involves expressing dissatisfaction with any matter other than an action described above. It may also include situations where the client's participation in filing a formal appeal is not feasible. Common grievance subjects include, but are not limited to:

- Quality of care or services provided;
- Timeliness of service provision or interpersonal issues, such as provider rudeness; **or**
- Failure to respect client rights.

Involved parties can contact SAPC-CCD to discuss their concerns, often resolving issues through informal discussions. If informal resolution is insufficient, a formal complaint, grievance, or appeal may be necessary. Oral inquiries about appeals are treated as formal appeals to establish an early filing date but need to be confirmed in writing unless expedited resolution is requested. Complaints, grievances, and appeals are processed by SAPC-QI, SAPC-UM, SAPC-FSD, or SAPC-CCD, depending on the nature of the issue and the responsible unit. SAPC will assist clients in completing forms and navigating procedural steps, including providing interpreter services and toll-free numbers with TTY/TTD and interpreter capabilities.

Provider agencies need to have clear and transparent policies and procedures for managing complaints, grievances, and appeals. These processes should be integrated into the agency's QI efforts and include signage informing clients of their rights to file grievances with SAPC, DHCS Office of Civil Rights, and the United States Health and Human Services Office of Civil Rights.

Clients, their authorized representatives, or providers with the client’s written consent can file complaints, grievances, and appeals. Involved parties may review and respond to evidence provided by QI and UM staff, and challenge denials of DMC eligibility verification or service authorizations for LOCs.

Complaint/Grievance Process

All provider agencies are required to maintain a clear, accessible, and up-to-date complaint and grievance policy in alignment with BHIN 25-015. This policy needs to be readily available to members and include instructions for submitting a complaint or grievance, description of the provider’s internal grievance process, including any timelines or escalation steps (e.g., arbitration), and contact information for both the provider and SAPC for submitting complaints.

SAPC expects providers to play an active role in addressing and resolving complaints that arise at the agency level, including making a good faith effort to resolve concerns before they escalate to SAPC. For certain complaints – particularly lower-severity or interpersonal concerns – SAPC may direct the client back to the provider to complete the agency’s internal grievance process prior to SAPC intervention. This is permissible as long as:

- The provider’s process is active, documented, and accessible;
- The client’s rights to access SAPC or DHCS grievance systems are upheld; **and**
- SAPC monitors the outcome to ensure the issue is addressed within regulatory timelines.

Complaint/Grievance Submission and Provider Role

Clients may file a complaint or grievance directly with the provider agency or SAPC. Provider agencies need to accept grievances verbally or in writing, including by phone, email, fax, or in person. Complaints may be submitted by the client, an authorized representative, or a provider acting on the client's behalf (with consent). For additional information regarding the grievance timelines, see **Table 24**.

Providers are required to:

- Accept and assist with grievances submitted at their sites, if requested;
- Make forms and submission instructions available at all service locations;
- Distinguish between inquiries and grievances, and respond accordingly;
- Respond to low-level complaints in a timely, professional, and respectful manner; **and**
- Maintain clear documentation of all grievances in an internal log.

Provider-Led Resolution (Level 1-2 Complaints/Grievances)

Providers may resolve a complaint or grievance internally, without SAPC involvement, only if all of the following conditions are met:

1. The issue is resolved to the member's satisfaction by the close of the next business day.
2. The issue does not involve an Adverse Benefit Determination.
3. The resolution is documented in the provider's internal grievance log.

Level 1 complaints/grievances do not require SAPC acknowledgement or a written Notice of Grievance Resolution (NGR) but need to be reported to SAPC on a quarterly basis. This ensures SAPC can monitor for trends and follow up on patterns over time.

SAPC-Directed Resolution (Level 3)

For complaints or grievances that:

1. Cannot be resolved to the client's satisfaction by the next business day
2. Are submitted in writing (email, mail, fax)
3. Involve clinical concerns, safety issues, failure to provide TGI-inclusive care, or Adverse Benefit Determinations

Provider agencies need to notify SAPC within one (1) business day of receipt of the grievance. SAPC will lead the formal resolution process, including written acknowledgements and NGR issuance using DHCS-approved templates. Providers are expected to:

1. Participate in the resolution process;
2. Submit all relevant documentation within ten (10) business days of resolution to ensure SAPC can comply with the 30-calendar-day deadline required by DHCS.

SAPC Oversight and Referral Back to Provider

SAPC may receive complaints that could reasonably be addressed by the provider using their internal grievance process. In these cases – typically involving Level 2 complaints – SAPC may refer the client back to the provider to complete the internal process, up to and including arbitration.

SAPC will retain oversight of the complaint and expects providers to:

1. Follow their internal policy and complete resolution within regulatory timelines.
2. Notify SAPC of the resolution or escalation within 10 business days.
3. Provide documentation of steps taken.
4. Redirect the client back to SAPC if they remain dissatisfied after the provider's internal process is complete.

This approach allows providers to remain the first line of resolution for concerns that originate at their site, while ensuring SAPC compliance with all DHCS reporting requirements.

Table 23: Complaint and Grievance Triage (SAPC Levels)

SAPC Level	Description	Handled By
Level 3	High-priority concerns such as abuse, neglect, discrimination, serious legal violations, or safety risks	SAPC-led investigations
Level 2	Access delays, interpersonal or communication concerns	SAPC resolution with provider support
Level 1	Low-priority or administrative issues resolved to the member's satisfaction within one (1) business day.	Provider resolved and logged (no NGR)

Reporting and Documentation Requirements

Provider agencies need to maintain an internal grievance log that includes all complaints received, dates received, issue summary, resolution and outcome. This log needs to be made available to SAPC upon request.

For Level 2 complaints/grievances:

- These need to be reported to SAPC immediately, within one (1) business day or receipt.
- Provider agencies need to assist in resolution and submit relevant documentation within ten (10) business days of resolution to allow SAPC to meet the 30-calendar day DHCS deadline.
- SAPC is responsible for issuing all required written responses using DHCS-approved templates.

For Level 3 complaints/grievances:

- These may be resolved internally by the provider, without SAPC involvement, if resolved to the client's satisfaction by the close of the next business day and not related to an Adverse Benefit Determination.
- These need to be logged and report to SAPC on a quarterly basis using the SAPC Grievance Summary Template.

Clinical Complaint/Grievance Review

Staff handling complaints or grievances will not have been involved in previous reviews or decisions related to the issue. Decision-makers have the appropriate clinical expertise to ensure fair and informed outcomes.

Complaints involving clinical matters will be reviewed by licensed clinical staff within SAPC-QI and SAPC-UM. These staff members will:

- Work with the involved parties (clients, providers) to gather facts.
- Conduct further investigation if necessary, such as contacting the treating provider.

Every attempt will be made to achieve a satisfactory resolution for the client.

- Clinical complaints/grievances will be addressed as a component of the QI activities within the SAPC-QI and SAPC-UM sections. Depending on the nature of the complaint/grievance, this may trigger more targeted follow-up at the provider level.

Appeals

An appeal is a request to review a decision related to an Adverse Benefit Determination (NOABD). For a full list of NOABD actions, see **Table 25**.

Involved parties can contact SAPC-CCD to discuss their concerns, often resolving issues through informal discussions. If informal resolution is insufficient, a formal complaint, grievance, or appeal may be necessary. Oral inquiries about appeals are treated as formal appeals to establish an early filing date but need to be confirmed in writing unless expedited resolution is requested. Complaints, grievances, and appeals are processed by SAPC-QI, SAPC-UM, SAPC-FSD, or SAPC-CCD, depending on the nature of the issue and the respective unit's responsibility. SAPC will assist clients in completing forms and navigating procedural steps, including providing interpreter services and toll-free numbers with TTY/TTD and interpreter capabilities.

Provider agencies need to have clear and transparent policies and procedures for managing complaints, grievances, and appeals. These processes should be integrated into the agency's QI efforts and include signage informing clients of their rights to file grievances with SAPC, DHCS Office of Civil Rights, and the United States Health and Human Services Office of Civil Rights.

Clients, their authorized representatives, or providers with the client’s written consent can file complaints, grievances, and appeals. Involved parties may review and respond to evidence provided by QI and UM staff, and challenge denials of DMC eligibility verification or service authorizations for LOCs.

Table 24: Grievance Timeline

<table>
<tr><td colspan="4">GRIEVANCE
Any complaint or expression of dissatisfaction about any matter (other than Adverse Benefit Determination)
Quality of care or services provided.
Aspects of interpersonal relationships (i.e., staff rudeness of miscommunication).
Delays in services or scheduling
Violation of client rights or discriminatory treatment</td></tr>
<tr><td colspan="2">Time of Filing</td><td colspan="2">Member/provider/authorized representative may file verbally or in writing at any time.</td></tr>
<tr><td colspan="2">Written Acknowledgment of Receipt</td><td colspan="2">Within five (5) calendar days of receipt unless the grievance is resolved to the member's satisfaction by the close of the next business day. Acknowledgement needs to include:
Date received; and
Contact info of County staff client may contact (Date received/ Name/ Phone/ Address</td></tr>
<tr><td colspan="2">Resolution:
Written Decision Notification</td><td colspan="2">May not exceed 30 calendar days from the date of initial grievance. A decision may not exceed 30 calendar days when the grievance is related to disputes of the County's decision to extend the timeframe for making an authorization decision.
NGR needs to include:
Decision date and result
Clear, concise reason for decision
Reviewer contact info
Fair hearing
Exemption
Written Notification is <u>not required</u> if:
Complaint received verbally (phone/in-person); and
Resolved (to member satisfaction) by close of next business day.</td></tr>
<tr><td rowspan="2">Extensions
(not to exceed 14 calendar days)</td><td>Initiated by</td><td>Member</td><td>County
ONLY when delays due to the need for additional information AND is in the client's best interest.</td></tr>
<tr><td>Written Notice</td><td>N/A</td><td>Requires:
Prompt verbal notice of delay; and
NOABD Grievance/Appeal Delay Resolution template sent within 2 calendar days of decision to extend.
Resolution may <u>not exceed</u> 14 days.
Exemptions <u>do not apply</u> when a dispute is related to an Adverse Benefit Determination that is resolved by the next business day. It needs to be in writing and logged.</td></tr>
<tr><td colspan="2">"APPEAL"
No appeal for grievances only additional actions</td><td colspan="2">If the client is dissatisfied with the results of the grievance, they may file another grievance; or
Submit grievance to the State Medi-Cal Managed Care Ombudsman office.</td></tr>
</table>

Notice of Adverse Benefit Determinations

A Notice of Adverse Benefit Determination (NOABD) is a formal letter sent to a Medi-Cal member when the Plan or, in certain cases, the Provider Agency acting on behalf of the Plan, takes specific actions that affect a member's services or benefits. These notices are governed by federal and state regulations to standardize the process and protect members rights.

When an NOABD Is Issued

A NOABD needs to be issued for any of the following actions:

1. Denial or limited authorization of a requested service
2. Reduction, suspension, or termination of a previously authorized service (if the member disagrees)
3. Modification of a service request with approval of an alternative
4. Partial or full denial of payment for a service
5. Failure to provide services in a timely manner
6. Failure to make authorization decisions in the required timeframe
7. Failure to resolve grievances or appeals within required timeframes
8. Denial of a request to dispute financial liability

Note: NOABDs ONLY apply to Medi-Cal members.

Purpose of the NOABD

The NOABD informs members in writing of their rights under the Medi-Cal program, and need to include the following:

1. The reason for the decision
2. The member's right to appeal
3. How to request a State Fair Hearing
4. The right to continue receiving benefits during the appeal process (if applicable)

NOABD Templates and Requirements

DHCS provides standardized NOABD templates that:

1. Need to not be modified (unless SAPC or DHCS policy is permitted to provide additional detail)
2. Are required to include:
3. The Your Rights attachment
4. Member Non-Discrimination Notice
5. The Language Assistance Taglines

NOABD Issuance

Multiple SAPC units are involved in issuing or reviewing NOABDs. Decision-makers are not incentivized to deny services.

Provider Agency Roles and Responsibilities in NOABD Issuance

Provider agencies need to:

1. Support clients who receive NOABDs by explaining their rights and guiding them on next steps
2. Issue provider-initiated NOABDs when:
3. A previously authorized service is terminated
4. There is a failure to provide services in a timely manner
5. Include the following three required attachments with each provider-issued NOABD:
6. Your Rights attachment
7. Non-Discrimination Notice
8. Language Assistance Taglines
9. Track and report all NOABDs by completing the NOABD/Appeal/Grievance Log and submitting it to SAPC quarterly

For NOABD timelines and procedures, see **Table 25**. Approved NOABD templates and related materials are available on the SAPC website: SAPC's Manuals, Bulletins, and Forms – Clinical Tab webpage.

Appeals Process

The Appeals Process allows Medi-Cal members, their authorized representatives, or providers (with written consent) to request reconsideration of adverse benefit determinations made by SAPC staff or providers. These determinations may involve:

1. Denials of DMC benefit verification
2. LOC decisions
3. Payment for services

Note: The appeals process ensures that Medi-Cal members have the opportunity for a full and fair review of adverse decisions.

Filing an Appeal

An appeal may be filed by:

1. Clients, their authorized representatives, or providers (with the client's written consent)
2. Submitting a completed Appeal Request Form (signed by the client) to SAPC, either electronically or via fax, within 60 calendar days from the date of the NOABD.
3. Oral appeals are accepted but need to be followed by a written and signed appeal unless an expedited resolution is requested.

Note: If the appeal is filed without the client's involvement (e.g., no written consent), the appeal needs to include an explanation as to why the client could not participate. If client involvement is not documented, the appeal will be treated as a complaint or grievance.

Available SAPC Assistance

1. Assist the client in completing appeal forms and other procedural steps, including preparing a written appeal.
2. Notify the client of the location of the appeal forms on the Plan's website or provide forms upon request.
3. Assist in requesting continued benefits during the appeal of an adverse benefit determination.

Appeal Review

1. Upon receipt, SAPC-QI staff will log the appeal and send a receipt notification to the requesting party within the timeframes outlined in **Table 25**.
2. SAPC-QI Clinical staff will investigate the initial denial, potentially contacting the treating provider, reviewing the ASAM criteria, and using relevant clinical resources.
3. Clients will be given a reasonable opportunity to present evidence and arguments—both in writing and in-person.

Appeal Timeframes and Extensions

After reviewing all case information, a final decision will be made. The rationale and outcome will be communicated to the appealing party within the timeframes outlined in **Table 25**. If additional information is needed, SAPC may request an extension of up to 14 calendar days to resolve the appeal, if it is in the client's best interest.

Notice of Appeal Resolution (NAR)

A Notice of Grievance Resolution (NGR) will be provided, and need to include:

1. Date and outcome of the appeal
2. Reasons and rationale for the decision (including criteria/clinical guidelines or policies used, if the appeal is denied)
3. Contact information for the reviewer
4. Information on the State Fair Hearing process and the client's right to continue benefits during the hearing process.

Note: If the appeal is denied, the client will be informed of their right to request a State Fair Hearing and how to do so, including their right to continued benefits during the appeal process.

Expedited Appeals

- **Expedited Appeal Request:** If the client's life, health, or functional status could be seriously jeopardized by waiting for a standard resolution, an expedited appeal can be requested. SAPC will process the appeal accordingly and notify the SUD treatment provider within the timeframe outlined in **Table 25**.
- **Residential Authorizations:** Appeals for initial Residential Authorizations and WM follow an expedited appeal timeframe, whereas residential reauthorizations follow the standard appeal timeframe.

Continued Benefits During the Appeal

The client will continue receiving benefits during the appeal process if the appeal involves:

1. Termination, suspension, or reduction of a previously authorized treatment plan;
2. Services were ordered by an authorized provider; **and**
3. The client or their representative requests continued benefits during the appeal.

Conditions for Continued Benefits:

Benefits continue until one (1) of the following occurs:

1. The client withdraws the appeal.
2. A State Fair Hearing issues an unfavorable decision.
3. The time or service limits of a previously authorized service are met.

Potential Outcomes

1. If the appeal results in an unfavorable decision (e.g., the denial is upheld), SAPC may seek to recover the cost of services provided during the appeal period—if those services were provided solely due to the pending appeal.
2. If the appeal results in a favorable decision (e.g., services are approved), SAPC will authorize and promptly provide the services.
3. If a State Fair Hearing overturns a denial, SAPC is required to cover the cost of services provided during the appeal.

Note: SAPC will not dismiss or delay an appeal resolution even if written confirmation of the appeal is not received.

Client Access to Case Information

Before and during the appeals process, the client and their representative should have access to the following:

1. Case file, including medical records
2. Any other documents and records considered during the appeals process

Quality Improvement and Follow Up

- **Appeals Trends:** The Quality Improvement and Risk Management Committee will review trends in the appeals process during their bimonthly meetings to identify areas needing improvement.
- **Learning Opportunity:** Concerns that arise during the appeals process will be discussed with SUD treatment providers and may lead to corrective actions, aimed at improving the system of care for SUD services.

Contact Information

For any questions or additional assistance regarding the appeals process, contact:

County of Los Angeles
Department of Public Health
Substance Abuse Prevention and Control Bureau
Office of the Medical Director and Science Officer (OMDSO)
1000 South Fremont Avenue, Building A-9 East, 3rd Floor
Alhambra, California 91803
(626) 293-2846

Note: Clients who have exhausted the Complaint/Grievance and Appeals process may request a State Fair Hearing with DHCS.

Table 25: Notice of Adverse Benefit Determination and Appeals Process Timeline

Type of Action	Notification Requirements	Responsible Party for Notification	Appeals *Member/provider/authorized representative MUST file within 60 days of NOABD[26]*				State Fair Hearing *Members must exhaust the appeal process prior to requesting*
			Written Acknowledgment of Receipt	Appeal Resolution (Standard)	Appeal Resolution (Expedited)	Extension (max. 14 calendar days)	
Termination Suspension or Reduction of previously authorized service	**CLIENT** in writing (mail) at least 10 days before the effective date of the action **using NOABD[27] Template & attachments** (Exceptions 42 CFR 431.213 and 431.214)	**PROVIDER AGENICIES**	Postmarked within 5 calendar days of appeal receipts. • Date received • Contact info of County staff client may contact (date received, name, phone, address)	May not exceed 30 calendar days from receipt of appeal. **NAR & attachments template** 1. Upheld NAR; **or** 2. Overturned NAR*	Resolved as expeditiously as health condition requires, but no longer than 72 hours after request. 1. **Request Denied** • Prompt Oral notice • Written Notice within 2 calendar days of decision. Applicable NOABD; reverts to standard	1. Initiated by Member 2. Initiated by County ONLY due to need for more information AND in best interest of client. County needs to provide: • Prompt Oral Notice • NOABD Grievance/ Appeal Delay Resolution	Member needs to request within 120 days of NAR or County failure to adhere to requirements. **Standard Hearing:** County needs to notify members that the State must reach its decision within 90 calendar days of date or request for hearing. **Expedited Hearing:** County needs to notify member that the

[26] Oral Appeals – see oral appeals bullet point in *Appeals Process* section.
[27] NOABD must include: 1) adverse benefit determination the County has made/plans to make; 2) clear explanation of the reasons for the determination, including clinical reasons if it involves medical necessity criteria, specifying why the member's condition does not meet the criteria; 3) description of criteria used; 4) member's right upon request and free of charge to access to and copies of all documents/records related to Adverse Benefit Determination.

Type of Action	Notification Requirements	Responsible Party for Notification	Appeals *Member/provider/authorized representative MUST file within 60 days of NOABD*[26]				State Fair Hearing *Members must exhaust the appeal process prior to requesting*
			Written Acknowledgment of Receipt	Appeal Resolution (Standard)	Appeal Resolution (Expedited)	Extension (max. 14 calendar days)	
					resolution time (30 days) 2. **Request Approved Resolve** within 72 hours or request 14-day extension. • Upheld NAR[28] • Overturned NAR* - If resolved wholly in favor of member	template & attachments Sent in 2 calendar days of decision to extend.	State must reach its decision within 3 days of the request. **Overturned Hearings**: County shall authorized/ provide disputed services as expeditiously as health condition requires, but no later than 3 working days.
Failure to Provide Services in Timely Manner	**PROVIDER** via fax/phone within 24 hours of decision. **CLIENT** in writing within 2 business days of the decision **NOABD Template & attachments**	**SAPC & PROVIDER AGENCIES**					
• Denial of authorization (residential) **• Denial of Payment** **• Failure to resolve grievance/ appeals** **• Denial of request to dispute financial liability**		**SAPC**					

** Plans need to authorize/provide services (not furnished during the appeal process) no later than 72 hours from the date it reverses the determination.*

[28] NAR – see *Appeals Process* section to see what must be included.

Risk Management and Reportable Incidents

Risk management involves strategies that aim to reduce the likelihood of adverse outcomes or losses while promoting positive opportunities. Effective risk management enhances the quality of client care, lowers the chance of harm, and helps limit the liability of healthcare providers. Strong risk management practices are grounded in established standards of care, quality improvement efforts, and the systematic collection, analysis, and use of data.

Risk Management Committee at the Provider Level

Risk management strategies are becoming increasingly important in an evolving healthcare landscape, including the specialty SUD system. As a result, each treatment provider agency providing services within the specialty SUD system is responsible for having a Risk Management Committee.

The functions and responsibilities of providers' Risk Management Committees need to be systematic and ongoing to include appropriate and timely responses for addressing areas of concern or deficiency. The goals and activities of the provider Risk Management Committees should:

- Assure the implementation of an agency-wide risk management strategy that includes developing policies and procedures and subsequent staff training on QI, fire safety, disaster preparedness, hazard reporting, etc.
- Assure a review, tracking, and documentation system for all reportable incidents, including follow-up and implementation of any corrective action until follow-up is no longer indicated.
- Provide thorough investigation on all reportable incidents, which need to be reported to SAPC.
- Investigate adverse events, as necessary and appropriate.
- Review safety and incident-related data and identify trends and patterns associated with risks or identify problem areas.
- Establish processes to maintain service/billing integrity and quality care, including implementation of peer review processes and QIPs.
- Promote QI activity by identifying opportunities to maximize the safety of the physical and therapeutic environment and reduce agency, staff, and client risks.
- Develop procedures to detect and prevent fraud, waste, and abuse.

Adverse Events

Adverse events are defined as incidents that directly or indirectly impact the community, clients, staff, and/or the SUD treatment provider agency as a whole and are required to be investigated and evaluated at the provider agency level. This information should be used on a routine basis to improve accessibility, health and safety, and address other pertinent risk management issues.

Reportable Incidents

Reportable incidents are client safety events that result in death, permanent harm, and/or severe temporary harm, and/or intervention required to sustain life. Provider agencies are required to report provider-preventable conditions in accordance with MHSUDS 17-046 and the Reporting Form (DHCS 5261).

Reportable incidents need to be investigated by the provider's Risk Management Committee and need to be reported to the SAPC Quality Improvement and Risk Management Committee immediately. These incidents may result in corrective actions and are viewed as learning opportunities to improve care and risk management processes.

Note: While reportable incidents need to be reported to the SAPC Quality Improvement and Risk Management Committee, adverse events and other risk management and quality-related issues may be reported to SAPC at the discretion of the leadership of the SUD treatment provider agency.

Section 5. PROVIDER QUALITY IMPROVEMENT EXPECTATIONS

Quality Improvement Expectations

Treatment providers within the specialty SUD system need to establish a culture and infrastructure to support Continuous Quality Improvement (CQI) to best serve their vulnerable client population. This focus on quality necessitates internal processes that support assessment, evaluation, identification of opportunities for improvement, and follow-up or action. The following describes the required QI processes that will facilitate this desired quality-focused culture and infrastructure at the provider agency level.

Peer Reviews

Provider agencies within the specialty SUD system need to incorporate peer reviews into their CQI activities and establish a formal process for regularly identifying processes or variations in care/services that may lead to undesirable or unanticipated events affecting clients or clinical care. The goal of the peer review process is to establish an educational and evaluative mechanism for providers to identify opportunities to improve care and services.

As part of the peer review process, SUD counselors and clinicians from various disciplines review their colleagues' client charts and provide feedback on the care recommended and provided in a professional and non-adversarial manner. Practitioners should conduct reviews within their appropriate scope of practice, and when possible, supervisors should review and follow up with counselors and clinicians to provide feedback based on the peer review process. Analyses of clinical decisions and practices should be based, as appropriate, on objective evidence drawn from relevant scientific literature, clinical practice guidelines, departmental historical experience and expectations, peer department experience and standards, and national standards.

The focus of these reviews may vary depending on needs determined by the provider agency and may highlight an individual event or aggregate data and information on clinical practices. However, at a minimum, peer reviews need to include:

- Review of diagnosis/diagnoses and assessment(s)
- Review of documentation clarity and organization
- Ensure Problem Lists (non-OTP settings) or Treatment Plans (OTP settings) are documented and updated accordingly
- Ensure documentation is signed by appropriate individuals

The quantity and frequency of reviews may also vary depending on needs determined by the provider An agency for each site, but no fewer than three (3) client charts for each counselor/clinician, need to be reviewed twice (2x) annually.

All records and information obtained during peer review functions should remain confidential and be used solely to review the quality and appropriateness of care for the purpose of improving practices.

Quality Improvement Projects

A QIP is a concentrated effort on an identified problem in one area of a provider agency. It involves systematically gathering information to identify and clarify issues or problems and intervening for improvements. A QIP aims to examine and improve care or services in high-priority areas that the agency identifies as needing attention, which will vary depending on variables including, but not limited to, the population served, workforce, and unique scope and capabilities of services provided. The QIP is not meant to replace other QIPs that organizations may already be using, which may be used or adapted to qualify as their QIP. Each provider is expected to be involved in a minimum of one (1) QIP at all times. SAPC staff will review treatment agency QIPs on an annual basis.

All QIPs should follow the CQI model and target improvement in relevant areas of clinical care, either directly or indirectly. Areas of focus may include improving access to and availability of services, improving continuity and coordination of care, improving the quality of specific interventions, enhancing service provider effectiveness, etc. Generally, a clinical issue selected for study should impact a significant portion of the client population served and potentially significantly impact health, functional status, or satisfaction. Over time, areas selected for improvement should focus on a broad spectrum of care and services.

Each provider agency must be involved in a minimum of one (1) QIP at all times.

QIPs will be reviewed on an annual basis by SAPC staff.

Performance Improvement Projects

Healthcare providers, including SUD providers, share the common goal of providing high-quality care. Performance Improvement Projects (PIPs) measure performance and outcomes. This helps organizations and providers understand how well they're meeting their quality care goal. It also allows for an analysis of where and what changes need to be made in the process of striving for continual improvement.

Metrics allow providers to understand what is working well so that others can learn from their success and what is not working well so that the necessary steps can be taken to seek improvement. The Performance Management System outlined in **Figure 2** provides a framework for how data from performance and outcome measures can be used for process improvement.

Performance and outcome measurement differ as follows:

- **Outcome measures** are used at the client level to examine substance use behaviors and psychosocial functioning changes. They are used to understand the effectiveness of treatment services in improving substance use and related functioning of individuals who have received treatment.
- **Performance measures** are used at the program level to evaluate how well a program is doing in achieving standards of quality. Performance measures can help identify where service problems exist, which programs are meeting or exceeding expectations of treatment quality, and what, if any, changes should be made to improve service delivery. They inform QI strategies aimed at changing *clinical practices* and *organizational cost management*.

Figure 2: Public Health Performance Management System

Source: Public Health Foundation. (n.d.). About the Performance Management System Framework. http://www.phf.org/focusareas/performancemanagement/toolkit/Pages/PM_Toolkit_About_the_Performance_Management_Framework.aspx.

Although performance and outcome measurement in the field of addiction is challenging due to the nuances of care that are not always easy to capture in metrics, performance and outcome metrics play a crucial role in moving the field ahead.

As a result, treatment providers operating within the specialty SUD system in LA County are required to input data into CalOMS/LACPRS, the electronic data collection system that resides within the Sage. **SUD providers are also required to have ongoing mechanisms for quality assessment and performance improvement.** These metrics help ensure that LA County has an evaluation system for its specialty SUD system, allowing for continuous improvement and high-quality clinical care at the system, provider, and client levels. As such, ensuring data integrity is of the utmost importance, and to the benefit of providers and clients, providers are required to develop internal processes to support data integrity efforts.

SAPC recognizes the importance of sharing performance and outcome data with its provider network and encourages providers to leverage available data analytic tools within Sage and their EHRs to allow for the detailed analysis of their provider- and client-level data. SAPC will also make every effort to provide metrics to assist providers in their CQI efforts.

Section 6. BUSINESS PROCESS STANDARDS

Contract Management

SAPC-CCD works with all contracted provider agencies to ensure full and accurate understanding and efficient management of their contract. This includes:

- Updating Provider's Contract
- Ongoing Compliance Monitoring
- DHCS Auditing and Corrective Action Plan (CAP) Support
- Contractual and Regulatory Technical Assistance

Additionally, SAPC-CCD is responsible for maintaining an avenue for new and existing DMC-certified providers to join the DMC-ODS provider network or add new services to their contract. To achieve this, SAPC-CCD develops and maintains a solicitation process that is fair, open, and reflective of the County's needs while setting a minimum standard of qualifications to ensure the highest level of treatment services for SUD clients.

Certification and Licensure Requirements

All contracted DMC-ODS LOCs and sites need to maintain the mandated certifications and licenses in accordance with State and County requirements; this includes when a Provider Agency seeks to add or expand services.

DMC-ODS Provider Qualifications

DMC-ODS services are provided to members by DMC-certified providers. DMC-certified providers offering these services need to:

- Be licensed, registered, enrolled, and/or approved in accordance with all applicable Federal and State laws and regulations;
- Abide by the definitions, rules, and requirements for stabilization and rehabilitation services
- established by DHCS; **and**
- Sign a provider agreement with the DMC-ODS county(ies) in which DMC-ODS services will be rendered.

DHCS DMC Certification Application

DMC certification is required for all treatment LOCs except RBH and RH. New providers to the network or current providers seeking to offer additional services under their existing contract need to apply for DMC certification. The link below provides information on the DMC certification application. Providers should note the following:

- DHCS is solely responsible for administering and processing the DMC certification process.
- Certification is site-specific. Providers should identify all sites where treatment is offered and ensure that the DMC certification application accurately reflects this information.
- Accuracy is key. Providers should make every effort to review their application for accuracy and completeness. The DMC certification process can be timely; a provider's careful attention may increase the likelihood of approval.

- All providers delivering Residential (ASAM 3.1, 3.3, 3.5) billed to DMC-ODS need to have either a DHCS LOC Certification and/or an ASAM LOC Designation.
- DMC-ODS residential treatment providers are subject to County verification of licensing by a state agency other than DHCS and need to also obtain an ASAM LOC Designation.

To access, Provider Application and Validation for Enrollment (PAVE), visit DHCH's DMC Application Information webpage.

Inpatient-Withdrawal Management (ASAM 3.7-WM and ASAM 4-WM)

A valid license from the California Department of Public Health (CDPH) is acceptable for DMC Certification of Chemical Dependency Recovery Hospitals (CDRHs) or freestanding Acute Psychiatric Hospitals (APHs). For additional information, visit CDPH's Licensing and Certification Program webpage.

DHCS AOD Certification

In accordance with BHIN 23-058, effective January 1, 2025, DHCS AOD certification is required for all OP services, except DUI and OTP. DHCS AOD certification is and will continue to be required for residential LOCs.

DHCS ASAM Designation

In addition to the DMC certification, all provider agencies need to have the appropriate ASAM designation on their AOD license. Much like the DMC Certification application process, this is a State-run process, and providers should be mindful to submit accurate and complete information to increase the likelihood their application is approved in a timely manner. For additional information, visit DHCS's Level of Care Designation webpage.

Updating Service Provider's Contract

Contracts may be updated to reflect changes at the Federal, State, and local levels that impact the delivery of SUD treatment. Contracts may be amended at the request of service providers who wish to update their organization's information or to update/add/remove services. For additional information, see SAPC IN 22-14 or the most recent version regarding Amendments.

SAPC Updates

These amendments may be implemented as a new contract or sent via SAPC Bulletin or IN. Providers will be notified of all pending changes in a timely manner and mandated to attend training or meetings on the new changes.

Service Provider Changes

Service Providers may wish to update, add, or remove services from their contracts to reflect organizational changes. For additional information on navigating the contract amendment process, see **Table 26**.

Table 26: Contract Amendment Process

Contract Action	When do I do this?	How do I do this?	How long does this take?
Funding Augmentation	Provider agencies should monitor their funding utilization and request any increases or decreases as needed. Funding augmentations are approved based on utilization, (providers need to have utilized at least 50% of their contracted allocation), performance, and community needs.	Provider agencies need to justify all requests with relevant data and supporting documentation and submit the request using the "Contract Amendment Form" in SAPC IN 22-14 or the most recent version regarding Amendments. All required and applicable fields of the Contract Amendment Form need to be completed, and appropriate justification, documentation, and attachments need to be provided that support the need for additional services and/or sites. Agencies are advised to provide a budget summary and narrative if they submit a funding augmentation request.	3 to 4 months
Add/Remove Services or locations	Providers may request to add or remove services (including adding beds) based on new certification or as a result of organizational changes. SAPC reserves the right to approve or deny any request for additional sites and/or services based on the provider's performance or in the interest of the County.	The same information is listed above.	2 to 3 months
Update Staff Names	As part of the contract, providers are required to notify SAPC of any program leadership changes. Staff may be subject to credentialing requirements.	Notify SAPC in writing of the new staff and describe their role and title. If staff are required to be credentialed, the provider should also include the required documents. Requests can be sent to SAPCMonitoring@ph.lacounty.gov and your assigned CPA.	1 month
Other Changes	Much of the service provider's information is entered into a database. To ensure the most current and accurate information, any organizational changes should be reported to SAPC.	Notify SAPC in writing of any organizational changes. Requests can be sent to SAPCMonitoring@ph.lacounty.gov and your assigned CPA.	Varies

Required Information

Provider agencies need to justify all requests with relevant data supporting the need for additional services or sites. The request need to include:

- Needs assessments showing how requested service/capacity increases better address community needs.
- Supporting evidence demonstrating that the existing network capacity does not meet community needs.
- Documentation and history of serving high-risk and/or special populations (if relevant to the request).
- Any other pertinent information supporting the requested change to the contract or agreement.

Ongoing Compliance Monitoring

As the steward of taxpayer funds and SUD treatment in LA County, SAPC is mandated to ensure treatment is delivered appropriately, effectively, and in accordance with contractual, Federal, State and local requirements. To meet these requirements, all Provider Agencies are subject to several types of monitoring, including:

- SAPC Compliance Monitoring;
- State Monitoring; **and**
- County Fiscal Monitoring.

SAPC Compliance Monitoring

SAPC-CCD conducts ongoing compliance visits with providers to ensure full and appropriate understanding and application of contractual, Federal/State/local requirements. Each Provider Agency is assigned a Contract Program Auditor (CPA), who serves as the primary point of contact for most non-clinical matters. This relationship is collaborative and intended to support compliance and continuous improvement. collaboration and partnership. The CPA conducts compliance checks and works with the service provider to correct any identified non-compliance issues. SAPC-CCD also works with SAPC-QI to conduct a clinical review of documentation. Major compliance activities include:

- **Personnel Review:** A comprehensive collection and review of the provider's staff records, including documents related to credentialing.
- **Administrative Review:** A collection and review of the provider's policies and procedures, protocols, licenses, certifications, or any other administrative documents.
- **Documentation Review:** A review of mandated client chart files, including authorization documentation, assessment notes, Progress Notes, including whether addiction medications were offered as a component of treatment, Problem Lists (non-OTP settings) and Treatment Plans (OTP settings), ROI authorization forms, acknowledgments, and other mandated documentation.
- **Client Interview/Activity Observations**: SAPC-CCD staff will contact clients and/or observe treatment activities to assess and confirm the delivery of treatment services.
- **Compliance with Training Requirements and All Treatment Provider Meetings:** SAPC-CCD staff will monitor provider agencies' participation in required trainings, including trainings related to CalAIM changes, and the All Treatment Provider Meetings; that requires the in-person attendance of at least one (1) agency representative at the Executive Leadership level.
- **Grievance/Complaint Review:** SAPC-CCD staff will investigate all submissions to SAPC to reach a determination and work with the provider to resolve any identified issues.
- **Other compliance activities:** SAPC will implement ongoing monitoring activities to assess quality, determine compliance, and confirm the delivery of services as contractually required. These activities include, but are not limited to, data review, key staff interviews, and facility inspections.

If deficiencies are identified, the CPA will work with the provider to develop and implement a CAP to resolve them. In accordance with regulations governing the use of taxpayer funds, certain deficiencies may necessitate the repayment of funds to the County. If repayment is necessary, the CPA can assist in developing and implementing a repayment plan. SAPC will disallow or recover payments for any services when fraud, waste, or abuse is identified, including situations where there is intent to commit fraud, waste, or abuse. As required by the State, SAPC-CCD will report any suspected fraud, waste, or abuse to DHCS.

State Monitoring

DHCS also conducts audits of treatment providers under AOD licensing and DMC Certification requirements. These audits may include Fiscal Reviews and Post Services/Post Payment reviews. SAPC-CCD will work with the Provider Agency to support the resolution of any audit findings, including CAP development and implementation. In addition to State audits, Provider Agencies that receive $750,000 or more in federal funding annually also need to submit a Single Audit report to the State.

County Fiscal Monitoring

SAPC partners with the County Auditor-Controller to conduct mandated fiscal monitoring. Fiscal monitoring involves reviewing the Provider Agency's financial records to verify compliance with the financial aspects of the contract and generally accepted accounting principles. Fiscal compliance reviews continue to be a requirement in accordance with County and funding policies, and they are a critical tool for supporting the effective management of funds, including verifying their appropriate use. Compliance requirements remain in effect and are not affected by changes at the state level resulting from CalAIM. Fiscal monitoring will review financial records annually, but for the prior closed FY. Fiscal monitoring focuses on the following areas:

- **Accounting Records:** To review overall contractor operations
- **Cash Position:** To determine if the contractor is fiscally viable
- **Financial Condition:** To verify that the contractor maintains a positive working capital position
- **Billing/Expenses:** To confirm the accuracy of service units and operating expenses
- **Payroll:** To ensure staffing is appropriate and payroll taxes are not delinquent

Provider Agencies are encouraged to collaborate with their accounting teams to establish strong internal systems that support accurate financial tracking and documentation. Key areas to address include:

- Cost Allocation Plan
- Ensure all expenditures are supported with adequate and acceptable documentation
- Internal Controls
- Accounting and Financial Reporting
- Fiscal Viability

Contracted Provider Agency and Staff Credentialing

SAPC-CCD will work with all treatment providers to credential and re-credential all providers and their staff. In accordance with MHSUDS 18-019 provider agencies need to submit an attestation as part of the contracting process. For additional information, see the most current version of the Prospective DMC Contract Application published on SAPC's website.

- Appropriate licenses, registrations, certifications
- History of loss of license or felony conviction
- Evidence of completed required education and training, including medical residency and ongoing education, if applicable
- Work history
- Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation

- Hospital and clinic privileges in good standing
- History of any suspension or curtailment of hospital and clinic privileges
- History of loss or limitation of privileges or disciplinary activity
- Current DEA identification number
- National Provider Identifier number
- Current malpractice insurance in an adequate amount, as required for the particular provider type
- History of liability claims against the provider
- Provider information, if any, entered in the National Practitioner Data Bank webpage, when applicable.
- History of sanction, termination from Medicare and/or Medicaid/Medi-Cal providers, or who appear on the Suspended and Ineligible Provider List webpage, may not participate in the Plan's provider network.
- History of sanctions or limitations on provider's license issued by any state agency or licensing board
- A lack of present illegal drug use
- The application's accuracy and completeness.

Staff Vaccination Requirements

SAPC providers should adhere to the latest SAPC Bulletins or INs describing COVID-19 testing and vaccination requirements.

Protected Health Information Requirements

All provider agency staff who access or assist with the disclosure of PHI or Personally Identifiable Information (PII), or who provide direct services to clients, need to complete the following before gaining access or starting client work:

- Complete a criminal background check through the California Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI), including fingerprint-based Live Scan submission.
    - Each provider agency needs to implement a protocol to ensure background checks are conducted before employment begins.
    - The criminal background check is processed through a qualified Live Scan vendor.
    - Records are retained for three (3) years after the individual leaves the organization.
    - ***Note for Youth Providers: All staff (including volunteers, interns, and contractors) who work with minors need to complete DOJ/FBI fingerprint-based Live Scan checks and enroll in the DOJ Subsequent Arrest Notification service. Youth providers need to include DOJ/FBI clearances for their staff.***
- Be enrolled in the DOJ's Subsequent Arrest Notification service for the duration of their employment.
- Complete annual information security and privacy training.
    - Each provider agency needs to implement protocol to ensure annual training completion.
    - Provider agencies need to maintain training records for compliance monitoring purposes.
- Sign an annual confidentiality statement acknowledging their responsibilities related to the protection of PHI/PII.
    - Each provider agency needs to have a process to ensure statements are completed and signed annually.
    - Signed statements are retained for six (6) years following contract termination or staff separation.

Contractual, Programmatic, Fiscal, and Regulatory Technical Assistance

Understanding all the regulations that govern services is critical to implementing a successful program. SAPC-CCD staff work with providers agencies to ensure understanding and appropriate implementation of all contractual and regulatory requirements. Additionally, SAPC-CCD and SAPC-QI teams monitor agencies' programmatic compliance with agency contracts and the most recent version of the Provider Manual. Service providers should contact their CPA with any questions or request technical assistance.

Regulations to be familiar with:

- Contract/Agreement with SAPC
- Substance Use Disorder Treatment Services Provider Manual (this manual)
- CCR Title 22 & CCR Title 9
- DHCS BHINs
- Certification Standards (DMC and AOD)
- DHCS's Adolescent Substance Use Disorder Best Practices Guide (October 2020)
- HIPAA & 42 CFR Part 2
- 42 CFR Part 438
- Federal Register
- Special Terms and Conditions (STCs) of the DMC-ODS waiver
- Los Angeles County Auditor-Controller's Contract Accounting and Administration Handbook
- Los Angeles County Auditor-Controller's County Fiscal Manual
- DHCS's Substance Use Disorder Perinatal Practice Guidelines (August 2024) (Contracted Perinatal Programs)
- CMS - Provider Reimbursement Manual
- DHCS DMC Billing Manual

SAPC Provider Policy Requirements

In accordance with the County's State contract, providers are mandated to develop and implement policies to ensure adherence to laws and guidelines that regulate SUD treatment. In addition to those mentioned throughout this manual, below is a partial list of policies that providers are required to have:

- **Record Retention:** Ensure both clinical administrative and financial records.
- **Program Integrity:** Develop a committee comprised of high-level staff to implement policies aimed at detecting and preventing fraud, waste, and abuse, see SAPC Bulletin 22-10.
- **Organizational Changes:** Develop a procedure to ensure SAPC is informed of any organizational changes, including changes in services, locations, or high-level staff.
- **Training:** Ensure that staff are properly trained on aspects of the DMC-ODS, including ASAM,
- **Hepatitis Program:** Develop policies and procedures to prevent and/or reduce the risk of Hepatitis A, B, and C transmission to staff and clients and make HAV/HBV/HCV resources readily available for clients to access; see SAPC Bulletin 19-01.

Note: Providers should work with their CPA to identify all the required policies and procedures.

Finance Management

Provider agencies' reimbursement methods continue to adapt due to LA County's participation in the DMC-ODS Waiver and CalAIM. Therefore, key business management practices need to be in place and monitored regularly (e.g., monthly) to ensure that the people served, and units of services claimed align with costs incurred. Any excess funds resulting from rates exceeding actual costs should be reinvested in allowable business and clinical capacity-building efforts well before the end of the FY. Long-term viability and sustainability will depend on the agency's ability to grow and reduce costs and expenditures based on staff productivity improvements resulting from delivering medically necessary treatment services at the right LOC.

Rates and Allowable Service Codes

The Rates Matrix in SAPC IN 25-02: Fiscal Year 2024-2025 Rates and Payment Policy Updates-revised (or most recent version) details allowable HCPCS and Current Procedural Terminology (CPT) codes billable for treatment and RBH services. It lists each approved code along with the corresponding reimbursing rate based on the performing provider's license type. The matrix also details the billing rules for each code, as defined by DHCS. SAPC releases an updated Rates Matrix each FY, with rates effective for the designated FY. Since codes and rates may change from FY to FY, it is the responsibility of Secondary Sage Users to ensure that their EHR systems are configured with the appropriate billing codes and rates for each FY.

Investments to Support a Modern SUD System

With the implementation of Behavioral Health Payment Reform in 2023, SAPC transitioned to a value-based environment and began offering DMC-ODS incentive payments to organizations that made foundational investments and demonstrated value-based care delivery. While SAPC has transitioned to a value-based environment, the current state is not the end goal. Rather, SAPC anticipates evolving its value-based reimbursement strategy over time.

Progress within SAPC's value-based framework requires strategic planning and ongoing investment across financial, clinical, organizational, and workforce focus areas. If agencies fail to reinvest revenue into program services (e.g., clinical training, competitive salaries, technology), they risk missing opportunities to better support clients and losing future revenue tied to client outcomes. To remain aligned with SAPC's expectations, agencies should regularly assess their business and clinical practices to determine if current strategies:

- Align with best practices;
- Support an efficient and effective system of care; **and**
- Identify areas for investment to address service gaps.

SAPC's implementation of Behavioral Health Payment Reform, including SAPC's Value-Based Incentives (formerly Capacity Building and Incentives), enables provider agencies to earn additional revenue tied to client care. This revenue can and should be reinvested in activities that strengthen service delivery. Additionally, agency contract budgets have been revised to include a Program Investment Fund, allowing providers to identify a specific amount for program investments.

Provider Agencies are strongly encouraged to make real-time investments that directly support service delivery, such as increasing staffing levels, specifically counselor salaries, to support staff retention. To make strategic financial decisions, organizations need to understand how their budget relates to their FFS revenue and service utilization, both projected and actual, such as the number of clients served or units of service delivered.

Figure 3: SAPC's Payment Reform 10-Year Roadmap

Phase 1		Phase 2		Phase 3		Phase 4		Phase 5	
Investing in the Foundation		Implementing Outcome-Focused Reforms		Delivering Quality + Value		Managing Risks + Rewards		Operating in an Advanced Value-Based or Population Health Environment	
2023-24	2024-25	2025-26	2026-27	2027-28	2028-29	2029-30	2030-31	2031-32	2032-33

For the entire SUD system of care to transition to a modern healthcare delivery system, all provider agencies need to recognize the value of making investments that affect clinical care and the broader service environment, identify their needs, and take action to implement changes. The types of investments outlined in Table 27 are strongly encouraged and align with Federal, State, and local regulations. Making some of these and other allowable investments will also enable Provider Agencies to implement and comply with the requirements of this Provider Manual.

Table 27: Recommended Clinical and Business Investments

Need	Considerations
Benefits Acquisition: Care Coordination needs to be used to help clients acquire benefits while concurrently receiving treatment. This helps prevent denial of services to clients who are ineligible for Medi-Cal, whose applications are still pending, or whose renewals are incomplete.	• How many billable services are lost when Medi-Cal eligible members are turned away for lack of current benefits? • Who is assigned to help clients acquire benefits? • Are there processes in place to track and confirm eligibility monthly? • Is training required? • Is equipment required?
EHR or Sage: Use of an approved EHR is required. Sage is free of charge for agencies that do not wish to purchase their own EHR.	• Is it better to use Sage? • Does your computer system meet expectations in SAPC IN 23-02? • Do you have enough computers for counselors and clinical staff?
Facility Environment and Access: Each outpatient site (except OTP) need to provide services two (2) evenings (5:00 p.m. – 9:00 p.m.) per week and eight (8) hours per weekend. Having a welcoming facility may also contribute to client satisfaction and retention.	• Do you comply with new service day and hour standards? • Would expanding days and hours of operation increase services? • Would minor facility improvements (e.g., paint, furniture) impact client care?
FBS: allowable at select non-agency operated sites provided the location has been pre-approved by SAPC.	• Are there costs associated with any of these sites? • Are there any transportation (e.g., mileage) costs? • Do you have equipment (e.g., computers, cell phones) to protect client confidentiality if lost/stolen?

Need	Considerations
MAT: Clinical and counselor staff need to be able to educate, refer, and link all clients with AUDs and/or OUDs to this available treatment option.	• Are staff trained? • Do policies and procedures reflect this requirement? • Are referral mechanisms in place?
Qualified Staff: Outpatient LOCs are now reimbursed based on the practitioner level.	• Would some services be more appropriately provided by other practitioner levels? • Will improved salaries or benefits for direct service staff increase retention and reduce turnover? • Would hiring LPHAs in addition to counselors improve client care?
Expanded Access: Reaching the 95% of people who need treatment but don't want it or don't access it	• How can you expand business practices to reach more people and draw down more revenue? • What training and support does your clinical and counselor team need to expand care?
Trainings for Clinical and Counselor Staff: ASAM Criteria and Medical Necessity, CBT, MI, and CLAS	• How many staff need training? • How often are trainings? • Who will conduct the trainings? • Will SAPC trainings be enough?
SBAT and SASH: The SASH will schedule appointments in real-time whenever possible, and the SBAT need to be updated daily.	• Is a receptionist or other staff always available during regular business hours? • What are the potential losses in referrals if nobody is available to receive SASH calls? • How will the SBAT be updated?

Previously, some of these decisions may have been determined by program or clinical administrative staff, sometimes without adequate funding in the budget. However, with new service standards, greater emphasis on client choice, and the need to meet utilization projections, it is essential for finance staff to also ensure that budgets align with service needs. Ultimately, the more effectively an organization engages and retains clients in medically appropriate services that address individualized needs and preferences, the more likely it is to make further investments that support business growth and expansion.

Understanding the relationship between clinical and business operations is critical under this new managed care model. These clinical and business investments should assist in the transition at the organizational level. Effective communication with agency staff, combined with research and analysis, will be crucial in determining the optimal investments for an agency's organization and its clients.

Budget Development Process

Now that the County and its Provider Agencies are operating under a managed care model, it is even more critical that the budget and expenditures clearly align with the organization's business and clinical needs. Therefore, when agencies develop the annual budget for all agency-operated locations, it is crucial to clearly articulate the essential expenditures that will support compliance with Federal, State, and local regulations, as well as the expectations outlined in this Provider Manual and other contract-related documents, and make a substantive contribution to positive client outcomes.

The Budget Approval System (BAS) will be used by all Provider Agencies when submitting a contract budget as outlined in SAPC IN 25-03. Each Provider Agency will submit one (1) budget that complies with the guidance in the IN and the attached instructions, including details by agency-operated site address. Any costs associated with FBS need to be estimated and detailed under the associated agency-operated site. Costs can either be direct or indirect:

- **Direct Costs**: Typical direct costs include, but are not limited to, compensation for employees who provide treatment, their related fringe benefits costs, the costs of materials, and other expenses incurred for treatment. These costs can be specifically identified with a particular final cost objective (2 CFR § 200.413).
  Note: Meal costs are only allowable in residential and inpatient programs (ASAM 3.1, 3.3, 3.5, 3.2-WM, 3.7-WM, 4-WM); snack costs are only allowable when provided to minors (ASAM 0.5, 1.0, 2.1). Non-SAPC funds need to be used for all other food purchases. Food costs need to be reported under the "Food and Snacks" line item under "Services and Supplies" category and be clearly tracked and managed.

- **Indirect Costs:** Typical indirect costs include, but are not limited to, depreciation, cost of operating and maintaining facilities, general administration, and general expenses, such as the salaries and expenses of executive officers, personnel administration, accounting, and utilities. These costs are incurred for common or joint objectives and cannot be readily identified with a particular final cost objective (2 CFR § 200.414).

Provider Agencies are encouraged to review SAPC IN 25-03 and the accompanying instructions to better understand how to complete program budgets. Additional guidance, including an instructional video, is available on the SAPC website under the “Finance” section on SAPC's Manual, Bulletins, and Forms - Finance webpage.

Claims Submission and Reimbursement Process

Provider Agencies submit claims through the electronic billing system (e.g., Sage) by the 10th of each month. Claims submitted for treatment services need to be submitted to SAPC via:

- Sage Fast Service Entry Submission form for Primary Sage Users
- EDI files submitted via the SFTP for Secondary Sage Users

Treatment services submitted to SAPC are generally processed within 24 hours and are subject to claim adjudication rules configured in Sage. These rules prevent approval and payment for services that do not meet the rules and policies outlined in the Provider Manual and Rates Matrix. Claims for services submitted against a service authorization in a pending status will be denied upon submission.

SAPC staff retrieves the Providers’ billing invoices by contract number and by reporting period to determine the appropriate payment amount. SAPC staff then verifies the payment amount information calculated by the system that is due for the reporting period. Adjustments for Accounts Receivables are also applied due to Audit findings, Cost Report Settlements, State denial takebacks, and refunds. SAPC’s reasonable timeline for processing payments is 15 calendar days after receipt of an invoice, which falls on the 25th of each month. The County Auditor-Controller’s Office issues payments to providers via direct deposit.

Treatment services billed to SAPC that are DMC reimbursable are generally billed to DHCS for second-level adjudication within two (2) to three (3) months of local-level (SAPC) approval. DHCS adjudication further evaluates the service information and member eligibility to determine if DHCS will reimburse SAPC for the service delivered. Upon DHCS denial of a service, the payment made to the provider may be subject to recoupment and takeback on a future date.

Provider support for claim denials or payment inquiries should be directed to the Sage Help Desk ticketing system. Providers should use the Request Billing Assistance form in the ticketing portal to submit the appropriate ticket type, including detailed information about the request. It is essential that no PHI is sent to SAPC via email or other electronic systems, except through the secure Help Desk portal, to minimize the risk of PHI exposure. General requests for information on finance policies or processes, not specific to a client or specific claim, can also be emailed to SAPC-FSD at SAPC-Finance@ph.lacounty.gov.

Fiscal Reporting

Effective FY 2023-2024, SAPC implemented a streamlined Fiscal Reporting process for all service agreements, including treatment contracts. This revised process aligns with CalAIM's objectives to reduce administrative burden while still meeting local funding requirements. This tool focuses solely on key expenditures, allowing treatment providers to submit a single report for the entire organization.

For FY 2022-2023 and prior, contracts will continue to adhere to DHCS' Cost Reporting process and forms, as required by law (California HSC § 11852.5 and California WIC § 14124.24), which mandate that cost reports be submitted to the State to determine how Federal and State funds are spent.

Provider Agencies should establish separate and unique cost centers for each contracted ASAM LOC and other services provided under a SAPC contract (e.g., RBH services) and non-treatment services (e.g., prevention programs). Establishing cost centers to reflect all contracted treatment and non-treatment services will allow for the efficient and accurate tracking of associated costs and revenue for each service. This information is essential to ensure fiscally viable services and to identify resources for reinvesting in the program. For additional information, see SAPC IN 23-10.

Overview of Fiscal Report Process

SAPC-FSD will issue the fiscal reporting tools for the prior FY at the start of the FY. The tool is designed to collect cost information at the agency level and should be completed within a reasonably short period of time, approximately two (2) weeks. SAPC-FSD will review the submitted information, finalize the report, and issue a final report letter by the end of the calendar year.

Note: For FY 2022-2023 and prior, DHCS will continue to manage reporting based on its internal timelines. Once released, SAPC-FSD will distribute the reports and supporting documentation in accordance with DHCS's instructions. Any changes to the cost report template format or formulas will render the cost report null and void.

DMC Cost Reconciliation Methodology

For FY 2022-2023 and prior, the rate at which a provider bills for DMC services is an interim rate until the cost report is finalized. SAPC will settle for the lower cost or charges.

Fiscal Report Records and Supporting Documentation

Provider agencies need to maintain a formal set of financial records, including a general ledger and books of original entries (e.g., cash receipts journal/register, cash disbursements journal/register, and a general journal). Entries in these records books of original entry need to be traceable to source documentation. Evidence of expenditure needs to be sufficient to substantiate that the expenditure was incurred, and that the expenditure was necessary for the provision of the service. This evidence includes paid invoices, canceled checks, contracts, purchase orders, and receiving reports.

In addition, provider agencies need to maintain fiscal and statistical records for the period covered by the cost report that is accurate and sufficiently detailed to substantiate the cost report data. All documentation needs to be retained until the later of the following:

1. A financial audit is conducted; **or**
2. A period of ten (10) years following the date of the interim cost settlement.

All records of funds expended and costs reported are subject to review and audit by DHCS and/or the Federal government pursuant to the California WIC § 14124.24(g)(2) and California WIC § 14170.

Fiscal Report Training and Preparation

The county provides cost report training to all providers every year during the month of August. If you do not receive an invitation from us, email SAPC-FSD at SAPC-Finance@ph.lacounty.gov.

To prepare a cost report, the following documents will be needed:

- County contract
- General ledger for each site
- Units billed for the FY
- Download cost report forms and instructions from SAPC's website; visit http://www.publichealth.lacounty.gov/sapc/providers/manuals-bulletins-and-forms.htm?tm#finance.

Fiscal Report Submission

Submit the complete set of cost reports via email to SAPC-FSD at SAPC-Finance@ph.lacounty.gov and mail with the original signature to:

County of Los Angeles
Department of Public Health
Substance Abuse Prevention and Control
Fiscal Reporting Unit
1000 S. Fremont Avenue., Building A-9 East
3rd Floor, North Wing, Unit # 34
Alhambra, California 91803

Fiscal Report Delinquent

SAPC may impose sanctions for non-receipt of the fiscal report. Under contract Section 6.G:

"If the Annual Cost Report is not delivered by Contractor to County within the specified time, Director may withhold all payments to Contractor under all service contracts between County and Contractor until such report is delivered to County and/or, at the Director's sole discretion, a final determination of amounts due to/from Contractor is determined on the basis of the last monthly billing received. Failure to provide the annual cost report may constitute a material breach of the Contract, at the sole discretion of the County, upon which the County may suspend or terminate this Contract."

Information Technology Management

As the specialty SUD system better integrates into mainstream health care, there is a need to transition from a largely paper-based SUD system to an electronic, technology-based system to support integration and enhance service delivery. As such, it is essential for SUD provider agencies to incorporate information technology (IT) considerations (e.g., staff, hardware, software, infrastructure) into their business planning to establish a solid foundation for technological success, both from a business and clinical perspective.

Sage and Electronic Health Record Requirements

SUD services are part of a specialty health system that operates under managed care. To participate in this system, provider agencies need to utilize EHR systems. EHRs enable providers to document, organize, bill for services, and share information with others within the SUD network and with external providers.

EHRs are digital client records that authorized providers can create, manage, and share with other providers. Interoperability between EHR systems supports Care Coordination and information exchange, which ultimately enhances client care. Additionally, EHR systems often contain information beyond client records, including assessment tools, processes to support UM, data reporting, and billing, among other functionalities.

Using a centralized platform to collect and share client information helps providers make more confident decisions when planning, delivering, monitoring, and billing for SUD services. For this reason, EHR systems are a core component of strong provider organizations and effective health systems.

All SUD provider sites are required to have a certified EHR to support the delivery of high-quality specialty SUD services within a managed care setting.

Sage

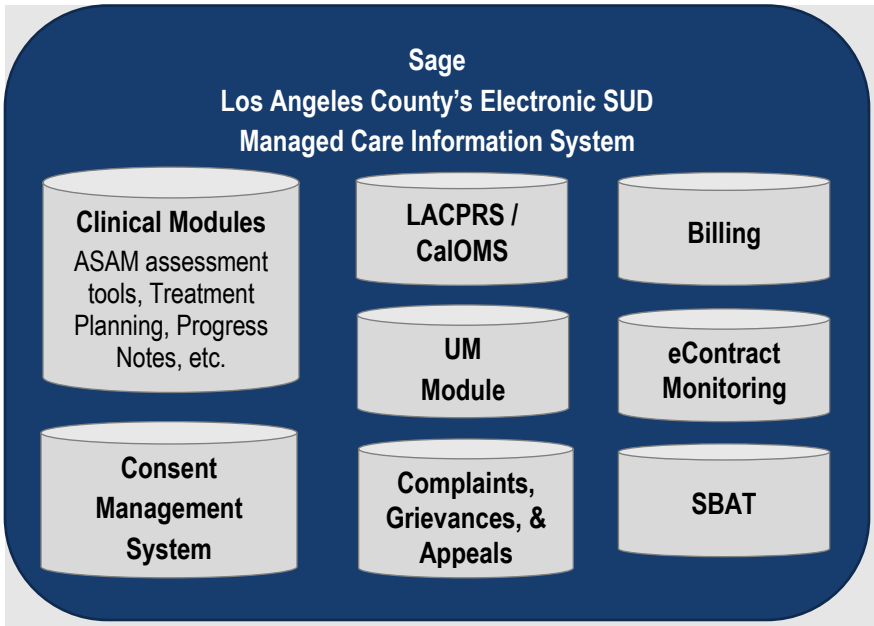
Sage is a certified, web-based SUD EHR system that consists of clinical, administrative, and data reporting modules that satisfy mandatory government reporting and interoperability requirements. Sage provides the structure needed to oversee and deliver SUD services in a managed care setting. The system is compliant with both 42 CFR Part 2 and HIPAA.

Figure 4 shows Sage's range of features, which cover all essential functions a specialty SUD provider needs to operate within the SAPC network. The provider-facing platform is called Sage-PCNX, also known as ProviderConnectNX.

SAPC continues to fund the development, implementation, ongoing maintenance, and support for Sage. SUD provider agencies will be responsible for ongoing training.

For additional information on Sage, including training details, User Access Groups, billing, and ASAM CONTINUUM™ Assessment trainings, visit www.publichealth.lacounty.gov/sapc/Sage/Sageinfo.htm.

Figure 4: Sage – LA County's Electronic SUD Managed Care Information System



Providers Eligible for Sage

Selecting an EHR system is a personalized business decision for specialty SUD providers. While providers are not required to use Sage as their agency's primary EHR system, all provider agencies need to use a certified EHR that is approved by SAPC.

Some functions need to be completed in Sage by all providers, regardless of whether they have their own EHR system. These include activities related to billing and authorizations, such as completing the following forms or processes directly in Sage:

- Patient admission (Admission (Outpatient) form)
- ASAM CONTINUUM™ Assessment and ASAM CO-Triage® Tool
- Youth and Young Adult Screener
- Financial Eligibility
- SAR
- Diagnosis

- Provider Site Admission
- Discharge and Transfer form
- RBH Discharge Form
- Real-Time Eligibility 270 Request
- Referral/Service Connections Log
- Women's Health History and Reproductive Health (for PPW clients)
- CalOMS Forms

Note: Additional forms may be required to be completed in Sage, depending on business needs.

Sage is available to SUD providers who do not currently have an EHR. Providers who elect to continue using a SAPC-approved EHR may do so, provided they coordinate with SAPC IT to ensure necessary data exchange capabilities. **Once a provider elects to use their own EHR system, they may not switch to Sage as their primary EHR in the future.**

For OTP providers, Sage cannot be used as the primary EHR due to specific system requirements. OTPs provider agencies need to maintain their own EHR system. Sage will be used to document admissions, access ASAM assessments, access the UM module, and report data. Otherwise, OTPs' clinical and billing functions will remain on their current EHR systems.

For non-OTP providers who elect to utilize Sage, it need to be used for all treatment services within SAPC's specialty SUD system.

Note: Prevention and DUI services do not utilize Sage at this time.

Sage User Roles

To fully utilize the benefits of Sage, SUD providers should actively manage the user roles assigned to their staff. Sage supports a wide range of staff roles, enabling providers to carry out various functions, including but not limited to:

- Varying Clinical Levels in LPHA, Counselors, and license-eligible LPHA, and those who also conduct financial tasks
- Financial Staff
- Clinical Trainees
- Audit User
- Operations
- Clerical
- Peer Support Specialist (also known as CMPSS or Certified Peer)
- LVN & MA

For additional information on managing access groups for staff on Sage, see the Sage User Enrollment webpage on SAPC's website.

Note: SAPC will review all user roles to ensure that roles are appropriately assigned.

Provider Responsibilities

SUD providers have several responsibilities related to the use and management of their EHR systems. These include:

- Acknowledging the essential role EHR systems play in delivering high-quality SUD care.
- Including IT planning as part of agency business operations. This includes maintaining appropriate hardware, up-to-date anti-virus protection, and the latest Windows security patches, as well as IT staff to support their EHR.
- Ensuring staff are properly trained able to use the EHR to use it effectively.
- Notifying SAPC of issues so collaborative solutions can be identified.
- Developing downtime procedures to avoid service disruptions during scheduled or unexpected system outages. To prepare for downtime, provider agencies need to keep hard copies or other formats not impacted by Sage of the following documents:
    - Current client roster
    - ASAM Assessment tool, Service Request Form template
    - Problem List (non-OTP settings) or Treatment Plan (OTP settings) template
    - Progress Note template
    - Discharge and Transform template (for all LOCs)
    - RBH Authorization Request form and Discharge form
    - Billing required documents
    - All required consent forms
    - Admission/Discharge forms
    - Any other documents required by the County
- Complying with SAPC policies and procedures by immediately reporting any potential data breaches or concerns related to data integrity.

Sage Trainings

SAPC will provide support for initial credentialing training for Sage for SAPC Provider Agencies using Sage. It is the responsibility of the Provider Agencies to ensure their staff receive ongoing training. This includes maintaining proficiency, staying current with new system features, and planning for staff turnover by developing internal super-user expertise.

All staff who will access Sage need to complete required trainings. To support this, SAPC has developed a series of enduring Sage learning modules available through the SAPC-LNC platform, along with user guides published on SAPC's website for most major Sage User Roles for providers to acquire the necessary knowledge and skills to use Sage effectively and to ensure quality and consistency of training across the network. The web-based trainings are accessible 24/7 on the SAPC-LNC platform and are module-based, allowing for completion in multiple sessions. Prior to being given access to Sage, users will be required to demonstrate proficiency by successfully completing these required trainings, reviewing the user guides, and passing the competency exam that is part of this training.

All practitioners for whom a provider agency intends to bill for services need to be credentialed in the Sage system, even if the performing provider will not use Sage directly. Failure to credential staff will result in claim denials. Provider Agencies who use their own EHRs need to complete the regular onboarding process in order

to be credentialed in the SAPC provider network. This process includes requesting an LA County C-number and submitting a Sage Help Desk ticket with the SAPC Sage User Creation Form. The form should include the practitioner's credentials (e.g., license number) and select Access Group #13 "Clinical Visible Only—No Login". This allows Sage to store practitioner data for billing purposes without granting full system access. This requirement applies to all billable staff, including those administering medications in OTP settings, but will not access the Sage system directly.

SAPC Learning and Network Connection Platform

The SAPC-LNC platform, a gateway to SAPC's programmatic and network training resources, is a learning and network management platform. This platform offers a range of free, on-demand trainings and content designed specifically created for SAPC Network Providers to support all types of substance use services. The trainings and content aim to strengthen clinical practice and address the operational needs of Provider Agencies.

Provider Agencies can complete trainings at their own pace and certificates of completion are available for download once a training is finished. Selected clinical trainings also offer CEs for eligible disciplines on this platform.

To access the SAPC-LNC platform, provider agencies need to register for an account directly on the SAPC-LNC platform. For guidance on registration, navigation, and technical support, refer to the SAPC-LNC Getting Started Guide.

Section 7. APPENDICES

Appendix A. Glossary

TERM	DEFINITION
ASAM CO-Triage® Tool	This is a short screener based on ASAM criteria used to determine whether adults and young adults need SUD treatment and the provisional LOC, which would most likely benefit them.
Assessment	The process for defining the nature of an issue, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis. ASAM-based assessments examine six (6) dimensions: 1. Acute intoxication and/or withdrawal potential 2. Biomedical conditions and complications 3. Emotional, behavioral, or cognitive conditions and complications 4. Readiness to change 5. Relapse, continued use, or continued problem potential 6. Recovery environment At a minimum, comprehensive assessments include the following elements: • History of the present episode • Substance use and addictive behavior history • Developmental history (as appropriate) • Family history • Medical history • Psychiatric history • Social history • Spiritual history • Physical and mental status examinations, as needed • Comprehensive assessment of the diagnosis and pertinent details of the case • Survey of assets, vulnerabilities, and supports • Treatment recommendations • Financial status/history • Educational history • Employment history • Criminal history/Legal status
BenefitsCal	BenefitsCal is a portal where Californians can get and manage benefits online. This includes food assistance (CalFresh) formerly food stamps, cash aid (CalWORKs, General Assistance, Cash Assistance Program for Immigrants), and affordable health insurance (Medi-Cal). Review the BenefitsCal How-to Videos on YouTube for additional information regarding BenefitsCal.
Campus-Like Provider	State DMC certification/approval with multiple addresses under ONE NPI#, ONE Provider ID, and ONE DMC Number.
Care Coordination	A service to assist clients in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. It is a collaborative process of assessment, planning, facilitation, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available

	resources to promote quality, cost-effective outcomes. In order to link clients with services and resources (e.g., financial, medical, or community services), care coordinators need to have a working knowledge of the appropriate services needed for the client to optimize care through effective, relevant networks of support.
Care Planning *(also known as Treatment Planning)*	The provider (certified SUD counselor or LPHA) needs to prepare an individualized Plan of Care that is reflected in the clinical notes documenting the client's care and aligned with the Problem List (non-OTP settings) or Treatment Plan (OTP settings). The requirements for this Problem List and Treatment Plan documentation are described in Table 17 and Table 18, respectively.
Certified Medi-Cal Peer Support Services *(also known as Peer Support Services or PSS)*	PSS may be delivered in various settings; however, if a Certified Peer does not provide services, then they may not be reimbursable by Med-Cal. PSS need to be based on an approved Plan of Care. The Plan of Care needs to be documented within the Progress Notes in the member's clinical record and approved by any treating provider who can render reimbursable Medi-Cal services. Certified Peers give and receive nonprofessional, nonclinical assistance to achieve long-term recovery for members. The support is provided by individuals who have experiential knowledge. Certified Peers provide assistance to promote a sense of belonging within the community. Another critical component that Certified Peers provide is the development of self-efficacy through role modeling and assisting their peers with ongoing recovery through mastery of experiences and finding meaning, purpose, and social connections in their lives.
Certified Medi-Cal Peer Support Specialists (CMPSS) *(also known as Certified Peers)*	CMPSS or Certified Peers are peer support specialists who have completed the specific certification requirements set by the DHCS and CalMHSA. To get certified, individuals need to apply, complete 80 hours of training, and pass a certification exam. Certified Peers are qualified to deliver PSS, which are reimbursable by Medi-Cal.

Chronic Homelessness *defined by HUD*	• A homeless individual with a disability as defined in section 401(9) of the McKinney-Vento Assistance Act (42 U.S.C. 11360(9)), who:
	  ○ Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter, and
	  ○ Has been homeless and living as described for at least 12 months* or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described.
	• An individual who has been residing in an institutional care facility for less, including jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria of this definition before entering that facility**; or
	• A family with an adult head of household (or, if there is no adult in the family, a minor head of household) who meets all of the criteria of this definition, including a family whose composition has fluctuated while the head of household has been homeless.
	
	A "break" in homeless is considered to be 7 or more nights.
	****An individual residing in an institutional care facility does not constitute a break in homelessness.***

Co-Occurring Disorder (COD)	A concurrent substance use and mental or medical disorder.
Cognitive Behavioral Therapy (CBT)	A short-term, goal-oriented psychotherapy treatment that takes a hands-on, practical approach to problem-solving. CBT focuses on exploring relationships between a person's thoughts, feelings, and behaviors. During CBT, a therapist will actively work with the client to uncover

	unhealthy patterns of thought and how they may be causing self-destructive behaviors and beliefs. By addressing these patterns, the client and therapist can work together to develop constructive ways of thinking that will produce healthier behaviors and beliefs.
Collateral Services	Collateral Services sessions are available at all LOCs and are defined as in-person, telephone, or telehealth contact between one (1) SUD counselor or LPHA, one (1) client—unless clinically inappropriate for the client to be present—and significant persons in the client's life.
Crisis Intervention Services	A crisis for DMC-ODS services means an actual relapse or an unforeseen event or circumstance that presents to the member an imminent threat of relapse. Crisis Intervention Services need to focus on alleviating the crisis problem, be limited to stabilizing the member's immediate situation, and be provided at the least intensive LOC that is medically necessary to treat the condition.
Culturally Responsive Services	Providers are required to ensure that treatment services are delivered in a way that effectively interacts with people representing culturally, linguistically, and developmentally diverse groups, addresses their individualized needs, and optimizes treatment engagement. Organizational policies, procedures, and practices need to be consistent with the principles outlined in the National Standards for CLAS in Health and Health Care and embedded into the organizational day-to-day operations.
Discharge and Transfer Form	The document that details the client's planned discharge. The Discharge/Transfer Form needs to include, but not be limited to, the following: • A description of each of the member's relapse triggers • A plan to assist the member to avoid relapse • A support plan
Discharge Planning	The process of preparing the client for referral into another LOC, post-treatment returns or reentry into the community, and/or the linkage of the individual to essential community treatment, housing, and human services. The discharge planning process should be initiated from the onset of treatment services. This serves to ensure sufficient time to plan for the client's transition to subsequent treatment or RS and, from a clinical standpoint, to convey that recovery is an ongoing life process not a unit of service.
Documentation	SAPC will require that providers generate initial documentation based on the ASAM Criteria. The documentation needs to provide justification for the care provided, including the demonstration of medical necessity. Documentation templates developed by SAPC are used for Problem Lists (non-OTP settings) or Treatment Plans (OTP settings), Progress Notes, and other documentation developed by the SAPC-QI and SAPC-UM sections. Services provided in the community, by telephone, or by telehealth require equivalent quality and comprehensiveness of documentation as in-person services provided within a certified facility.
Drug Testing	While there is currently no widely agreed upon standard for drug testing in SUD treatment, it is often a useful tool to monitor engagement and provide an objective measure of treatment efficacy and progress to inform treatment decisions. The frequency of drug testing should be based on the client's progress in treatment, and the frequency of testing should be higher during the initial phases of treatment when continued drug use has been identified to be more common. Additionally, drug testing is best when administered randomly as opposed to being scheduled, and the method of drug testing (e.g., urine, saliva) would ideally vary as well.
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	A benefit that provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. It is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, substance use, developmental, and specialty services.

Evidence-Based Practice (EBP)	Practices that have been implemented and are supported by evidence. Providers will be expected to implement, at a minimum, the two (2) EBPs of MI and CBT. Other EBPs include relapse prevention, trauma-informed treatment, family therapy, and psychoeducation.
Face-to-Face	Occurring in-person at a certified facility. Telephone contacts, telehealth, home visits, and hospital visits are not considered face-to-face.
Family Services	Services are provided to clients and their family members to strengthen, enhance, and preserve the family unit. These services may include but are not limited to care coordination, childcare, crisis counseling, transportation, family therapy, or counseling.
Family Therapy	Psychotherapy involves the client and their family members, using specific techniques and EBPs (e.g., family systems theory, structural therapy, etc.). The effects of addiction are far-reaching, and clients' family members and loved ones are also affected by the disorder. By including family members in the treatment process, clinicians provide education about factors that are important to the client's recovery as well as their own recovery. Family members can provide social support to the client, help motivate the client's loved ones to provide social support to the client, help motivate the client to remain in treatment and receive help and support for their own family recovery as well. These services need to be provided by an LPHA-level therapist.
Field-Based Services (FBS)	Services that are provided at a location other than a brick-and-mortar treatment provider agency. Services may be provided to adults and youth, as well as parents or guardians, as needed. Service locations include, but are not limited to, client's residence, recreational centers, sober living facilities, homeless encampments, and co-locations in EDs, primary care, mental health, court, jail reentry (not in-custody), probation, and child protective services settings. FBS for MAT should be provided by staff who are specifically trained to recognize and respond to the unique biopsychosocial needs of their clients. FBS are responsive and appropriate to clients' cultural, linguistic, and developmental needs, and are supported by EBPs.
Group Counseling	In-person or telehealth contact between one (1) or more certified or registered SUD counselors or LPHA, and two (2) or more clients at the same time (with a maximum of 12 clients in the group). Psychosocial issues related to substance use are addressed utilizing relevant best-practice clinical interventions and a focus on peer support.
Homeless *defined by HUD*	**HUD's Four (4) Categories of the Homeless Definition:** 1. **Literally Homeless:** Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: **(a)** has a primary nighttime residence that is a public or private place not meant for human habitation; or **(b)** is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by Federal, State and local government programs); **or (c)** is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution. 2. **Imminent Risk of Homelessness:** An individual or family who will imminently lose their primary nighttime residence, provided that: **(a)** residence will be lost within 14 days of the date of application for homeless assistance; **(b)** no subsequent residence has been identified; **and (c)** the individual or family lacks the resources or support networks needed to obtain other permanent housing. *(Note: Includes individuals and families who are within 14 days of losing their housing, including housing they own, rent, are sharing with others, or are living in without paying rent.)*

	3. **Homeless Under Other Federal Statutes:** Unaccompanied youth under 25 years of age, or families with Category 3 children and youth, who do not otherwise qualify as homeless under this definition, but who: **(a)** are defined as homeless under the other listed Federal statutes; **(b)** have not had a lease, ownership interest in permanent housing during the 60 days prior to the homeless assistance application; **(c)** have experienced persistent instability as measured by two moves or more during in the preceding 60 days; **and (d)** can be expected to continue in such status for an extended period of time due to special needs or barriers. 4. **Fleeing/Attempting to Flee DV:** Any individual or family who: **(a)** is fleeing, or is attempting to flee, DV; **(b)** has no other residence; **and (c)** lacks the resources or support networks to obtain other permanent housing.
High Utilizer	A high utilizer is a person who is diagnosed with an SUD and meets any of the following criteria: • 3+ ED visits related to SUD within the past 12 months • 3+ inpatient admissions within the past 12 months for physical and/or mental health conditions and co-occurring SUD • Homelessness with SUD (as defined by HUD homelessness definition) • 3+ residential SUD treatment admissions within the past 12 months • 5+ incarcerations with SUD in 12 months
Imminent Danger	Imminent danger has the following three (3) components: 1. A strong probability that certain behaviors will occur (e.g., continued alcohol or drug use or relapse or non-compliance with psychiatric medications). 2. The likelihood that these behaviors will present a significant risk of serious adverse consequences to the individual and/or others (as in a consistent pattern of driving while intoxicated). 3. The likelihood that such adverse events will occur in the very near future ***Note: In order to constitute "imminent danger," ALL THREE (3) ELEMENTS need to be present.***
Individual Counseling	Clinical contact between an LPHA or counselor and a client that addresses psychosocial issues related to SUDs. SAPC's required EBPs include MI and CBT. Services may be provided in person, by telephone, or by telehealth.
Intake	Intake is the process of determining that a client meets the medical necessity criteria for care and then admitting a client into an SUD treatment program. It includes the assessment or analysis to determine whether an individual meets the current DSM-5TR criteria for an SUD diagnosis or is at risk for SUD. It also involves using the ASAM Criteria to determine if treatment is medically necessary and identifying the appropriate LOC. Intake for a pharmacological intervention includes a physical examination and laboratory testing necessary for determining and providing appropriate SUD treatment.
Lapse	A brief return to substance use following a sustained period of abstinence, despite the client remaining committed to recovery and demonstrating a willingness to re-engage with the recovery journey.
Licensed Practitioner of the Healing Arts (LPHA)	An LPHA possesses a valid clinical licensure or certification in one of the following professional categories: • Physician (MD or DO) • Nurse Practitioner (NP)

	• Physician Assistant (PA) • Registered Nurse (RN) • Registered Pharmacist (RP) • Licensed Clinical Psychologist (LCP) • Licensed Clinical Social Worker (LCSW) • Licensed Professional Clinical Counselor (LPCC) • Licensed Marriage and Family Therapist (LMFT) • Licensed Vocational Nurse (LVN) • Licensed Psychiatric Technician (LPT) • Licensed Occupational Therapist (LOT) • Licensed-eligible LPHAs working under the supervision of licensed clinicians All LPHAs need to operate under their established scope of practice. This does not include rendering diagnoses for RNs, LVNs, LPTs, and LOTs. As such, these specific LPHAs also cannot finalize ASAM CONTINUUM™ Assessments.

Medical Necessity	Medical necessity for all SUD treatment provided under a SAPC contract is defined as:
	
	Adults (age 21 and over)
	• To begin service delivery prior to completion of the full assessment:
	  ○ Services are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain (California WIC § 14059.5(a)); **or**
	  ○ For OTPs, a history and physical exams conducted by an LPHA at admission, pursuant to Federal and State regulations, qualify for medical necessity determination.
	• To fully establish medical necessity:
	  ○ At least one diagnosis of a substance-related and addictive disorder, with the exception of tobacco-related disorders, from the current edition of the DSM-5-TR.
	  ○ Appropriate placement in an SUD LOC that is consistent with recommended services and medical necessity based on the current edition of the ASAM Criteria.
	
	Youth (age 17 and under) and Young Adults (age 18-20)
	• At least one diagnosis of a substance-related and addictive disorder, with the exception of tobacco-related disorders, from the current edition of the DSM-5-TR; **or**
	• Meet EPSDT criteria to ameliorate or correct a substance misuse-related condition.
	• Any qualified provider operating within the scope of their practice, as defined by state law, can provide a screening service to trigger EPSDT coverage and medically necessary SUD treatment for Youth (age 17 and under) and Young Adults (age 18-20).
	
	Appropriate placement in an SUD LOC that is consistent with recommended services and medical necessity based on the current edition of the ASAM Criteria.

Medical Psychotherapy	"Medical Psychotherapy" is a counseling service to treat SUDs other than OUD is conducted by the medical director of a s on a one-to-one basis with the client. See Title 9 CCR § 10345.
Medication Services	Medication Services, including addiction medications, will be discussed and offered as a concurrent treatment option for individuals with an alcohol—and/or opioid-related SUD condition. Staff lawfully authorized to provide such services within their scope of practice and licensure should prescribe or administer addiction medications and assess the side effects and/or impact of these medications. Youth (age 17 and under) are eligible to be treated with addiction

	medications when these are clinically indicated.
Member	Recipient of Medi-Cal.
Methadone	An opiate agonist medication used to treat OUD.
Motivational Interviewing (MI)	MI focuses on exploring and resolving ambivalence and centers on motivational processes within the individual that facilitate change. The method differs from more "coercive" or externally driven methods for motivating change as it does not impose change (that may be inconsistent with the person's values, beliefs, or wishes) but rather supports change in a manner congruent with the person's values and concerns.
Client Education	The presentation of research-based education on addiction, treatment, recovery, and associated health risks with the goal of minimizing the use of addictive substances, lowering the risk of dependence, and minimizing adverse consequences of substance use. Client Education sessions are defined as in-person, by telephone, or by telehealth contact between up to two (2) registered or certified SUD counselors or LPHAs, and between 2-12 clients at the same time in non-residential settings and between 2-30 clients at the same time in residential settings.
Physical Examination	Appropriate medical evaluation need to be performed prior to initiating treatment services, including physical examinations when deemed necessary.
Provisional LOC	The initial LOC that is determined by the ASAM CO-Triage® Tool. It will be replaced with the actual LOC once the client has received a full ASAM CONTINUUM™ Assessment or Assessment Tool - Youth (Paper Version) found on the SAPC website at the provider agency. The purpose of the provisional LOC is to increase the likelihood that the client is directed to the appropriate provider agency for them the first time.
Recovery Bridge Housing (RBH)	RBH is defined by SAPC as a type of abstinence-focused, peer-supported housing that combines a payment for recovery residences with concurrent treatment in OP, IOP, OTP, or OP-WM settings. RBH is often appropriate for individuals with minimal risk with regard to acute intoxication/withdrawal potential, biomedical, and mental health conditions. If there is risk potential, these concerns are to be managed by the treating provider.
Recovery Services	RS will address all needs identified in Dimension 6 of the ASAM Criteria (See Recovery Environment of the ASAM Criteria), and services will be provided in-person, by phone, or via a telehealth modality. RS will include monitoring all six (6) ASAM dimensions. Relapse education and warning sign monitoring will occur throughout the duration of RS. Adults and youth will both be linked to services that will address their psychosocial issues, help them develop self-management skills, and reinforce skills gained during treatment.
Relapse	A prolonged episode of substance use during which the client is not interested or open to a therapeutic intervention.
Telehealth Services	Telehealth is defined as SUD service that can be delivered between a Certified Peer Support Specialist, a registered or certified SUD counselor, and/or an LPHA and a client via audio and video communications which is 42 CFR Part 2 and HIPAA-compliant and where the SUD counselor/LPHA and client are not required to be at the same location.
Transportation Services	Providing transportation or making arrangements for transportation for members receiving behavioral health residential, inpatient, or ED services. There are two types of transportation in the Medi-Cal program: • NMT for members who do not need medical assistance during transit. • NEMT for when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated.

Treatment Planning	See ***Care Planning***.
Warm Handoff	When a provider agency, care coordinator, counselor, etc. refers a client for additional services related to their treatment, this is not a simple referral but entails going the extra step to ensure that the client feels supported and is not left to their own devices. An example is when a counselor calls another counselor, introduces the client to the counselor, and then sets up a meeting between the client and the new counselor. The client will go into the meeting having already been introduced to the new counselor.

Appendix B. Acronyms Glossary

ACRONYM	TERM
AAR	Adult At-Risk
AB	Assembly Bill
ACCBC	Addiction Counselor Certification Board of California
ADA	Americans with Disabilities Act of 1990
AMA	Against Medical Advice
AEVS	Automated Eligibility Verification System
AI/AN	American Indian and Alaska Native
AIDS	Acquired Immunodeficiency Syndrome
ALP	All Plan Letter
AOD	Alcohol and Other Drugs
APH	Acute Psychiatric Hospital
API	Asian Pacific Islander
APRN	Advanced Practice Nurse
ASAM	American Society of Addiction Medicine
ATC	Alternatives to Custody
AUD	Alcohol Use Disorder
AWD	Alcohol Withdrawal Delirium
AWOL	Absence Without Leave
BAS	Budget Approval System
BBS	California Board of Behavioral Sciences
BFSS	BRIDGE Family Support Specialist
BHIN	Behavioral Health Information Notice (DHCS)
BPC	Business and Professions Code (California)
BRIDGE	Building Relationship, Inspiring Development, and Growing Engagement
CAADE	California Association for Alcohol and Drug Educators
CADTP	California Association of DUI Treatment Programs
CalAIM	California Advancing and Innovating Medi-Cal
CalMHSA	California Mental Health Services Authority
CalOMS	California Outcomes Measurement System
CalSAWS	California Statewide Automated Welfare System
CalWORKs	California Work Opportunity and Responsibility to Kids
CAP	Corrective Action Plan
CARF	Commission on Accreditation of Rehabilitation

CBO	Community-Based Organization
CBT	Cognitive Behavioral Therapy
CCAPP	California Consortium of Addiction Programs and Professionals
CCR	California Code of Regulations
CDPH	California Department of Public Health
CDRH	Chemical Dependency Recovery Hospital
CE	Continuing Education
CENS	Client Engagement and Navigation Services
CEO	Chief Executive Officer
CES	Coordinated Entry System
CEU	Continuing Education Unit
CF	Correctional Facility
CFCI	Care First Community Investment
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CIBHS	California Institute for Behavioral Health Solutions
CIN	Client Index Number
CINA	Clinical Assessment of Narcotic Assessment
CIV	Civil Code (California)
CIWA	Clinical Institute Withdrawal Assessment
CIWA-Ar	Clinical Institute Withdrawal Assessment for Alcohol
CLAS	Culturally and Linguistically Appropriate Services
CM	Contingency Management
CMPSS	Certified Medi-Cal Peer Support Specialists (or Certified Peers)
CMS	Centers for Medicare & Medicaid Services
COD	Co-Occurring Disorder
COIN	Co-Occurring Integrated Care Network
CORE	Connecting to Opportunities for Recovery and Engagement
COWS	Clinical Opioid Withdrawal Scale
CPA	Contract Program Auditor
CPT	Current Procedural Terminology
CQI	Continuous Quality Improvement
CRLA	Cultural Responsiveness and Language Assistance
CRRC	Community Reentry and Resource Center
CRS	Change Report Summary
CSW	Children's Social Worker

CTRC	California Telehealth Resource Center
DATAR	Drug and Alcohol Treatment Access Report
DAPO	California Department of Correction and Rehabilitation, Division of Adult Parole Operations
DCFS	Los Angeles County Department of Children and Family Services
DEA	United States Drug Enforcement Administration
DHCS	California Department of Health Care Services
DHS	Los Angeles County Department of Health Services
DHS-CHS	Los Angeles County Department of Health Services, Correctional Health Services
DHS-HFH	Los Angeles County Department of Health Services, Housing for Health
DHS-ODR	Los Angeles County Department of Health Services, Office of Diversion and Reentry
DJJ	State of California Division of Juvenile Justice
DMC	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal Organized Delivery System
DMH	Los Angeles County Department of Mental Health
DNC	Did Not Complete
DO	Doctor of Osteopathic Medicine
DOJ	California Department of Justice
D.O.O.R.S	Developing Opportunities Offering Reentry Solutions
DPH	Los Angeles County Department of Public Health
DPO	Deputy Probation Officer
DPSS	Los Angeles County Department of Public Social Services
DPSS-CU	Los Angeles County Department of Public Social Services, Centralized Unit
DQR	Data Quality Report
DSM	Diagnostic and Statistical Manual of Mental Disorders
DT	Delirium tremen
DUI	Driving Under the Influence
DV	Domestic Violence
DYD	Los Angeles County Department of Youth Development
EBP	Evidence-Based Practice
ECD	Enhanced Care Management
ED	Emergency department
EHR	Electronic Health Record
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
ER	Emergency room
EV	Eligibility Verification
EW	Eligibility Worker

FAM	Family Code (California)
FBS	Field-Based Services
FDA	United States Food and Drug Administration
FFS	Fee-for-service
FQHC	Federally Qualified Health Center
FY	Fiscal Year
GAIN	Greater Avenues for Independence
GPS	Global Positioning Satellite
GR	General Relief
GSW	GAIN Services Worker
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HMIS	Homeless Management Information System
HN	Housing Navigation
HSC	Health and Safety Code (California)
HUD	United States Department of Housing and Urban Development
ICD-10	International Classification of Diseases, Tenth Revision
ICRP	In-Custody to Community Referral Program
ICT	Inter-County Transfers
IHCP	Indian Health Care Provider
IHOP	Interim Housing Outreach Program
IMS	Incidental Medical Services
IN	Information Notice (SAPC)
IOP	Intensive Outpatient
IPV	Intimate Partner Violence
IT	Information Technology
IV	Intravenous
JCOD	Los Angeles County Justice Care and Opportunities Department
JJCPA	Juvenile Justice Crime Prevention Act
LA	Los Angeles
LA-HAT	Los Angeles–Housing Assessment Tool
LAC	Los Angeles County
LAC-Probation	Los Angeles County Probation Department
LACOE	Los Angeles County Office of Education
LACPRS	Los Angeles County Participant Reporting System

LAHSA	Los Angeles Homeless Services Authority
LASD	Los Angeles County Sheriff's Department
LCP	Licensed Clinical Psychologist
LCSW	Licensed Clinical Social Worker
LEAD	Los Angeles Law Enforcement Assisted Diversion
LEP	Limited English Proficiency
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer ("+" represents other identities such as non-binary, asexual, pansexual, two-spirit, and more)
LMFT	Licensed Marriage and Family Therapist
LOC, LOCs	Level of Care, Levels of Care
LOT	Licensed Occupational Therapist
LPCC	Licensed Professional Clinical Counselor
LPHA	Licensed Practitioner of the Healing Arts
LPJH	Los Padrinos Juvenile Hall
LPT	Licensed Psychiatric Technician
LRS	LEADER Replacement System
LVN	Licensed Vocational Nurse
M.A.	Master of Science
M.S.	Master of Arts
MA	Medical Assistant
MAR	Monthly Activity Report
MAT	Medication for Addiction Treatment *(also known as Medication Assisted Treatment)*
MCP	Managed Care Plan
MD	Doctor of Medicine
MDT	Multi-Disciplinary Team
MEDS	Medi-Cal Eligibility Data System
MEDS ID	Medi-Cal Eligibility Data System Identification Number
MEDSLITE	Medi-Cal Eligibility Data System Lite
MI	Motivational Interviewing
MOTP	Mobile Opioid Treatment Program *(also known as Mobile Narcotic Treatment Program)*
MOU	Memorandum of Understanding
MSUDRP	Mandatory Substance Use Disorder Recovery Program
MST	Military Sexual Trauma
MSW	Master of Social Work
N3	Non-violent, Non-serious, and Non-sexual
NACA	Network Adequacy Certification Application

NACT	Network Adequacy Certification Tool
NAR	Notice of Appeal Resolution
NARR	National Alliance for Recovery Residences
NCCA	National Commission for Certifying Agencies
NDP	Naloxone Distribution Project (DHCS)
NEMT	Non-emergency medical transportation
NGR	Notice of Grievance Resolution
NMT	Non-medical transportation
NOA	Notice of Action
NOABD	Notice of Adverse Benefit Determination
NP	Nurse Practitioner
MPPES	National Plan and Provider Enumeration System
NPI	National Provider Identification Number
NTP	Narcotic Treatment Program
OHC	Other Health Coverage
OMDSO	Office of the Medical Director and Science Officer
OON	Out-of-Network
OP	Outpatient
OP-WM	Outpatient-Withdrawal Management
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
PA	Physician Assistant
PACT	Parole and Community Team
PATH	Pregnancy/Parenthood, Attitudes, Timing, and How Important
PAUR	Los Angeles County Probation Department, Prospective Authorization and Utilization Review Unit
PAuth	Provider Authorization
PAVE	Provider Application and Validation for Enrollment
PAWWS	Prediction of Alcohol Withdrawal Severity Scale
PCP	Primary Care Provider
PEH	People Experiencing Homelessness
PEN	Penal Code (California)
PES	Psychiatric Emergency Services
PhD	Doctor of Philosophy
PHI	Protected Health Information
PII	Personally Identifiable Information
PIP	Performance Improvement Project

PNA	Provider No Activity
PPW	Pregnant and/or Parenting Women
PSH	Permanent Supportive Housing
PSS	Peer Support Services (also known as Certified Medi-Cal Peer Support Services)
PsyD	Doctor of Psychology
QI	Quality Improvement
QIP	Quality Improvement Project
R95	Reaching the 95%
RBH	Recovery Bridge Housing
RDP	Rapid Diversion Program
RH	Recovery Housing
RHS	Reproductive Health Screening
RI-CM	Recovery Incentives-Contingency Management
RICMS	Reentry Intensive Case Management Services
RN	Registered Nurse
ROI	Release of Information
RP	Registered Pharmacist
RS	Recovery Services (*formerly Recovery Support Services or RSS)*
RSC	Recovery Support Court *(formerly Family Dependency Drug Court or FDDC)*
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPC	Substance Abuse Prevention and Control Bureau
SAPC-CCD	SAPC's Contracts and Compliance Division
SAPC-CST	SAPC's Clinical Standards and Training Section
SAPC-FSD	SAPC's Finance Services Division
SAPC-HODA	SAPC's Health Outcomes and Data Analytics Division
SAPC-LNC	SAPC Learning and Network Connection
SAPC-SOC	SAPC's Treatment Systems of Care Division
SAPC-QI	SAPC's Quality Improvement Section
SAPC-UM	SAPC's Utilization Management Section
SAR	Service Authorization Request
SASH	Substance Abuse Service Helpline
SB	Senate Bill
SBAT	Service & Bed Availability Tool
SCL	Service Connections Log
SLN	Sober Living Network
SMART	Specific, Measurable, Attainable, Realistic, and Time-bound

SMHS	Specialty Mental Health Services
SPA	Service Planning Area
SRH	Sexual and Reproductive Health
SSG	Special Services of Groups
SSN	Social Security Number
START-Community	Substance Treatment and Re-Entry Transition – Community
STC	Special Terms and Conditions
STI	Sexually Transmitted Infection
StimUD	Stimulant Use Disorder
SUBG or SUPTRS BG	Substance Use Prevention, Treatment, and Recovery Services Block Grant *(formerly known as Substance Abuse Prevention and Treatment Block Grant or SABG*)
SUD	Substance Use Disorder
SUD-TIPS	Substance Use Disorder Trauma-Informed Parent Support
SYTF	Secure Youth Treatment Facilities
TB	Tuberculosis
TBI	Traumatic Brain Injury
TDD	Telecommunications Device for the Deaf
TGI	Transgender, Gender Diverse, or Intersex
TIP	Treatment Improvement Protocol
ToT	Training of Trainers
TPS	Treatment Perceptions Survey
TTY	TeleType
TUD	Tobacco Use Disorder
UCC	Urgent Care Center
UCSF	University of California, San Francisco
UM	Utilization Management
VA	Veterans Affairs
VI-SPDAT	Vulnerability Index – Service Prioritization Decision Assistance Tool
WIC	Welfare and Institutions Code (California)
WM	Withdrawal Management
WCRTS	Women and Children's Residential Treatment Services
WtW	Welfare to Work

Appendix C. Care Coordination References

Care Coordination Scenarios		
Note: Although not an exhaustive list, these scenarios are meant to help provider staff distinguish between the types of services that are and are **NOT** billable under Care Coordination. The non-billable scenarios listed include activities that **should be conducted**, when appropriate, but **cannot be billed** under Care Coordination.		
	Billable	**Non-Billable**
Connection	With the client present and participating, • Actively helping clients apply for Medi-Cal. • Completing the CES Survey Packet, including the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) for adults, or the Next Step Tool for Youth; **and** linking clients to housing resources. • Transferring Medi-Cal benefits for clients who have moved from their previous county of residence to LAC. • Linking clients to community resources such as food and clothing assistance.	• Time spent waiting with the client to be seen by a provider (e.g., sitting with a client in the ER waiting room). • Providing transportation for clients to scheduled appointments. Provider staff should arrange transportation for clients to and from appointments and attend scheduled appointments if client consent is given. However, the time spent traveling to and from appointments is non-billable (except for clients in Residential Treatment, which is covered in the day rate and Perinatal clients in the DHCS's Substance Use Disorder Perinatal Practice Guidelines (August 2024).
Coordination	With the client present and participating, • Identifying a referral provider agency by using the Service & Bed Availability Tool (SBAT) **and** scheduling an appointment for a Level of Care (LOC) transition (e.g., from Intensive Outpatient or ASAM 2.1 to Low-Intensity Residential or ASAM 3.1, etc.). • Coordinating action plans with mental health providers to ensure clients are provided complementary services.	• Documenting Care Coordination activities in Progress Notes, including information regarding recent primary care and specialist visits, ER visits, auxiliary treatment services (e.g., dialysis), and any community resources received.
Communication	With the client present and participating, • Corresponding with justice system partners (ex. Courts, Probation, Jail, etc.) to provide progress report updates as necessary. • Time spent communicating with service providers, county workers, judges, etc., either in-person, by telephone, or by telehealth (e.g., meeting with client and doctor during a primary care visit). • Following up with other agencies regarding scheduled services and/or services received by clients. • Providing written or verbal status reports to health and mental health providers, and county partners (e.g., DCFS, LAC-Probation).	• Entering data into Sage (pre-authorizations, authorizations, Progress Notes, etc.). • Time spent waiting on hold without the client present to arrange the client's connection to a resource (e.g. DPSS) • Attempting, but not successfully contacting service providers either by phone, email, telehealth, or in-person. Provider agencies should only bill for Care Coordination when they successfully communicate with other service providers on the client's behalf.

Care Coordination Checklist			
Note: This checklist is a reference tool for use during Care Coordination sessions to ensure that core functions of Care Coordination, and their respective activities, are being performed. This is not meant to be an exhaustive list of Care Coordination activities. This table is intended to offer examples of activities that should be covered in sessions, when applicable, and can be billed as Care Coordination.			
Topics		**Potential Activities**	**Performed in session? (Y/N)**
Connection	Establishing & Maintaining Benefit	**Actively help clients to apply for and maintain health and public benefits (e.g., Medi-Cal, Minor Consent Program, GR, Perinatal, Housing, etc.).**	
		Transfer Medi-Cal benefits from the previous county of residence to LA County for clients who have moved.	
	Community Resources	**Link clients to community resources and services (e.g., transportation, food and clothing assistance, family planning services, legal assistance, educational services, vocational services, housing, etc.).**	
Coordination	Transitions in SUD LOCs	**Facilitate necessary transitions in SUD LOCs (e.g., initiating referrals to the next LOC, coordinating with and forwarding necessary documentation to the accepting provider agency, etc.).**	
	Health Services	**Coordinate care with physical health, community health clinics and providers, and mental health providers to ensure a coordinated approach to whole person health service delivery.**	
	Social Services	**Coordinate activities with state, County and community (e.g., DPSS, DCFS, LAC-Probation, LA Superior Courts, Housing Providers, etc.) entities.**	
Communication	Other Health Providers	**Communicate in-person, by telephone or by audio-visual contact with physical health, community health clinics and providers, and mental health providers.**	
	Service Partners	**Communicate in-person, by telephone or by audio-visual contact with DPSS workers, DCFS social workers, DMH workers, LAC-Probation Officers, Housing Providers, etc.**	
	Advocacy	**Advocate for clients with health/social service providers, County and community partners, and others in the best interests of clients.**	

Appendix D. ICD-10 Clinical Modification Codes Z55-Z65

Persons with Potential Health Hazards Related to Socioeconomic and Psychosocial Circumstances

Category	Code	Description
Problems related to education & literacy (8)	Z55.0	Illiteracy and low-level literacy
	Z55.1	Schooling unavailable and unattainable
	Z55.2	Failed school examinations
	Z55.3	Underachievement in school
	Z55.4	Educational maladjustment and discord with teachers and classmates
	Z55.5	Less than a high school diploma
	Z55.8	Other problems related to education and literacy
	Z55.9	Problems related to education and literacy, unspecified
Problems related to employment and unemployment (11)	Z56.0	Unemployment, unspecified
	Z56.1	Change of job
	Z56.2	Threat of job loss
	Z56.3	Stressful work schedule
	Z56.4	Discord with boss and workmates
	Z56.5	Uncongenial work environment
	Z56.6	Other physical and mental strain related to work
	Z56.81	Sexual harassment on the job
	Z56.82	Military deployment status
	Z56.89	Other problems related to employment
	Z56.9	Unspecified problems related to employment
Occupational exposure to risk factors (11)	Z57.0	Occupational exposure to noise
	Z57.1	Occupational exposure to radiation
	Z57.2	Occupational exposure to dust
	Z57.31	Occupational exposure to environmental tobacco smoke
	Z57.39	Occupational exposure to other air contaminants
	Z57.4	Occupational exposure to toxic agents in agriculture
	Z57.5	Occupational exposure to toxic agents in other industries
	Z57.6	Occupational exposure to extreme temperature
	Z57.7	Occupational exposure to vibration
	Z57.8	Occupational exposure to other risk factors
	Z57.9	Occupational exposure to unspecified risk factor
Problems related to housing and economic	Z58.6	Inadequate drinking-water supply
	Z59.00	Homelessness unspecified

Category	Code	Description
circumstances (17)	Z59.01	Sheltered homelessness
	Z59.02	Unsheltered homelessness
	Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
	Z59.2	Discord with neighbors, lodgers and landlord
	Z59.3	Problems related to living in residential institution
	Z59.41	Food insecurity
	Z59.48	Other specified lack of adequate food
	Z59.5	Extreme poverty
	Z59.6	Low income
	Z59.7	Insufficient social insurance and welfare support
	Z59.811	Housing instability, housed, with risk of homelessness
	Z59.812	Housing instability, housed, homelessness in past 12 months
	Z59.819	Housing instability, housed unspecified
	Z59.89	Other problems related to housing and economic circumstances
	Z59.9	Problem related to housing and economic circumstances, unspecified
Problems related to social environment (7)	Z60.0	Problems of adjustment to life transitions (life phase, retirement)
	Z60.2	Problems related to living alone
	Z60.3	Acculturation difficulty (migration, social transplantation)
	Z60.4	Social exclusion and rejection (physical appearance, illness, behavior)
	Z60.5	Target of (perceived) adverse discrimination and persecution
	Z60.8	Other problems related to social environment
	Z60.9	Problem related to social environment, unspecified
Problems related to upbringing (19)	Z62.0	Inadequate parental supervision and control
	Z62.1	Parental overprotection
	Z62.21	Child in welfare custody (non-parental family member, foster care)
	Z62.22	Institutional upbringing (orphanage or group home)
	Z62.29	Other upbringing away from parents
	Z62.3	Hostility towards and scapegoating of child
	Z62.6	Inappropriate (excessive) parental pressure
	Z62.810	Personal history of physical and sexual abuse in childhood
	Z62.811	Personal history of psychological abuse in childhood
	Z62.812	Personal history of neglect in childhood
	Z62.813	Personal history of forced labor or sexual exploitation in childhood
	Z62.819	Personal history of unspecified abuse in childhood
	Z62.820	Parent-biological child conflict

Category	Code	Description
	Z62.821	Parent-adopted child conflict
	Z62.822	Parent-foster child conflict
	Z62.890	Parent-child estrangement NEC
	Z62.891	Sibling rivalry
	Z62.898	Other specified problems related to upbringing
	Z62.9	Problem related to upbringing, unspecified
Other problems related to primary support group, including family circumstances (12)	Z63.0	Problems in relationship with spouse or partner
	Z63.1	Problems in relationship with in-laws
	Z63.31	Absence of family member due to military deployment
	Z63.32	Other absence of family member
	Z63.4	Disappearance/death of family member (assumed death, bereavement)
	Z63.5	Disruption of family by separation and divorce (marital estrangement)
	Z63.6	Dependent relative needing care at home
	Z63.71	Stress on family due to return of family from military deployment
	Z63.72	Alcoholism and drug addiction in family
	Z63.79	Other stressful events affecting family/household (ill/disturbed member)
	Z63.8	Other specified problems related to primary support group (discord or estrangement, inadequate support)
	Z63.9	Problems related to primary support group, unspecified
Problems related to psychosocial circumstances (3)	Z64.0	Problems related to unwanted pregnancy
	Z64.1	Problems related to multiparity
	Z64.4	Discord with counselors
Problems related to other psychosocial circumstances (8)	Z65.0	Conviction in civil and criminal proceedings without imprisonment
	Z65.1	Imprisonment and other incarceration
	Z65.2	Problems related to release from prison
	Z65.3	Problems related to other legal circumstances (arrest, custody, litigation)
	Z65.4	Victim of crime and terrorism
	Z65.5	Exposure to disaster, war and other hostilities
	Z65.0	Conviction in civil and criminal proceedings without imprisonment
	Z65.1	Imprisonment and other incarceration

Appendix E. CENS: Procedure for Additional Co-Location Sites

All negotiations with any entity regarding the possible co-location of CENS staff will be at the direction of SAPC. CENS are to refer all interested parties to SAPC about the possibility of co-locating at a new site, continuing to co-locate at a site, or returning to a site that has been vacated.

CENS providers interested in co-locating at a state, county, city, or community facility need to follow the steps below:

6. Complete, sign and send the Request for CENS co-location Site form to SAPC, along with a brief narrative justifying the request to co-locate. The narrative should include the following information:
    - Name and address of agency/organization requesting a CENS to be co-located at their site (e.g., Probation, Court, etc.)
    - The justification for the co-location (e.g., incarcerated clients unable to go to the CENS Area Office for a screening)
    - Number and level of staff needed and hours of operation (i.e., the number of full-time equivalents (FTE) and days and hours at the co-located site)
    - Expected number of clients to be seen at the site (e.g., per day, per week, per month, etc.)

7. Unless otherwise directed by SAPC, execute a Memorandum of Understanding (MOU) or Letter of Agreement with the proposed entity that includes the following information:
    - The host organization contact information, including name, title, phone number and email address.
    - Agreed upon days and times that CENS will be co-located.
    - Detailed description of the roles and responsibilities of the involved entities.
    - Steps taken to assure adherence to de rules and regulations, including 42 CFR Part 2 and HIPAA.

8. SAPC reserves the right to approve or deny submitted Requests for CENS Co-Location form at its sole discretion based on the information provided in the narrative and the MOU. SAPC will disallow any services that CENS provides at sites not approved by SAPC.

9. Upon approval of the Request for CENS Co-Location Site form and a facility site walk-through by SAPC, the CENS will be notified of the date when services can begin. CENS co-locations will be reviewed as part of the provider agency's annual SAPC audit.

10. Should SAPC or CENS determine that a site is no longer viable, notification need to be submitted to the other party at least 30 calendar days in advance of the proposed vacancy date.

Appendix F. SUD Referral and Tracking Form

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL
CLIENT ENGAGEMENT AND NAVIGATION SERVICES (CENS)

Confidential Client Information

Section 1: Completed by Individual Requesting SUD Screening				
Requestor's Name:			Requestor's E-mail:	
Department/Agency:			Office Phone:	Fax:
Location Name and Address:				
Date of Referral:	Name of Client:			Client's Date of Birth:
Client's Gender: ☐ Male ☐ Female ☐ Transgender (F to M) ☐ Transgender (M to F) ☐ Unknown		Is the Client Pregnant: ☐ Yes ☐ No		Client's phone number:
Client's email:			Case/Program Identifying #:	
Select Program(s) or Population(s) that best fits with the client:	☐ AB 109 ☐ DCFS ☐ Juvenile Probation ☐ General Relief	☐ Mental Health ☐ Family Solutions Center ☐ MAMA's Neighborhood ☐ CalWORKs	☐ Mainstream Services Interim Housing ☐ ☐ Homeless Outreach / Encampments ☐ Permanent Supportive Housing	☐ Other, specify: _____

Refer the client directly to the CENS counselor at assigned co-location if information is known. Otherwise, you may refer the client to one of the CENS Area Office listed below.

CENS Providers and Sites

☐ SPA 1: Tarzana Treatment Centers
(661) 726-2630 (Phone)
(661) 723-3211 (FAX)
☐ Co-Located Site
Specify Facility name and Address:
_____

☐ SPA 3: Prototypes
(626) 444-0705 (Phone)
(626) 444-0710 (FAX)
☐ Co-Located Site
Specify Facility Name and Address:
_____

☐ SPA 5: Didi Hirsch Mental Health Services
(310) 895-2300 (Phone)
(310) 895-2353 (FAX)
☐ Co-Located Site
Specify Facility Name and Address:
_____

☐ SPA 7: Los Angeles Centers for Alcohol and Drug Abuse
(562) 273-0462 (Phone)
(562-273)-0013 (FAX)
☐ Co-Located Site
Specify Facility Name and Address:
_____

☐ SPA 2: San Fernando Valley Community Mental Health Center (818) 285-1900 (Phone) (818) 285-1906 (FAX) ☐ Co-Located Site Specify Facility Name and Address: _____	☐ SPA 4: Homeless Health Care Los Angeles (213) 744-0724 (Phone) (213) 748-2432 (FAX) ☐ Co-Located Site Specify Facility name and Address: _____	☐ SPA 6: Special Service for Groups (323) 948-0444 (Phone) (323) 948-0443 (FAX) ☐ Co-Located Site Specify Facility Name and Address: _____	☐ SPA 8: Behavioral Health Services (310) 973-2272 (Phone) (310) 973-7813 (FAX) ☐ Co-Located Site Specify Facility Name and Address: _____

I agree to schedule an appointment at one of CENS site and show up to the referred treatment site for SUD assessment and treatment services determined by the CENS counselor.

Signed: _____ Date: _____

Client

Signed: _____ Date: _____

Referral Requestor

Section 2: Completed by CENS counselor

Client has Medi-Cal:	☐ If yes, Medi-Cal: _____	☐ If no, Application #: Submitted on: _____ _____	Client's Sage Member ID Number: _____ Sage Referral ID Number *(auto generated in Sage)* _____

SUD Screening Completed by CENS Counselor:

Date of Screening:		Screened by:		Phone:
CENS Agency:			Email:	

For CENS Counselors only - SUD Screening Results

Based on the American Society of Addiction Medicine (ASAM) Triage Tool the CENS Counselor recommends the following Provisional Level of Care (LOC):

SCREENED NEGATIVE OR EARLY INTERVENTION FOR TREATMENT

☐ SUD Treatment Not Recommended ☐ ASAM Level 0.5: Early Intervention (Only eligible for Youth and Young Adults)

➥WAS AT RISK EDUCATION WORKSHOPS PROVIDED?

☐ Yes ☐ No

SCREENED POSITIVE FOR OUTPATIENT TREATMENT	SCREENED POSITIVE FOR INPATIENT TREATMENT
☐ ASAM Level 0.5: Early Intervention Services only for the 0-18 population that is eligible for EPSDT ☐ ASAM Level 1.0: Outpatient Services ☐ ASAM Level 2.1: Intensive Outpatient Services ☐ ASAM Level 1-OTP: Opioid (Narcotic) Treatment Program ☐ ASAM Level 1-WM: Ambulatory WM without Extended On-Site Monitoring **SCREENED POSITIVE FOR RESIDENTIAL TREATMENT** ☐ ASAM Level 3.1: Low-Intensity Residential Services ☐ ASAM Level 3.3: High-Intensity Residential Services, Population-Specific ☐ ASAM Level 3.5: High-Intensity Residential Services, Non-Population Specific ☐ ASAM Level 3.2-WM: Clinically Managed Residential WM	☐ ASAM Level 3.7-WM: Medically Monitored Inpatient WM ☐ ASAM Level 4-WM: Medically Managed Intensive Inpatient WM **REFERRED TO OTHER SUPPORT SERVICES** ☐ Recovery Services ☐ Recovery Bridge Housing (requires concurrent enrollment in ASAM 1.0, 2.1, 1-OTP, or 1-WM) ☐ Other (Specify): _____

Client Referred to SUD Treatment: ☐ Yes ☐ No ☐ Refused

If Yes, complete the following information:

Name of Treatment Agency:			
Address:		Phone:	
Contact Person:		Email:	
Appointment Date:		Time:	

If client is referred to SUD treatment, please complete Release of Information (ROI) form

ROI – In Provider Agency; ROI – Out of Network

The Release of Information (ROI) form has been signed. ☐ Yes ☐ No

Section 3: Treatment Provider Agency Needs to Complete this Section and Return to CENS

Client showed up to appointment: ☐ Yes ☐ No	If no, rescheduled to: _____ (Date) _____ (Time)

If admitted LOC is different than the ASAM CO-Triage® LOC, specify below: _____ (Specify LOC)	If admitted:	Admission Date:	Expected Completion Date:
		Weekly Treatment Hours:	Admission Counselor's Name:

Please return this form to the CENS via [Secure] FAX or email upon Admission, No Show, or Rescheduled Appointment.

Comments:

Appendix G: Program Incident Form

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL
Substance Treatment and Re-entry Transition – Community (START-Community)

START PROGRAM FACILITY	ACTIVITY SITE / LOCATION	DATE	TIME

TYPE OF ACTIVITY

Client Name: _____ Admit Date:_____ Discharge Date: _____

Client progress to date (program phase, satisfactory progress to date, unsatisfactory progress to date):

What happened (objective brief description of incident):

When did it happen (time and date)?

Who was involved (client, staff name and title, and actual witnesses): Staff Members:

How did it happen (if applicable briefly describe cause of incident)?

Actions taken (briefly describe steps taken during incident and if applicable steps required to prevent future incidents):

Notified: County Program Offices ___ LASD____ SAPC___

Follow up (if applicable briefly describe plans for follow up):

Actions Taken:

NAME/TITLE/SIGNATURE OF REPORTING STAFF	DATE

Appendix H. Reportable Incident Reporting Form

SUBSTANCE ABUSE PREVENTION AND CONTROL

Reportable Incident Reporting Form

A reportable event is any unanticipated event resulting in death or serious physical or psychological injury to a client or clients.

CLIENT INFORMATION			
1. Name (Last, First, and Middle):		2. Date of Birth (mm/dd/yyyy):	3. Medi-Cal or MHLA Number:
4. Address:			5. Phone Number: Okay to Leave a Message? ☐ Yes ☐ No
6. Gender:	7. Preferred Language	8. Race/Ethnicity	
PROVIDER AGENCY WHERE INCIDENT OCCURRED			
9. Provider Agency Name:		10. Contact Person:	11. Phone Number:
12. Address:			13. Email Address:
14. Date of Incident (mm/dd/yyyy):			15. Time of Incident:

16. Reportable Incident Type:

☐ Death – Medical Condition	☐ Client Injured another Client, Staff, or Visitor
☐ Death – Suspected Suicide	☐ Medication Error/Medication Event
☐ Death – Other	☐ Alleged Abuse by Staff
☐ Suicide Attempt	☐ Other
☐ Client Injured Self (Not Suicide Attempt)	

DESCRIPTION OF THE INCIDENT
17. Please describe the nature of the incident. Include any important information about the incident, such as the date, person(s) involved, witnesses, etc. Attach any additional information, as necessary. 18. List any pre-disposing factor(s) or root cause(s) relevant to this incident:
RESPONSE AND FOLLOW UP ACTION
19. Please describe the staff response to the incident. Include a description of intervention(s) applied when dealing with the incident. Attach any additional information, as necessary. 20. List any case reviews, trainings, changes to policies and procedures, or follow up by the Risk Management Committee that were performed or instituted in order to prevent similar events in the future.

21. Reporting Staff Name:	22. Date:

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to APPLICABLE Welfare and Institutions Code, Civil Code, HIPAA Privacy Standards, and 42 CFR Part 2.

Duplication of this information for further disclosure is prohibited without the prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law.

EXTERNAL SAPC REVIEW *This section will include communication between SAPC and the agency/provider.*

Comments:

Assigned Staff: Reviewed by: _____ Signature: _____ Date:

INTERNAL SAPC USE ONLY *This section is reserved for internal SAPC use only.*

Comments:

Assigned Staff: Reviewed by: _____ Signature: _____ Date:

Revised: 6/21/2017

Clinical Incident Form Instructions

CLIENT INFORMATION

1. Enter the client's name in the order of last name, first name, and middle name.
2. Enter the client date of birth.
3. Enter the client Medi-Cal number. If the number is not known, leave the space blank.
4. Enter the client address.
5. Enter the client phone number. Check box to indicate if it is okay to leave a message at this phone number.
6. Enter the client gender.
7. Enter the client preferred language.
8. Enter the client race/ethnicity

PROVIDER AGENCY WHERE INCIDENT OCCURRED

9. Enter the provider agency name.
10. Enter the name of the provider agency contact person.
11. Enter the contact person phone number.
12. Enter the provider agency address.
13. Enter the provider agency or the contact person email address.
14. Enter the date of incident.
15. Enter the time of incident.
16. Please describe the incident.
17. List any pre-disposing factor(s) or root cause(s) relevant to this incident.

INCIDENT RESPONSE AND FOLLOW UP ACTION

18. Please describe the staff response to the incident. Include description of intervention(s) applied to when dealing with the incident.
19. List any case reviews, trainings, changes to policies and procedures, or follow up by the Risk Management Committee that were performed or instituted in order to prevent similar events in the future.
20. Enter the name of the reporting staff.
21. Enter the date

EXTERNAL SAPC REVIEW

This section will include communication between SAPC and the agency/provide.

INTERNAL SAPC USE ONLY

This section is reserved for internal SAPC use only.

SUBMIT THE FORM TO:

Fax: (323) 725-2045 Phone: (626) 299-4193

FOR ADDITIONAL SAPC DOCUMENTATION PLEASE SEE

http://publichealth.lacounty.gov/sapc/NetworkProviders/Forms.htm

Revised: 6/21/2017

Appendix I. Juvenile Justice SUD Screening Referral Form (For CENS)

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL
CLIENT ENGAGEMENT AND NAVIGATION SERVICES (CENS)

Los Padrinos Juvenile Hall
Juvenile Justice Substance Use Disorder (SUD) Screening Referral Form

Email form to: falesana@lacada.com

If referral is from outside Department of Probation (Probation), please include contact information of person submitting the referral for tracking purposes. Referral outcomes will only be disclosed if the client signs a Release of Information (ROI).

THIS SECTION TO BE COMPLETED BY REFERRAL SOURCE		
Referral Initiated by: ☐PROBATION ☐DMH ☐DHS ☐DYD ☐LACOE ☐COURT ☐Client/Self-Referral ☐Other: _____ **Name/Email:** _____		
Client Name: _____	**Client Date of Birth:** ____/____/____	**Client PDJ Number:** _____
Assigned DPO Name and Email: _____ **Assigned DMH Clinician and Email:** _____	**Client Housing Unit:** _____	**Client Date of Referral:** ____/____/____
Date Referral Form Submitted to Onsite DPH-SAPC CENS Counselor: ____/____/____	**Next Court Date** (if applicable): ____/____/____	**Release Date** (if applicable): ____/____/____

THIS SECTION TO BE COMPLETED BY ONSITE DPH-SAPC CENS COUNSELOR	
ROI Completed? ☐ Yes ☐ No **Client Completed Screening?** ☐ Yes ☐ No	**Date of Screening:** ____/____/____
In-custody SUD Screening Results and Services	
Based on the *American Society of Addiction Medicine (ASAM) Screener for Youth and Young Adults* (youth = age 17 and under and young adults = ages 18-20) or *ASAM CO-Triage® Tool* (age 21 and over), the onsite DPH-SAPC CENS Counselor recommends the following service(s):	
SCREENED NEGATIVE ☐ No further SUD needs at this time	**SCREENED POSITIVE** ☐ Recommend Onsite Early Intervention Services Client Accepted? ☐ Yes ☐ No ☐ Recommend Referral to Community SUD Treatment Provider Client Accepted? ☐ Yes ☐ No
Onsite DPH-SAPC CENS Counselor/Screener (Name): _____ **Agency:** _____ **Phone No.:** _____ **Email:** _____ **Returned form to DPO (Name):** _____ **Date form returned to DPO: / /**	

Post-release/Community SUD Services Follow-up
Date of Initial Contact to SUD Treatment Agency: ____/____/____ Provisional Level of Care (*ASAM CO-Triage® Tool* only): _____ Name of SUD Treatment Agency: _____ Address: _____ Contact Person: _____ Phone: _____ Email: _____ Appointment Date: ____/____/____ Time: _____
Client Referred to Other Support Services: ☐ Recovery Services ☐ Recovery Bridge Housing ☐ Other (Specify): _____
Attended post release appointment? ☐ Yes ☐ No

ADDITIONAL INFORMATION

PROBATION REFERRER

1) Positive Urinalysis (UA) Result	☐	Yes	☐	No	If yes, date(s):
2) Found with Substance(s) (Contraband)	☐	Yes	☐	No	If yes, date(s):
3) Substance Overdose	☐	Yes	☐	No	If yes, date(s):

Additional Notes/Comments:

NON-PROBATION REFERRER

Additional Notes/Comments:

DPH-SAPC CENS COUNSELOR

Additional Notes/Comments:

Revised: 5/30/2024

Appendix J. Juvenile Justice SUD Screening Referral Form (For SYTF)

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL
EARLY INTERVENTION AND SUD TREATMENT SERVICES

Secure Youth Treatment Facilities (SYTF)
Juvenile Justice Substance Use Disorder (SUD) Screening Referral Form

Please email completed form as follows:
Camp Kilpatrick/Dorothy Kirby Center: LVTpatientReferral@phoenixhouseca.org
Barry J. Nidorf Juvenile Hall: vcardona@tarzanatc.org and dneal@tarzanatc.org

If referral is from outside Department of Probation (Probation), please include contact information of person submitting the referral for tracking purposes. Referral outcomes will only be disclosed if the client signs a Release of Information (ROI).

*THIS SECTION TO BE COMPLETED BY PROBATION CASE WORKER		
Referral on Behalf of: ☐PROBATION ☐DMH ☐DHS ☐DYD ☐LACOE ☐Client/Self-Referral ☐Other: _____ **Name/Email:** _____		
Client Name: _____	**Client Date of Birth:** ____/____/____	**Client PDJ Number:** _____
Location: Housing Module/Unit/Cottage ☐ **Barry J. Nidorf** _____ ☐ **Camp Kilpatrick** _____ ☐ **Dorothy Kirby Center** _____	**Assigned DPO Name and Email:** _____ **Assigned DMH Clinician Name and Email:** _____	**Client Date of Referral:** ____/____/____
Date Referral Form Submitted to Onsite DPH-SAPC SUD Service Counselor: ____/____/____	**Next Court Date** (if applicable): ____/____/____	**Release Date** (if applicable): ____/____/____

THIS SECTION TO BE COMPLETED BY ONSITE DPH-SAPC SUD SERVICE COUNSELOR	
ROI Completed? ☐ Yes ☐ No **Client Completed Screening?** ☐ Yes ☐ No	**Date of Screening:** ____/____/____

In-custody SUD Screening Results and Services

Based on the *American Society of Addiction Medicine (ASAM) Screener for Youth and Young Adults* (youth = age 17 and under and young adults = ages 18-20) or *ASAM CO-Triage® Tool* (age 21 and over), the onsite DPH-SAPC SUD Service Counselor recommends the following service(s):

SCREENED NEGATIVE	SCREENED POSITIVE
☐ No further SUD-related needs at this time	☐ Recommend Onsite Early Intervention or SUD Treatment Services Client Accepted? ☐ Yes ☐ No ☐ Recommend Referral to Community SUD Treatment Provider Client Accepted? ☐ Yes ☐ No

Onsite DPH-SAPC SUD Service Counselor/Screener (Name): _____
Agency: _____
Phone No.: _____ **Email:** _____
Returned form to DPO (Name): _____ **Date form returned to DPO:** ____/____/____

Post-release/Community SUD Services Follow-up
Date of Initial Contact to Community SUD Service Agency: ____/____/_____ Provisional Level of Care (*ASAM CO-Triage® Tool* only): _____ Name of Community SUD Service Agency: _____ Address: _____ Contact Person: _____ Phone: _____ Email: _____ Appointment Date: ____/____/____ Time: _____
Client Referred to Other Support Services: ☐ Recovery Services ☐ Recovery Bridge Housing ☐ Other (Specify): _____
Attended post release appointment? ☐ Yes ☐ No

ADDITIONAL INFORMATION

PROBATION REFERRER

1) Positive Urinalysis (UA) Result	☐	Yes	☐	No	If yes, date(s):
2) Found with Substance(s) (Contraband)	☐	Yes	☐	No	If yes, date(s):
3) Substance Overdose	☐	Yes	☐	No	If yes, date(s):

Additional Notes/Comments:

DPH-SAPC CENS COUNSELOR

Additional Notes/Comments:

Revised: 5/30/2024

Appendix K. DPSS – CalWORKs Program Forms

CW 61 - AUTHORIZATION TO RELEASE MEDICAL INFORMATION

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY — CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

DEAR HEALTH CARE PROVIDER:

The California Work Opportunity and Responsibility to Kids (CalWORKs) program requires that non-exempt individuals participate in work, training, or educational activities for 32 or 35 hours (for one or two-parent households, respectively) per week. CalWORKs participants must make "satisfactory progress" in their activities.

We ask your help in evaluating this individual by providing us with information regarding how his/her mental or physical condition will affect the ability to participate in a work/training program. With this information, we can better assign the participant to an appropriate activity. It will also help us to determine if the participant's condition will enable him/her to participate or successfully complete 32 or 35 hours per week of work and/or training requirements.

Please complete Section 2 of the attached form and sign (or have your authorized representative sign) the Certification in Section 3. Please also complete the Physical Capacities and/or Mental Capacities form(s), as appropriate.

Thank you for your assistance.

WORKER NAME	
WORKER PHONE NUMBER	FAX NUMBER

CW 61 (7/01) COVERSHEET - REQUIRED FORM - SUBSTITUTE PERMITTED

STATE OF CALIFORNIA-HEALTH AND HUMAN SERVICES AGENCY — CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

COUNTY USE ONLY	
CASE NAME:	CASE NUMBER:
WORKER NAME:	WORKER NUMBER:

Section I must be completed by the patient/client. Sections 2 and 3 are to be completed by the type of provider *(or his/her authorized representative)* checked below: *(County worker to check appropriate box below.)*

- ☐ Licensed physician or certified psychologist.
- ☐ Health care professional licensed or certified by a state to diagnose/treat physical or mental impairments affecting the ability to work or participate in education/training activities including, but not limited to, medical doctors, osteopaths, chiropractors, and licensed/certified psychologists.

SECTION 1. PATIENT/CLIENT INFORMATION AND AUTHORIZATION TO RELEASE INFORMATION

NAME OF PATIENT/CLIENT *(LAST, FIRST, MIDDLE)*	SEX *(CIRCLE)*	BIRTH DATE	SOCIAL SECURITY NUMBER	AGE(S) OF CHILD(REN) IN HOME
	M F	- -	- -	

I authorize _____ of _____
NAME OF PROVIDER — CLINIC OR MEDICAL GROUP

to release information to the county welfare department from my records on the conditions checked below:

☐ Physical Condition ☐ Mental Condition ☐ Other *(Describe)* _____

I know this authorization may be used by the county welfare department for up to one year to obtain medical information. I may revoke this authorization at any time, except for information that has already been given to the welfare department. This information is needed by the county welfare department to determine eligibility for cash aid or food stamps. It is also needed to decide the type of work or training activities that I can take part (participate) in, and the CalWORKs services that I need. This information will be kept in the case file and will not be disclosed without my signed consent for each disclosure unless the disclosure is specifically required or allowed by law. I have read this form (or had this form read to me) after it was completed. I know I can get a copy of this form if I ask for it.

PATIENT/CLIENT SIGNATURE	RELATIONSHIP TO PATIENT, IF NOT SELF	DATE SIGNED

SIGNATURE OF WITNESS TO MARK, INTERPRETER, OR PERSON ACTING FOR PATIENT/CLIENT	DATE SIGNED

SECTION 2. STATEMENT OF PROVIDER

The information requested is needed to evaluate eligibility for public assistance for the person named above and to determine his/her work assignment. Please answer the following questions as indicated by check mark:

☐ Questions 1 through 5 ☐ Question 6 ☐ Question 7

1. Does the patient have a medically verifiable condition that would limit or prevent him/her from performing certain tasks? ☐ YES ☐ NO
   If YES, complete the rest of this form, and the Physical Capacities and/or Mental Capacities form *(if attached)*, as appropriate.
   If NO, just complete the Health Care Provider Certification Section below.
2. Onset Date of Condition _____. The condition is ☐ Chronic ☐ Acute, expected to last until _____
3. Is the patient actively seeking treatment? ☐ YES ☐ NO Next appointment date _____
4. Is this person able to work? ☐ YES ☐ NO
   If YES, how many hours per day? _____
5. Does this person have any limitations that affect his/her ability to work or participate in education or training? ☐ YES ☐ NO
6. It is necessary to determine whether child care needs to be provided to enable the other parent to work. Does the patient's condition prevent him/her from providing care for the child(ren) in the home? ☐ YES ☐ NO
7. Does the patient's condition require someone to be in the home to care for him/her? ☐ YES ☐ NO

SECTION 3. PROVIDER CERTIFICATION

SIGNATURE OF PROVIDER OR PROVIDER'S AUTHORIZED REPRESENTATIVE	DATE SIGNED

PRINT NAME AND TITLE/SPECIALTY	PHONE NUMBER
	( )

STREET ADDRESS *(MAILING ADDRESS, IF DIFFERENT)*	CITY	STATE	ZIP CODE

CW 61 (7/01) REQUIRED FORM - SUBSTITUTE PERMITTED

GN 6006A – CALWORKS CLINICAL ASSESSMENT PROVIDER REFERRAL

CalWORKs
CLINICAL ASSESSMENT PROVIDER REFERRAL

[(Participant's Name and Address)] [(GAIN Regional/REP Office)_____]

[(GSW/CCM/RCM Name/File Number) _____] [(Participant Case Number)_____]

IMPORTANT CLINICAL ASSESSMENT APPOINTMENT NOTICE

Completed by GSW/CCM/RCM:

The following appointment has been scheduled for you to attend a clinical assessment for:

☐ Mental Health ☐ Substance Abuse

On:____/____/____ at_____
Date Time

Address: _____

_____

Phone No.: _____

Fax No.: _____

Contact Person: _____

It is important for you to keep this appointment and take this notice with you. If for any reason you cannot keep this appointment or have a problem, please contact your GAIN Services Worker immediately.

GSW/CCM/RCM Making Referral:	File No.:	Phone No.: ( )	Fax No.: ( )

I understand that I am being referred to Clinical Assessment as indicated above. If I fail to attend this appointment, I understand I may be subject to additional contact by a service provider. If additional contact is unsuccessful, I may be put into non-compliance.

_____ _____
GAIN Participant's Signature Date

GN 6006A (Rev. 04/10) Page 1 0f 2

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC SOCIAL SERVICES

CalWORKs CLINICAL ASSESSMENT RESULTS

To: _____ From: _____

Attention: _____
GSW/CCM/RCM Name/Worker ID

Fax No.: _____

Section A - Completed by GSW/CCM/RCM

Participant Name:		CalWORKs Case Number:
Residence Address: (Do not use for domestic violence if confidential address is requested.)		Mailing Address:
Primary Language:	Birth Date:	Sex: ☐ M ☐ F / Phone No.: (Confidential for DV)

Section B - Completed by Clinical Assessor (Complete and return to the GAIN Services Worker within 5 workdays.)

Results of the assessment appointment: IMMEDIATE NEED ☐

- ☐ Participant did not appear/complete the assessment.
- ☐ Participant completed the assessment, but does not need a referral for treatment.
- ☐ Participant completed assessment **& needs a referral**, but does not agree to treatment for ☐ MH ☐ SUD
- ☐ Participant completed assessment **and agrees** to recommended treatment for ☐ MH ☐ SUD
- ☐ Participant completed assessment and does not agree; requests third party assessment. ☐ MH ☐ SUD

REFERRAL MADE FOR: ☐ MH and/or ☐ SUD

Referred to: On: ___/___/___ at _____
Date Time

Name of Provider: _____
Address: _____
_____
_____
Phone No.: _____
Fax No.: _____
Contact Person: _____

Name of Assessor:	Facility Name:	Phone No.:

Section C - Completed by GAIN Participant

I authorize the release of information to DPSS regarding the results of my assessment and possible need for treatment services and recommended service plan.

_____ _____
GAIN Participant's Signature Date

Original Copy To Case File and Copy To Participant

GN 6006A (Rev. 04/13) Print

Page 2 of 2

GN 6006B – CALWORKS SPECIALIZED SUPPORTIVE SERVICES PROVIDER REFERRAL

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC SOCIAL SERVICES

CalWORKs SPECIALIZED SUPPORTIVE SERVICES PROVIDER REFERRAL

[(Participant's Name and Address)] [(CalWORKs District or GAIN Regional Office)]

[ ] [ ]

IMPORTANT APPOINTMENT NOTICE

You have been scheduled to attend the following appointment for:

☐ Mental Health Services ☐ Substance Use Disorder

☐ Domestic Violence (DV) Case Management ☐ DV Family Law ☐ DV Immigration Law

(For Mental Health: Immediate Need/Urgent within 2 workdays, Less Urgent within 5-10 workdays and Non-emergent within 10-15 workdays)

On: ____/__/____ at _____
Date Time

Address: _____

_____

Telephone No.: _____

Fax No.: _____

Contact Person: _____

It is important for you to keep this appointment. Take this notice with you.

If for any reason you cannot keep this appointment or have a problem, please call me immediately.

GSW/CCM/RCM Making Referral:	File No:	Telephone No.: ( )	Fax No.: ( )

I understand that I am being referred to an appointment to begin specialized supportive services as indicated above. If I fail to attend this appointment, I understand that I may be called by the clinical assessor and/or service provider. If additional contact is unsuccessful, a compliance process may follow, which may result in the lowering of my cash aid.

GAIN Participant's Signature: Date:

GN 6006B (Rev. 03/23/15)

Page 1 of 2

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC SOCIAL SERVICES

CalWORKs SPECIALIZED SUPPORTIVE SERVICES RESULTS

[To: (GAIN Regional/REP Office)] [From: Name & Address of Facility/Provider]

Attention: _____
GSW/CCM/RCM Name/ID

[Fax No.: _____] [ ]

A - Completed by GSW/CCM/RCM

Participant Name:			CalWORKs Case No.:	
Residence Address **(Do not use for DV if confidential address requested)**:			Mailing Address: (DV only)	
Primary Language:	Birth Date:	Sex: ☐ M ☐ F	Is there an existing exemption? ☐ Y ☐ N	Telephone No. (Confidential for DV)

B - Completed by Service Provider (Complete as applicable and return to the GSW/CCM/RCM within 5 work days from the appointment date)

I. TYPE OF SERVICE ☐ Residential ☐ Non-Residential

☐ **SUBSTANCE USE DISORDER** ☐ **MENTAL HEALTH**

☐ **DOMESTIC VIOLENCE CASE MANAGEMENT** ☐ **DV FAMILY LAW** ☐ **DV IMMIGRATION LAW** ☐VAWA ☐U VISA

1. ☐ Participant *failed* to appear for treatment services. Reschedule an appointment on: ____/____/____
2. ☐ Participant *began* treatment services on: ____/____/____ for _____ hours per week. Expected duration___ months.
3. ☐ Participant is able to participate in *another* Welfare-to-Work (WtW) activity in addition to treatment services for ___ hours per week.

Note: ***MH/SUD*** participants may participate less than 20/30/35 hours-per-week during the evaluation period.
DV participants may be granted a waiver of any CalWORKs and/or /WtW requirement with a clock stopper/extender. Review the CW 2199-LA, CalWORKs/Welfare-to-Work Domestic Violence Waiver Request.

II. ☐ DOMESTIC VIOLENCE ASSESSMENT

1. ☐ Participant *failed* to appear for Assessment appointment. Rescheduled Assessment appointment on: ___/___/_____.
2. ☐ Participant's DV situation impairs his/her ability to participate in WtW, he/she shall be granted DV *good cause* for not participating in WtW.
3. ☐ Participant began receiving DV services (complete Section B.I accordingly).
4. ☐ Participant *declined* DV services at this time; however, is *able* to participate in WtW activities.

III. OTHER SUPPORTIVE SERVICES NEEDS

Participant needs the following supportive services: ☐ Child care ☐ Public Transportation ☐ Mileage: _____per month
☐ Work Related/Ancillary Expenses such as: ☐ Books ☐ Fees ☐ Uniforms or ☐ Other:

IV. OTHER – Court ordered treatment services: ☐ DV Counseling ☐ Substance Use Disorder ☐ Mental Health

V. Name of Person Completing this form: (Print Name)	Title:	Telephone No.:	Date:

C - Completed by GAIN Participant: (Complete as applicable)

I authorize the Department of Public Social Services and the above service provider to verify information regarding the status of my CalWORKs, GAIN case and/or continuing eligibility to receive CalWORKs Specialized Supportive Services.

☐ I am aware that my Mental Health or Substance Use Disorder treatment will be incorporated in my CalWORKs Welfare-to-Work plan, and my Domestic Violence services may be incorporated now, or eventually, in a CalWORKs Welfare-to-Work plan. *The determination will be made by my GAIN Services Worker/Contracted/REP Case Manager in consultation with the service provider.*

Participant's Signature:	Date:

GN 6006B (Rev. 04/14/18) Page 2 of 2

GN 6007A – NOTIFICATION OF CHANGE FROM SPECIALIZED SUPPORTIVE SERVICES PROVIDER

County of Los Angeles — Department of Public Social Services

NOTIFICATION OF CHANGE FROM SPECIALIZED SUPPORTIVE SERVICES PROVIDER

TO:	**GSW/CCM/RCM:**	**File Number:**	**GAIN Regional/REP Office:**
	Address:		
FROM:	**Treatment Services Provider:**		
	Address:		
	Provider Staff Person:	**Telephone Number:**	**Date:**

PARTICIPANT INFORMATION

Participant Name:	**Case Number:**	**GAIN Activity:**

SECTION A – PARTICIPANT ABILITY TO PARTICIPATE IN WtW ACTIVITIES/EMPLOYMENT

☐ Number of participation hours per week has increased to _____hrs per week.

☐ Number of participation hours per week has decreased to _____hrs per week.

SECTION B – CONCURRENT PARTICIPATION IN OTHER WtW ACTIVITIES/EMPLOYMENT

☐ Participant is now able to participate in other WtW activities in addition to treatment services for _____hrs per week.

☐ Participant is no longer able to participate in other WtW activities in addition to treatment services.

SECTION C - SUPPORTIVE SERVICES NEEDS

Participant needs assistance with: ☐ Child Care ☐ Transportation

☐ Work Related/Ancillary Expenses. Explain: _____

SECTION D - COMMENTS

_____

_____

_____

_____

GN 6007A (4/10)

GN 6007B – CALWORKS SUPPORTIVE SERVICES ENROLLMENT TERMINATION NOTICE

CalWORKs SUPPORTIVE SERVICES ENROLLMENT TERMINATION NOTICE

[To: (GAIN Regional/REP Office)] [From: Service Provider Name & Address]

Attention: _____
[GSW/CCM/RCM Name/Number] [ ]

Provider Certification

Participant Name:	Participant Address:
Case No.:	
GAIN Activity:	

This is to inform you that the above-named participant has:

☐ Successfully completed his/her services/treatment activity on: _____

☐ Dropped-out of services with good cause on: _____

☐ Dropped-out of services without good cause on: _____

Reason: _____

☐ Services not completed; participant entered employment on: _____

☐ Services not completed; participant transferred to other WtW activity: _____

☐ Terminated his/her services; participant transferred to another provider on: _____

☐ Other: _____

_____

_____

Service Provider Representative:	Title:	Phone No.: ( )	Date:

GN 6007B (Rev. 04/10)

GN 6008 – PROGRESS REPORT

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC SOCIAL SERVICES

PROGRESS REPORT
MENTAL HEALTH/SUBSTANCE USE DISORDER/ DOMESTIC VIOLENCE/FAMILY PRESERVATION/REUNIFICATION PROGRAMS

[GAIN Regional/Contracted Office] [Service Provider's Name and Address]

[ ] [ ]

OUR RECORDS INDICATE THAT THE FOLLOWING PARTICIPANT IS RECEIVING SERVICES IN YOUR PROGRAM. VERIFICATION OF PROGRESS IS NEEDED FOR HIS/HER CONTINUING ELIGIBILITY TO CalWORKs AND WELFARE-TO-WORK PROGRAMS. PLEASE COMPLETE THIS FORM AND RETURN IT TO THE ABOVE ADDRESS WITHIN **FIFTEEN (15) CALENDAR DAYS** FROM THE POST DATE. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE GAIN SERVICES WORKER AT THE TELEPHONE NUMBER POSTED IN SECTION A BELOW.

A. Completed by GAIN SERVICES WORKER / CONTRACTED CASE MANAGER

Participant:	Date of Birth	Case No.:	Exempt Volunteer Status ☐ Y ☐ N

GSW/CCM:	Worker ID:	Telephone No.:	Fax No.:	Date:

B. Completed by Service Provider (Complete and return within 15 calendar days from the post date)

I. TYPE OF SERVICE ☐ **Residential** ☐ **Non-Residential**

☐ Mental Health (MH)* ☐ Substance Use Disorder (SUD)*
☐ Family Preservation (FP) ☐ Family Reunification (FR)
☐ Domestic Violence (DV) Case Management ☐ DV Family Law ☐ DV Immigration Law ☐ VAWA ☐ U-Visa

II. DUAL DIAGNOSIS (if applicable) ☐ MH ☐ SUD Please check if referral is needed ☐

III. PROGRESS (Complete as applicable) The above-referenced CalWORKs participant:

1. ☐ Is currently participating in the above DV/MH/SUD services or FP/FR activity for _____ hours/week.
   * Prior month's actual participation hours of MH _____ or SUD _____.
2. ☐ Has Dropped-out of services effective _____/ _____ /_____.
3. ☐ Has Completed services on _____/ _____ /_____.
4. ☐ Is Recommended for an extension of the DV/MH/SUD services or FP/FR activity until _____/ _____ /_____.

IV. CONCURRENT ACTIVITY (Evaluate participant's ability to participate in a concurrent activity every three (3) months from start date of treatment services. Does not apply to FP/FR Providers).

☐ Participant is able to participate concurrently in WtW activities for _____ hours/week.

NOTE: *If participant is **not** able to participate for a total of 20/30/35 hours per week in WtW activities:*
- *DV – The participant may be eligible for a Good Cause DV waiver of the WtW program requirements; or*
- *MH/SUD – The participant may be eligible for a medical exemption via the CW 61 and receive services as an Exempt Volunteer.*

The GAIN Services Worker will determine Good Cause or exemption eligibility and appropriate WtW activity with participant.

Service Provider/Staff Person's Name:	Title:	Telephone No.:	Date:

GN 6008 (Rev. 09/03/18) Page 1 of 2

PA 1923 - CALWORKS TREATMENT/SERVICES VERIFICATION

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC SOCIAL SERVICES

CalWORKs TREATMENT/SERVICES VERIFICATION

[To: **PA 1923 (SSS RR) Centralized Unit**
West Valley GAIN Region II
21415 Plummer Street, Suite B
Chatsworth, CA 91311
FAX Number: (818) 775-6969
] [From:]

A. PROVIDER CERTIFICATION

As an authorized employee of the treatment service provider agency named above, I certify that the individual named below is receiving CalWORKs Specialized Supportive Services (**DOMESTIC VIOLENCE, SUBSTANCE ABUSE, OR MENTAL HEALTH**) to help him/her overcome a barrier to employment. I understand that payment to contracted service provider is contingent on the CalWORKs participant maintaining eligibility to CalWORKs and complying with all requirements, assuming that the provider has been notified of the non-compliance by DPSS. In instances of substance abuse/mental health problems, includes the appropriate treatment services and signing a Welfare-to-Work (WtW) plan. For victims of domestic violence, certain requirements can be waived, including a WtW plan. In addition, the service provider must have received the GN 6008, Mental Health/Substance Abuse/Domestic Violence/Family Preservation Program Services Provider Progress Report, 90-days from service start date/assignment date, to confirm participant's continued eligibility to CalWORKs. This form must be submitted within 10 workdays of client's signature (not to exceed 30 days).

Print Name/Title of Authorized Person:	Date Signed:	Telephone No:	Fax No:

B. PARTICIPANT IDENTIFICATION

Name (First/Last):			CalWORKs Case No.:
Social Security No. : - -	Date of Birth:	Primary Language:	Telephone No.: (Confidential for DV) ( )

C. TYPE OF TREATMENT SERVICES (Complete as applicable) ☐ Residential ☐ Non-Residential

I. ☐ **MENTAL HEALTH** ☐ **SUBSTANCE ABUSE**

Participant began treatment services on ____/____/____ for ____ hours per week.*

Expected duration of needed treatment services: ____ months.

☐ Participant is able to participate in another WtW activity in addition to treatment services for ____ hours per week.

☐ Participant is Exempt from GAIN and will participate in GAIN as an Exempt Volunteer.

Note: *MH/SA participants may participate less than 32/35 hours-per-week with Good Cause for a 90-day period.

II. **DOMESTIC VIOLENCE CASE MANAGEMENT** ☐ **DV FAMILY LAW** ☐ **DV IMMIGRATION LAW** ☐ VAWA ☐ Uvisa

Participant began treatment services on ____/____/____ for ____ hours per week.

Expected duration of needed treatment services: ____ months.

☐ Participant is able to participate in another WtW activity in addition to treatment services for ____ hours per week.

☐ Participant is Exempt from GAIN and will participate in GAIN as an Exempt Volunteer.

Note: Participant shall be granted a DV waiver from the mandatory WtW Program rules with a clock stopper/extender.

D. OTHER SUPPORTIVE SERVICE NEEDS (Complete as applicable)

Participant needs the following supportive services: ☐ Child care ☐ Public Transportation ☐ Mileage: ____ per month
Work Related/Ancillary Expenses such as: ☐ Books ☐ Fees ☐ Uniforms or ☐ Other: ____

E. OTHER Court-ordered treatment services : ☐ DV Counseling ☐ Substance Abuse ☐ Mental Health

F. PARTICIPANT AUTHORIZATION (Complete as applicable)

I authorize the Department of Public Social Services and the above services provider to verify information regarding the status of my CalWORKs /GAIN case status and/or continuing eligibility to receive CalWORKs Specialized Supportive Services.

☐ I am aware that my Mental Health or Substance Abuse treatment/services will be incorporated in my Welfare-to-Work plan.

☐ I am aware that my Domestic Violence services may be incorporated now or eventually in my Welfare-to-Work plan.

The determination will be made by my GAIN Services Worker/Contracted/REP Case Manager in consultation with the service provider.

Participant's Signature:	Date:

G. COUNTY ACTION: ☐ **ACCEPTED** ☐ **REJECTED** **DATE:**

PA 1923 (Rev. 04/12/10)

Appendix L. DCFS – RSC Client Referral Form

DEPARTMENT OF PUBLIC HEALTH-SUBSTANCE ABUSE PREVENTION AND CONTROL
RECOVERY SUPPORT COURT (RSC) REFERRAL FORM

Section A – COMPLETED BY RSC CSW

Participant Name: _____	**RSC CSW's Name:** _____
Address: _____	**DCFS Address:** _____
_____	_____
Phone: _____	**Office Phone:** _____
Date of Birth: _____	**Email:**

Case Name:	**Primary Language:**	**Notes:**

Section B – COMPLETED BY SUD TREATMENT PROVIDER

The following appointment has been scheduled:

Date: **Time:**

Treatment Provider Name: _____

Address: _____

Care Navigator:	**Phone:**	**Email:**

Any known disability? NO ☐ YES ☐ (Describe accommodations needed.)

Section C – COMPLETED BY SUD TREATMENT PROVIDER (Return to RSC CSW within 5 working days)

Results of the admission appointment: **Participant did not attend / complete the information** ☐ **Participant completed admission** ☐	**Date:**

Intake Staff:	**Phone:**	**Email:**

Section D – COMPLETED BY PARTICIPANT

I authorize the release of information concerning my treatment admission to Department of Children and Family Services and to the Recovery Support Court.

_____ _____
DCFS Participant's Signature **Date**

Disposition: RSC CSW completes Section A - Green. Provider Sections B&C-Yellow. Participant Section D-white.