START

SYSTEM TRANSFORMATION TO ADVANCE RECOVERY AND TREATMENT OF SUBSTANCE USE DISORDERS

The Los Angeles County Department of Public Health, Substance Abuse Prevention and Control

Implementation Plan for Drug Medi-Cal Organized Delivery System Waiver

February 11, 2016

COUNTY OF LOS ANGELES
Public Health
Substance Abuse Prevention and Control

PART I
PLAN QUESTIONS

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

☒ County Behavioral Health Agency
☒ County Substance Use Disorder Agency
☒ Providers of drug/alcohol treatment services in the community
☒ Representatives of drug/alcohol treatment associations in the community
☒ Physical Health Care Providers
☒ Medi-Cal Managed Care Plans
☒ Federally Qualified Health Centers (FQHCs)
☐ Clients/Client Advocate Groups
☐ County Executive Office
☒ County Public Health
☒ County Social Services
☐ Foster Care Agencies
☒ Law Enforcement
☒ Court
☒ Probation Department
☐ Education
☒ Recovery support service providers (including recovery residences)
☐ Health Information technology stakeholders
☒ Other (specify) Public Defender, Criminal Justice Council

2. ***How was community input collected?***

☒ Community meetings
☒ County advisory groups
☐ Focus groups
☒ Other method(s) (explain briefly): Online survey via SurveyMonkey

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

☐ Monthly
☐ Bi-monthly
☐ Quarterly
☒ Other/s, specify: about bi-monthly through 2016 and quarterly thereafter

Review Note: One box must be checked.

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

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

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

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

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

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

5. ***What services will be available to DMC-ODS clients under this County plan?***

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

6. ***How will these required services be provided?***

<u>REQUIRED</u>

☐ All county operated
☒ Some county and some contracted
☐ All contracted.

<u>OPTIONAL</u>

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

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

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

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

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

☒ Yes (required)
☐ No

9. ***The County will comply with all quarterly reporting requirements as contained in the STCs.***

☒ Yes (required)
☐ No

PART II
PLAN DESCRIPTION

Narrative Description

1. COLLABORATIVE PROCESS

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

Review Note: Stakeholder engagement is required in the development of the implementation plan.

The Department of Public Health (DPH), Substance Abuse Prevention and Control (SAPC) developed a draft of the implementation plan based on what is most needed to advance care for individuals with substance use disorders (SUD), and made it available on the website with distribution by email to contracted providers and other key stakeholders (e.g., County agencies, County Medi-Cal managed care health plans). DPH-SAPC proceeded with conducting a series of stakeholder engagement meetings to ensure adequate opportunities for the public to provide feedback on the draft implementation plan and how it will ultimately be operationalized.

The initial kickoff meeting on August 13, 2015 presented key features of California's DMC-ODS Waiver, the County draft implementation plan, and the process for eliciting stakeholders' feedback. This initial meeting was followed by nine regional meetings conducted between August 19 and September 9, 2015 at locations throughout Los Angeles County that provided a review of the plan and produced feedback on each major section of the plan (Table 1).

Table 1: Regional Stakeholder Meetings

SPA	SD	CITY	FACILITY	DATE
1	5	Lancaster	High Desert Medical Center	August 24, 2015
2	3	Lake View Terrace	Phoenix Houses of Los Angeles	August 31, 2015
3	5	Arcadia	Arcadia Park	September 1, 2015
4	1	Los Angeles	Eagle Rock Library	September 8, 2015
5	4	Marina del Rey	Burton W. Chace Park	September 3, 2015
6	2	Los Angeles	MLK Community Engagement Center	August 19, 2015 September 9, 2015
7	1	Commerce	Department of Health Services	August 20, 2015
8	2	Gardena	Behavioral Health Services	August 27, 2015
Legend: (SPA) Service Planning Area, (SD) Supervisorial District				

To ensure feedback from County agencies, health plans, and other organizational partners, DPH-SAPC conducted an invitational briefing and feedback session on August 26, 2015 that included representatives from the following entities:

- County Agencies:
    - Department of Children and Family Services (DCFS)
    - Department of Health Services (DHS)
    - Department of Mental Health (DMH)
    - DPH, Office of Strategic Planning
    - DPH, Children's Medical Services
    - Department of Public Social Services (DPSS)
    - District Attorney's Office
    - Probation Department
    - Public Defender's Office
    - Sheriff's Department
- Health Plans:
    - Health Net
    - L.A. Care Health Plan
- Other Entities:
    - California Community Foundation
    - Countywide Criminal Justice Coordination Committee (CCJCC)

An online survey was also developed that allowed stakeholders to provide detailed written feedback about each major section of the plan. Information from the online survey and the regional meetings was compiled and distributed via email to all SUD network contractors and meeting participants, and the implementation plan was updated based on feedback where appropriate. On December 17, 2015, DPH-SAPC held a system-wide meeting to report the results of its stakeholder engagement for the first phase of the feedback process and provided an overview of the major themes, as well as key system transformation efforts that will occur in the next one to three years. Stakeholders could attend in-person or via a real-time webinar. Overall, 88 percent of current SUD treatment providers participated in the stakeholder process held between August and December 2015, in addition to other County partners and interested parties (Table 2):

Table 2: Stakeholder Attendance

FEEDBACK TYPE	INDIVIDUALS	AGENCIES
Kick-Off Meeting	98	61
Regional Meetings	107	47
County/Health Plan Meeting	34	13
Online Survey (Complete)	65	60
Online Survey (Incomplete)	25	21
Results Meeting (In-Person)	107	70
Results Meeting (Webinar)	114*	87

* Represents the number of logins only so participation is underrepresented when sharing a viewing station

Submission of the DMC-ODS implementation plan will be the first step in the *System Transformation to Advance Recovery and Treatment of Substance Use Disorders* (START) and initiation of the operational plan to improve clinical care and outcomes. Efforts will occur in four major categories: business development, infrastructure development, clinical development, and system of care development. Stakeholder engagement workgroups, and technical assistance and training, will be central to ensuring development of an effective service system design and the ability to improve patient access, health outcomes, and quality of life with cost savings to the healthcare system overall due to greater investment in quality SUD services (Figure 1).

This is a placeholder for Figure 1; a flow chart showing *System Transformation to Advance Recovery and Treatment of Substance Use Disorders* (START).

DPH-SAPC will convene the following anticipated stakeholder engagement workgroups now that the implementation plan has been submitted and will occur throughout the waiver period as needed.

- *System of Care Development*
  - Youth/Young Adult Services
  - Adult Services
  - Integration of Care
- *Clinical Development*
  - Quality Improvement
  - Utilization Management

- *Business and Infrastructure Development*
  - System Operations
    - Financing
    - Contracts
    - Information Technology
  - System Innovations and Network Capacity Building

These workgroups will be comprised of representatives from various agencies/groups including but not limited to the SUD provider network, the Commission on Alcohol and Other Drugs (County advisory body appointed by the Board of Supervisors), County entities/departments (CCJCC, DCFS, DMH, DHS, DPH, DPSS, Probation, Sheriff's Department, unions), managed care plans (Health Net, L.A. Care), consumer advocacy groups, education, and other interested community members. Information gathered from the previous regional meetings and the online survey will also be used to inform this process, including development of the standards of practice and overall system design. An email listserv was also developed to ensure that the entire SUD provider network, as well as other interested stakeholders, could stay informed about this process even when sending representatives to workgroup meetings is not feasible.

2. PATIENT FLOW

Describe how clients move through the different levels identified in the continuum of care (referral, assessment, authorization, placement, and transitions to another level of care). Describe what entity or entities will conduct ASAM Criteria interviews, how admissions to the recommended level of care will take place, how often clients will be re-assessed, and how they will be transitioned to another level of care accordingly. Include the role of how the case manager will help with the transition through levels of care. Also describe if there will be timelines established for the movement between one level of care to another.

Review Note: A flow chart may be included.

DPH-SAPC operates two systems of care for SUD treatment services: one for adults (25 years of age and older) and one for youth (under 18 years of age), which will soon be expanded to include young adults (18 through 25 years of age). Services are delivered through contracts with community-based State-certified and/or licensed SUD treatment programs, and the County-operated Antelope Valley Rehabilitation Centers (AVRC), an outpatient and residential treatment facility for adults. Referrals are accepted from all sources, including County Medi-Cal managed care health plans, other County departments, criminal justice and juvenile justice agencies, child dependency system, community-based human service agencies, employers, schools, families, and self. Services available include the entire range of services contained in the youth and adult benefit packages (Attachment 1). Beneficiaries move through the system of care via the Beneficiary Access Line and the SUD provider network (Figure 2).

There is no "wrong door" to enter SUD services. All individuals seeking admission to SUD services can access them by contacting the toll-free Beneficiary Access Line (see description below) or by contacting any contracted-SUD network provider. At that time, the individual will participate in a brief triage assessment to determine the provisional level of care (LOC) based on

the American Society of Addiction Medicine (ASAM) Criteria and Medi-Cal eligibility status. Adults and young adults will be referred to the provisional LOC for further assessment whereas youths will be referred to a qualified youth outpatient treatment agency where they will receive a full assessment and referral to an appropriate higher LOC as necessary. If the individual initially presents at a 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 beneficiaries will be referred to, and/or served by, a DMC certified agency for DMC reimbursable services.

In either case, individuals who need SUD care must be scheduled for an appointment within three business days and receive a face-to-face appointment within 15 business days from the brief triage assessment date; beginning in July 2017 the face-to-face target will be five business days for outpatient and 10 business days for residential LOCs and five business days for all LOCs by July 2018. At this appointment, the provider will conduct a more intensive biopsychosocial clinical assessment using a standardized tool based on the ASAM Criteria to establish and/or confirm the appropriate LOC placement, and initiate services as indicated. The initial medical necessity determination will be conducted through a face-to-face or telehealth review by a Licensed Practitioner of the Healing Arts (LPHA). If the initial triage assessment and the fuller ASAM-based assessment to determine medical necessity and the appropriate LOC involve different providers, efforts will be made to ensure a "warm hand-off" to support completion of the assessment appointment and enrollment in services.

This is a place holder for Figure 2: Los Angeles County System of Care Beneficiary Flow.

When the brief triage assessment and/or the full ASAM assessment indicates that placement in a residential treatment program (ASAM level 3.1, 3.3, 3.5) is needed, the selected provider will submit a pre-authorization request to DPH-SAPC's Office of the Medical Director and Science Officer, which will conduct a pre-authorization review, and then approve or deny the request within 24 hours of receiving the request. If relapse risk is deemed to be significant without immediate placement in residential care, a residential treatment provider may admit an individual prior to receiving residential authorization, with the understanding that authorization denials will result in financial loss whereas authorization approvals will be retroactively reimbursed to the date of admission. Pre-authorization by the County is not required for admission into other ASAM LOCs, though it will be required for Medication-Assisted Treatment for those under age 18.

Once admitted into services, an individualized treatment plan will be developed by at minimum a Certified Counselor and signed by an LPHA. To reflect progress, the treatment plan for adolescents and adults will be reviewed, updated, and adjusted accordingly at least every 30-days in all treatment settings, and it is recommended that the treatment plan in more intensive LOCs, such as residential settings, be updated more frequently if an individual is unstable or if there is a notable event that requires a change in the treatment plan. If the individual's condition does not show improvement at a given LOC or with a particular intervention, then a progress review, focused assessment, and treatment plan modification will be made to improve therapeutic outcomes. Should it be determined that the individual requires a change in LOC during the course of treatment, the current treatment provider will assist the individual in transferring to the appropriate LOC within the provider organization or by coordinating a referral to another treatment program with assistance from the Beneficiary Access Line as needed. An individual can move between LOCs, or in some cases be in services concurrently (e.g., residential and opioid treatment programs), as clinically appropriate (Figure 3). Transitions between LOCs will be documented as required by DPH-SAPC to better ensure successful connections with the new service location/provider, including the facilitation of warm hand-offs whenever possible.

This is a place holder for Figure 3; diagram showing how an individual can move between appropriate levels of care.

Discharge planning is an integral component of the treatment process and begins at the time of admission. Processes to prepare the individual for return or reentry into the community include linkages to essential supportive services such as education, employment training, employment, housing, benefit enrollment, and other human services as indicated at assessment and during the treatment process.

Individuals who no longer meet medical necessity criteria for SUD treatment services, or prematurely exit the SUD system of care, are eligible to receive recovery support services from the last treatment provider of care, which will reengage the individual into treatment if needed.

Case-management and care coordination will be an essential component to ensuring that individuals successfully engage in the initial treatment episode, receive necessary services, and transition through care as clinically appropriate. Case management will be provided by the current SUD provider to facilitate engagement, coordination, and transitions. DPH-SAPC is in the process of determining its role in providing case management services, as the administrative oversight of its provider network, and is determining how best to coordinate case management with the managed-care health plans, and DHS and/or DMH for those receiving services for co-occurring conditions. A model of case management that is tiered based on risk and/or the level of patient service need (e.g., SUD only versus co-occurring conditions) is being considered and procedures will be finalized before service delivery.

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

3. BENEFICIARY ACCESS LINE

For the beneficiary toll-free access number, what data will be collected (i.e., measure the number of calls, waiting times, and call abandonment)?

Initially, the Beneficiary Access Line will be operated by the existing Community Assessment Service Centers (CASC) contracted by DPH-SAPC using an existing toll-free line and automated system that routes callers to the nearest of 19 CASC sites located throughout the County. The line will be staffed on weekdays from at minimum 8 AM to 6 PM with a message system after hours, and on weekends and holidays. The line will be answered by live-person at all times during operating hours. Calls received after hours or on weekends and holidays will be returned on the first following business day according to instructions left by the caller. Callers with emergency or urgent needs will be directed to contact 911 or to proceed to the nearest hospital emergency department. Services will be offered in English and Spanish, and a translation service will be immediately available during staffed hours for all other threshold languages.

At a minimum, certified substance abuse counselors will conduct screening interviews with callers or those seeking services in-person using the standardized adolescent or adult brief triage assessment based on the ASAM Criteria, make a provisional LOC determination, determine Medi-Cal eligibility, and schedule an assessment/admission appointment with a network provider. DPH-SAPC is developing an automated system to schedule assessment/admission

appointments; in the interim, appointments will be scheduled with the selected provider while the caller is on the line whenever possible, but no later than three business days, and tracked according to DPH-SAPC requirements. A reminder and follow-up process will be established in accordance with "warm hand-off" procedures to better ensure that beneficiaries attend the assessment/admission appointment. All access line procedures will be conducted with the individual as a full participant in the decision-making process, including offering referral options that align with geographic, service hour availability, cultural, and other preferences.
The following information will be collected by the Beneficiary Access Line for continuous quality improvement purposes:

- Number of calls received by day and time blocks;
- Rate of call abandonment;
- Rate of unanswered calls;
- Number of brief triage assessments conducted;
- Number of referrals to treatment by LOC;
- Number of days from initial call/contact to assessment/admission appointment;
- Number of individuals who attended assessment/admission appointment;
- Analysis of wait time to treatment enrollment;
- Demographic characteristics of callers (age, gender, ethnicity/race, primary language if non-English speaking, ZIP Code of residence); and
- Insurance status by health plan (e.g., L.A. Care, Health Net) and funding source (e.g., DMC).

DPH-SAPC is presently considering various options for how the Beneficiary Access Line is operated long-term, including continuing the use of CASCs, a County-operated service (e.g., adding functionality and capacity to an existing DMH line), or contracting with an independent entity for this service. In addition, DPH-SAPC is exploring extending the operating hours to accommodate beneficiaries who may seek services or information after regular business hours. A decision will be made based on experiences within the first year of DMC-ODS plan implementation.

4. TREATMENT SERVICES

Describe the required types of DMC-ODS services (withdrawal management, residential, intensive outpatient, outpatient, opioid/narcotic treatment programs, recovery services, case management, physician consultation) and optional (additional medication assisted treatment, recovery residences) to be provided. What barriers, if any, does the county have with the required service levels? Describe how the county plans to coordinate with surrounding opt-out counties in order to limit disruption of services for beneficiaries who reside in an opt-out county.

Review Note: Include in each description the corresponding ASAM level, including opioid treatment programs. Names and descriptions of individual providers are not required in this section; however, a list of all contracted providers will be required within 30 days of the waiver implementation date.

The County will implement an initial benefit package of SUD services within the initial 12 months of execution of the new State and County contract (Table 3, Attachment 1). For adolescents this will include ASAM LOCs 1, 2.1, 3.1 and 3.5; for adults this will include ASAM LOCs 1, 2.1, 3.1, 3.3, 3.5, 1-WM, 3.2-WM, and 1-OTP as well as medication-assisted treatment. Medication-assisted treatment will be available to youth on a case-by-case basis depending on clinical need, and case-management/care coordination, recovery support, and physician consultation services will be available to all beneficiaries served within the DPH-SAPC system of care. By year three, ASAM LOC 2-WM will be added to the benefit package for adults. Several LOCs are funded outside of the SUD system of care (ASAM 0.5, 2.5, 3.7 and 4.0); however, DPH-SAPC and its network providers will coordinate referrals where needed to better ensure delivery of services that best match the beneficiaries' level of need.

DPH-SAPC-Funded LOC Descriptions

Outpatient Services (ASAM Level 1.0): Services are provided by a DHCS-certified outpatient facility and consist of counseling for up to nine hours per week for adults and up to six hours per week for youth. Services include: intake, assessment, treatment planning, group counseling, individual counseling, family therapy, patient education, crisis intervention services, collateral services, medication services, and discharge planning services. Services can be provided in any appropriate setting in the community, including in-person, by telephone, or by telehealth. Medication-Assisted Treatment (MAT) will be discussed and offered as a concurrent treatment option for individuals with an alcohol and/or opioid related SUD condition that are receiving services at this LOC.

Intensive Outpatient Services (ASAM Level 2.0): Services are provided by a DHCS certified intensive outpatient facility and include structured programming provided to beneficiaries for a minimum of nine hours with a maximum of 19 hours a week for adults and a minimum of six hours with a maximum of 19 hours a week for youth. Services include: intake, assessment, treatment planning, group counseling, individual counseling, family therapy, patient education, crisis intervention services, collateral services, safeguarding medications, transportation services, and discharge planning services. Services can be provided in any appropriate setting in the community, including in-person, by telephone, or by telehealth. MAT will be discussed and offered as a concurrent treatment option for individuals with an alcohol and/or opioid related SUD condition that are receiving services at this LOC.

Low Intensity Residential Services (ASAM Level 3.1): Services are provided by a California Department of Social Services (CDSS) licensed group home facility for youth or a DHCS licensed residential facility for adults each with a DHCS ASAM Level 3.1 designation, and include 24-hour care with at least five hours of clinical services per week. Services include: intake, treatment planning, group counseling, individual counseling, family therapy, patient education, crisis intervention services, collateral services, medication services, and discharge planning services. Services are provided primarily in the facility setting. MAT will be discussed and offered as a concurrent treatment option for individuals with an alcohol and/or opioid related SUD condition that are receiving services at this LOC.

TABLE 3: SUD Benefit Package and Timeline

Level Of Care (LOC)/Service	ASAM Level	DMC-ODS LOC End Year One		DMC-ODS LOC End Year Three	
		Youth	Adult	Youth	Adult
Early Intervention	0.5	No	No	No	No
Outpatient	1	Yes	Yes	-	-
Intensive Outpatient	2.1	Yes	Yes	-	-
Partial Hospitalization	2.5	No	No	No	No
Low Intensity Residential	3.1	Yes	Yes	-	-
High Intensity Residential Population Specific	3.3	N/A	Yes	N/A	-
High Intensity Residential Non-Population Specific	3.5	Yes	Yes	-	-
Intensive Inpatient Services Medically Monitored	3.7	No	No	No	No
Intensive Inpatient Services Medically Managed	4.0	No	No	No	No
Ambulatory Withdrawal Management Without Extended On-Site Monitoring	1-WM	N/A	Yes	N/A	-
Ambulatory Withdrawal Management With Extended On-Site Monitoring	2-WM	N/A	No	N/A	Yes
Residential Withdrawal Management Clinically Managed	3.2-WM	N/A	Yes	N/A	-
Inpatient Withdrawal Management Clinically Managed	3.7-WM	No	No	No	No
Inpatient Withdrawal Management Medically Managed and Intensive Services	4-WM	No	No	No	No
Opioid (Narcotic) Treatment Program	1-OTP	N/A	Yes	N/A	-
Addiction Medications With Concurrent Outpatient/Residential		N/A	Yes	N/A	-
Case Management/Care Coordination		Yes	Yes	-	-
Recovery Support Post Discharge		Yes	Yes	-	-

High Intensity Residential Services – Population Specific (ASAM Level 3.3): Services are provided by a DHCS licensed residential facility for adults with a DHCS ASAM Level 3.3 designation, and include 24-hour care for individuals who are unable to successfully function in a more active milieu. Services include: intake, treatment planning, group counseling, individual counseling, family therapy, patient education, crisis intervention services, collateral services, medication services, and discharge planning services. Services are provided primarily in the facility setting. This LOC is not available for youth. MAT will be discussed and offered as a

concurrent treatment option for individuals with an alcohol and/or opioid related SUD condition that are receiving services at this LOC.

High Intensity Residential Services – Non-Population Specific (ASAM Level 3.5): Services are provided by a CDSS licensed group home facility for youth or a DHCS licensed residential facility for adults each with a DHCS ASAM Level 3.5 designation, and include 24-hour care for those who are able to successfully function in a more active milieu. Services include: intake, treatment planning, group counseling, individual counseling, family therapy, patient education, crisis intervention services, collateral services, medication services, and discharge planning services. Services are provided primarily in the facility setting. MAT will be discussed and offered as a concurrent treatment option for individuals with an alcohol and/or opioid related SUD condition that are receiving services at this LOC.

Ambulatory Withdrawal Management – No Extended On-Site Monitoring (ASAM Level 1-WM): Services are provided by a DHCS certified outpatient facility with a Detox Certification and a physician/licensed prescriber, and are for individuals with mild withdrawal who require daily or less than daily supervision. Services include: intake, observation, medication services, and discharge planning services. This LOC is generally not available for youth except with DPH-SAPC prior authorization. MAT will be discussed and offered as a referral option for individuals with an alcohol and/or opioid related SUD condition that are receiving services at this LOC.

Ambulatory Withdrawal Management – Extended On-Site Monitoring (ASAM Level 2-WM): Services are provided by a DHCS certified outpatient facility with a Detox Certification and a physician/ licensed prescriber, and are for individuals with moderate withdrawal who require all day support and supervision, but who have a supportive family or living situation at night. Services include: intake, observation, medication services, and discharge planning services. This LOC is generally not available for youth except with DPH-SAPC prior authorization. MAT will be discussed and offered as a referral option for individuals with an alcohol and/or opioid related SUD condition that are receiving services at this LOC.

Ambulatory Withdrawal Management – Extended On-Site Monitoring (ASAM Level 3.2-WM): Services are provided by a DHCS licensed residential facility with a Detox Certification and a physician/licensed prescriber, and are for individuals with moderate withdrawal who require 24-hour support and supervision. Services include: intake, observation, medication services, and discharge planning services. This LOC is generally not available for youth except with DPH-SAPC prior authorization. MAT will be discussed and offered as a referral option for individuals with an alcohol and/or opioid related SUD condition that are receiving services at this LOC.

Opioid (Narcotic) Treatment Program (ASAM Level 1-OTP): Services are provided by a DHCS licensed Narcotic Treatment Program (NTP) facility with a physician/licensed prescriber, and are for individuals who require daily or several times weekly opioid agonist medications and counseling to address severe opioid use disorder. Services include: intake, treatment planning, group counseling, individual counseling, patient education, crisis intervention services, collateral services, medication services, medical psychotherapy, and discharge planning services. This LOC is generally not available for youth except with DPH-SAPC prior authorization.

Note: For youth, the benefit package is established as a developmentally-appropriate set of services. Not all LOCs or types of services available to adults are included in the benefit package for youth, such as Withdrawal Management and Medication-Assisted Treatment because these services are generally not approved or appropriate for this population. However, on a case-by-case basis as determined as medically necessary with prior authorization by DPH-SAPC, such services will be made available to youth.

DPH-SAPC Other Service Descriptions

Recovery Support: These services are available to all patients who enter the SUD treatment system, and should be available for a minimum of six months by the last treatment provider of care and who will reengage the individual in treatment if needed. Services include: individual counseling, group counseling, recovery monitoring, and peer-to-peer substance abuse assistance as well as linkages to schools/educational programs, job skills development, support groups, family support, and other ancillary services.

Case-Management/Care Coordination: These services are available to all patients who enter the SUD treatment system, and are available throughout the treatment episode and may be continued during recovery support as allowed by DPH-SAPC. Services include: regular assessment and reassessment to determine need for continued services at the appropriate level, transitions in LOCs, treatment plan development and updates, coordination of referrals (including connections with and transportation to physical and mental health services), monitoring progress in services, and patient advocacy.

Recovery Residences: These services are currently available to perinatal and AB 109 patients on a limited basis. The degree to which this can be further expanded, especially to facilitate step-down from residential services, will be determined during year one of implementation. This process includes ensuring adequate quality standards and determining what facility types would be expanded (e.g., National Association of Recovery Residences, Sober Living Network), what criteria would be used to determine patient eligibility, and the degree to which DPH-SAPC would provide funding for specific patients or simply establish a referral network based on determined facility standards. Services would not be provided on-site at recovery residences, but any resident receiving rent support would need to participate in outpatient, intensive outpatient, case-management, and/or recovery support services, as necessary.

Physician Consultation: This includes consultations for DMC physicians with addiction-trained physicians to ensure that SUD providers have access to non-emergency clinical and medical information that can be used to improve care and services for individuals with substance use disorders. These consultations will occur either telephonically or electronically, via the DPH-SAPC website or Electronic Health Record (EHR), and will not occur in real-time. Question topics may include medication-assisted treatments, dosage recommendations, the management of unusual or difficult cases, and LOC recommendations. This service will either be directly operated by DPH-SAPC or subcontracted.

Additional Medication Assisted Treatment: See Section 19 for more information.

Expansion of Services and Barriers to Implementation

A system transformation this extensive will require substantial investment in the clinical, business, and technological infrastructure at both the County- and provider-level, to ensure success of the DMC-ODS pilot and the ability to demonstrate desired outcomes. This infrastructure includes the quality and care coordination standards (e.g., use of the ASAM Criteria, evidence-based practices) that will help improve patient care. Meeting these requirements also comes with additional costs such as hiring and maintaining a well-qualified workforce, providing on-going training and the ensuring fidelity to evidence-based practice models and other standards. Therefore, the reimbursement rates must adequately account for the associated costs to build this improved system of care while also moving it into closer alignment with the mental and physical health systems in accordance with parity. It will also be essential to ensure adequate availability of services, which necessitates expanding the number of providers/service sites (especially residential service sites that also include licensing and zoning requirements) and certifying new agencies and sites quickly.

Cross-County Coordination

In the event that a Medi-Cal beneficiary from another county seeks SUD services that are determined medically necessary but who is not able to receive services directly from that County, DPH-SAPC will provide the services based on those benefits offered by the County of residence and notify the County of residence with written authorization from the beneficiary to share protected confidential information. DPH-SAPC will request DHCS to provide reimbursement from the County of residence.

6. COORDINATION WITH MENTAL HEALTH

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

A current Memorandum of Understanding (MOU) between DPH-SAPC and DMH defines the coordination of mental health and SUD services for Medi-Cal beneficiaries. DPH-SAPC and DMH work closely together to ensure that services are being provided adequately and appropriately for beneficiaries with co-occurring conditions. Increasingly, DMH has added DPH-SAPC network providers to its contracted specialty mental health provider network to support an integrated approach to services.

The two County Medi-Cal managed care health plans (Health Net and L.A. Care) are responsible for addressing the mental health services needs of its members with mild to moderate mental health conditions. DPH-SAPC coordinates care with the two County health plans for those with co-occurring SUD and mild to moderate mental health conditions. This relationship is established and defined through MOUs with the two County health plans. DPH-SAPC and the two County health plans are actively assisting the County-contracted SUD network providers to

become credentialed by the health plans to provide services for mild to moderate mental health conditions as a means to implement integrated care for this population.

7. COORDINATION WITH PHYSICAL HEALTH

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

In compliance with the DMC-ODS Standard Terms and Conditions, DPH-SAPC is establishing MOUs with the two County Medi-Cal managed care health plans (Health Net and L.A. Care) that define coordination of physical health and SUD services for Medi-Cal beneficiaries (Attachment 2).

DPH-SAPC has already established MOUs with the two County health plans, DHS, DMH, and DPSS for the County's participation in the Cal MediConnect demonstration project for dual Medicare and Medi-Cal beneficiaries. DPH-SAPC, DMH, and the two County health plans will use the care coordination infrastructure established for the Cal MediConnect project to build the DMC-ODS care coordination infrastructure.

The Behavioral Health Steering Committee and Program Administration Team will provide overall policy and programmatic leadership for the coordination of care across physical health, mental health, and SUD service systems. Meetings will be bi-monthly and include leadership from the health plans and County departments. Interdisciplinary care coordination teams comprised of clinical personnel from the health plans and County partners meet regularly to discuss care coordination for beneficiaries with multiple co-occurring conditions. Sharing of patient information is conducted with patient consent in accordance with all applicable patient confidentiality requirements to support decisions about care coordination involving the County-contracted SUD network providers, County health plan network providers, and DMH specialty mental health network providers. The County-contracted SUD provider network is already actively engaged in care coordination with mental health and physical health providers through the infrastructure established for the Cal MediConnect project as described above.

DPH-SAPC coordinates with the County Medi-Cal managed care health plans to ensure that beneficiaries have access to and receive SUD services through health plan network providers for services reimbursable by Medi-Cal but not included in the DMC-ODS benefits such as voluntary inpatient detoxification services in general acute hospitals (ASAM Levels 3.7-WM, 4-WM) and Screening, Brief Intervention and Referral to Treatment (SBIRT) services (ASAM Level 0.5) in primary care settings.

DPH-SAPC also has a well-established care coordination relationship with DHS, which provides physical health services for Medi-Cal beneficiaries under an agreement with L.A. Care, and also for the uninsured safety net population.

The expansion of SUD services available under the DMC-ODS implementation plan greatly improves access to SUD services for persons with co-occurring mental health and physical health conditions, particularly in terms of access to residential treatment services, which have historically been difficult to access for medically indigent individuals due to limited County, State and federal funding.

8. COORDINATION ASSISTANCE

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

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

The following challenges have been identified for effective provision of coordinated and integrated mental health, physical health, and SUD services for beneficiaries with multiple, co-occurring conditions:

- Patient Data-Sharing Between Systems – The current requirements of 42 Code of Federal Regulations (CFR) Part 2 make sharing of patient information between systems cumbersome. State advocacy to revise or waive these requirements for the Waiver demonstration would allow more effective and efficient care coordination practices.

  DPH-SAPC is presently an active participant in County efforts to establish an electronic health records system that would allow patient data exchange between physical health, mental health, and SUD service systems. DPH-SAPC is also engaged with DMH, DHS, and County health plans to establish a patient consent form that would be used by all partners to authorize exchange of patient information for the purposes of care coordination.

- Payment Reform – Current Medi-Cal payment systems for mental health, physical health, and SUD services are cumbersome, and discourage effective and efficient coordinated or integrated care approaches. The changes to permit same-day billing for Medi-Cal reimbursed services (physical, mental health, SUD) for counties participating in the waiver is a significant step to improving and supporting cross-system coordinated and integrated care and should be maintained. Payment and provider enrollment incentives for Medi-Cal providers with coordinated and integrated care approaches to service delivery would further promote the adoption of such approaches as the standard for statewide service delivery.

DPH-SAPC is actively engaged with the County lobbyist, the advocacy efforts of provider associations and the County Behavioral Health Directors Association of California, and DHCS to enact federal, State, and County legislation and regulatory changes needed to advance coordinated and integrated care by removing barriers described above.

- Cross-System Workforce Development – The workforces in mental health, physical health and SUD service networks have limited expertise in identifying and addressing multiple co-occurring conditions through care coordination, with a cross-systems, integrated approach. Workforce training on best practices for patient screening, problem and risk identification, brief intervention for substance use problems, and patient engagement in SUD services are needed for the mental health and physical health workforces. Training in care coordination is needed by all three workforces.

  DPH-SAPC is actively engaged with DHS and DMH along with the County-designated Medi-Cal managed care health plans, and other stakeholder groups to implement cross-system workforce training on effectively working with persons with SUD among other multiple co-occurring conditions.

9. ACCESS

Describe how the county will ensure access to all service modalities. Describe the county's efforts to ensure network adequacy. Describe how the county will establish and maintain the network by addressing the following:

- ***The anticipated number of Medi-Cal clients;***
- ***The expected utilization of services;***
- ***The numbers and types of providers required to furnish the contracted Medi-Cal services;***
- ***Hours of operation of providers;***
- ***Language capability for the county threshold languages;***
- ***Timeliness of first face-to-face visit, timeliness of services for urgent conditions, and access to afterhours care; and***
- ***The geographic location of providers and Medi-Cal beneficiaries, considering distance, travel time, transportation, and access for beneficiaries with disabilities.***

DPH-SAPC conducted an analysis to project utilization of SUD services given the expansion of Medi-Cal eligibles and LOCs reimbursable under DMC. Based on analysis of 2013 census data, approximately 2.8 million people are estimated to be at or below 138 percent of the federal poverty limit (FPL) and potentially eligible for Medi-Cal in Los Angeles County. Of those 2.8 million people, about 951,880 are estimated to be youth and 1.8 million are estimated to be adults. According to the National Survey on Drug Use and Health (NSDUH) data, the estimated prevalence of SUDs among adults in poverty is about 13 percent, and about 7.4 percent in youth. Using these prevalence rates, DPH-SAPC estimates that approximately 70,439 youth and 236,338 adults are DMC eligible in Los Angeles County.

Averaging historical youth (12-17) utilization data over the last 10 years, the annual unique patients served amounted to 9,812 with an average of 1.1 readmissions per patient. DPH-SAPC's projected utilization assumed either stable (low –1.1) or increased (medium – 1.3; high – 1.6) readmissions per patient to the same or different LOC given increased access to appropriate care and improved care coordination. Utilizing these readmission variables to estimate total utilization and applying them to the aforementioned DMC eligible estimates, the estimated range of annual youth patients served is 10,793 (low readmission estimate) to 20,549 (high readmission estimate). This range of utilization numbers provides an estimate of anticipated volume for early phases of the DMC-ODS waiver, in addition to anticipated volume in late phases of the DMC-ODS waiver, assuming enhanced access to SUD services and flow between LOCs. Using medium-level estimates (readmission variable 1.3), Los Angeles County anticipates total utilization of at least 16,696 duplicated youth served annually, with another 60,627 youth in need of SUD services (Figure 4).

This is a place holder for Figure 4: DMC-ODS Medium Utilization Estimation for Youth.

Averaging historical adult utilization data over the last 10 years, the annual unique patients served amounted to 50,336 with an average of 1.2 readmissions per patient. DPH-SAPC's projected utilization assumed either stable (low –1.2) or increased (medium – 1.4; high – 1.8) readmissions per patient to the same or different LOC given increased access to appropriate care and improved care coordination. Utilizing these readmission multipliers to estimate total utilization and applying them to the aforementioned DMC eligible estimates, the estimated range of annual patients served is 60,403 (low readmission estimate) to 114,041 (high readmission estimate). This range of utilization numbers provides an estimate of anticipated volume for early phases of the DMC-ODS waiver, in addition to anticipated volume in late phases of the DMC-

ODS waiver, assuming enhanced access to SUD services and flow between LOCs. Using medium-level estimates (readmission multiplier 1.4), Los Angeles County anticipates total utilization of at least 88,698 duplicated adults served annually, with another 186,002 adults in need of SUD services (Figure 5). It is expected, however, that utilization may increase for both youth and adults as services become more accessible County-wide, individuals become aware of the SUD benefits, care coordination and case-management improves, and stigma declines.

This is a place holder for Figure 5: DMC-ODS Medium Utilization Estimation for Adult.

Using the medium utilization estimates described above and the provider survey on bed and slot capacity conducted by DPH-SAPC last year, there is a potential deficit in adult outpatient, intensive outpatient, residential, withdrawal management and opioid (narcotic) treatment programs services depending on how quickly new services are accessed and how quickly capacity is expanded (Figures 6, 7, 8, 9, 10). DPH-SAPC plans to conduct a similar analysis for youth utilization estimates and will use both adult and youth utilization estimation analyses and other analyses (e.g., primary language hot spot analysis) to determine service gaps/needs. These data will inform a solicitation process to further improve access to care for beneficiaries by year two of the pilot, with continued expansion in year three as needed.

This is a place holder for Figure 6; Adult Outpatient – Medium Utilization Estimate.

This is a place holder for Figure 7; Adult Intensive Outpatient – Medium Utilization Estimate.

This is a place holder for Figure 8; Adult Residential – Medium Utilization Estimate.

This is a place holder for Figure 9; Adult Residential Medical Detox– Medium Utilization Estimate.

This is a place holder for Figure 10; Adult Opioid Treatment Program Outpatient – Medium Utilization Estimate.

DPH-SAPC currently contracts with community-based organizations to provide all LOCs and directly operates one residential facility and outpatient program (AVRC) for adults. Facilities may serve youths only, adults only, or youth and adults. Approximately 52 percent of outpatient, 55 percent of intensive outpatient, one percent of residential, 88 percent of opioid (narcotic) treatment program, and zero percent of withdrawal management sites are currently DMC certified. Given the very limited number of youth serving programs in DPH-SAPC's network, significant expansion of outpatient, intensive outpatient and residential LOCs will be needed. (Table 4, Attachment 3).

According to DHCS information, state-licensed residential treatment and residential detoxification programs have a total of 5,895 beds available in Los Angeles County, including those already contracted by the DPH-SAPC. A total of 277 state-certified non-residential treatment programs operate in the County, including those already contracted by the DPH-SAPC. Therefore, there exists a large inventory of outpatient services and residential beds that presently are not contracted by the County. While some of this capacity is likely committed to other purchasers of services, such as the State correctional system and commercial health insurance plans, it is likely that a substantial inventory remains unfunded and demonstrates potential for DMC certification to support expanded service needs as DMC-ODS is implemented.

Table 4: Number of Contracts and Sites by Population Served

Level of Care	DMC Certified		Non-DMC Certified		Total # Agencies (N=93)	Total # Sites (N=383)
	# of Agencies	# of Sites	# of Agencies	# of Sites		
Youth Serving Only						
Outpatient	0	0	7	7	7	7
Intensive Outpatient	0	0	0	0	0	0
Residential	0	0	1	1	1	1
Youth and Adult Serving						
Outpatient – General	6	10	2	2	8	12
Outpatient – Perinatal	0	0	0	0	0	0
Intensive Outpatient – General	0	0	0	0	0	0
Intensive Outpatient – Perinatal	0	0	0	0	0	0
Residential – General	1	1	2	3	3	4
Residential – Perinatal	0	0	0	0	0	0
Residential – Detox	0	0	0	0	0	0
Narcotic Treatment – General	0	0	0	0	0	0
Narcotic Treatment – Perinatal	0	0	0	0	0	0
Adult Serving Only						
Outpatient – General	44	85	26	84	61	169
Outpatient – Perinatal	14	21	7	13	20	34
Intensive Outpatient – General	22	31	12	28	30	59
Intensive Outpatient – Perinatal	12	15	6	9	16	24
Residential – General	0	0	39	94	39	94
Residential – Perinatal	0	0	7	14	7	14
Residential – Detox	0	0	3	4	3	4
Narcotic Treatment – General	16	39	2	6	17	45
Narcotic Treatment – Perinatal	1	4	0	0	1	4
Recovery Residence-Perinatal	0	0	9	53	9	53
Recovery Residence	0	0	9	14	9	14

Efforts are underway to better define requirements for site-specific certification and to increase the number of SUD network providers with the DMC certification. The greatest concern for the County, however, is the timeliness with which the State is able to process new DMC applications, particularly for residential services. Until DPH-SAPC's network providers of residential services are DMC-certified, these benefits must be funded under other capped funding sources, which limit the number of available treatment beds, causing patients to be served in LOCs below what is determined to be medically necessary. As a result, both the County and State may be at risk for liability by not providing adequate medically determined LOCs.

Additional Accessibility Factors

While increasing the availability of services in underserved parts of the County is essential to increasing rates of SUD treatment and improving health outcomes, so is meeting the needs of beneficiaries in terms of flexible hours of operation, services in their preferred language, the ability to receive services when needed, and easily accessible locations (non-clinic based, proximity to home/work). DPH-SAPC will encourage and assist SUD network providers to continually take steps to provide services that meet beneficiaries' needs and preferences, but at minimum this includes the following standards:

- Hours of Operation: All outpatient and intensive outpatient services will operate at least five days a week (including one weekend day), and at least two days will include evening hours (5:00 PM to 9:00 PM, at a minimum). Residential programs will operate 24 hours per day, seven days a week, and will accept intakes at least during regular weekday business hours (9:00 AM to 5:00 PM).

- Language Capability: Currently about 71 percent of DPH-SAPC contracted sites offer bilingual services and 68 percent of them are in Spanish, according to the provider survey. Services will be provided in all threshold languages as needed. Services in Spanish will be offered by all network providers. Services in other languages may be offered by specific programs that serve specific cultural populations. The County also maintains a contract with Interpretation Services that provides oral translation services in at least the 12 threshold languages (other than English) as indicated by the Medi-Cal Eligibility Data System (MEDS) that is accessible to all of its network providers. These languages are: Arabic, Armenian, Cantonese, Farsi, Khmer (Cambodian), Korean, Mandarin, Russian, Spanish, Tagalog, Vietnamese and other Chinese.

- Timeliness of Services:

  First face-to-face visit – The Beneficiary Access Line will set the appointment for the initial assessment/intake with the selected provider while the beneficiary is on the call except under limited circumstances (e.g., the caller is unable to schedule, the automated appointment system is not yet developed/not working), but no longer than three business days from the brief triage assessment. Unless the beneficiary has specific provider or other preferences (e.g., cultural/linguistic specific services), the assessment/intake with a qualified SUD network provider that is geographically accessible will be conducted within 15 business days from the initial brief triage assessment; beginning in July 2017 the assessment/intake target will be five business days for outpatient and 10 business days for residential LOCs and five business days for all LOCs by July 2018.

  For individuals that present at the provider site first, the same timeliness expectations apply and alternate referrals should be offered and documented if this cannot be achieved before placing the individual on a waitlist. Expedited or other suitable/appropriate accommodations for scheduling appointments will be made for urgent situations whenever possible. DPH-SAPC will regularly evaluate timely receipt of services, including seeking service expansion to improve the ability to receive services upon demand.

Emergencies – For emergency situations when a life-threatening condition is present, the Beneficiary Access Line or network provider will immediately contact emergency medical services for intervention. Network providers will be required to establish procedures for appropriately handling urgent conditions presented by actively enrolled beneficiaries.

Afterhours care – Network providers will be required to establish procedures for appropriately handling afterhours care needs of actively enrolled beneficiaries.

- Geographic Location of Providers: A criterion for making referrals for placement in outpatient services will be that the program should be within one-hour travel time by personal or public transportation to and from the beneficiary's location of choice. In some outlying semi-rural areas of the County such as in the Antelope Valley, the low population density may make this criterion impossible to meet, particularly through public transportation. In such cases, every effort will be made to accommodate the beneficiary to minimize excessive travel time.

  Telehealth approaches will also be considered after the initial 12-month implementation period as a means to expand access to services for beneficiaries in outlying areas and for those with transportation challenges.

All County-contracted SUD network providers will be fully compliant with the Americans with Disabilities Act requirements as a contract provision.

10. TRAINING PROVIDED

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

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

All network providers will be required to establish and operate an employee training plan for their employees that includes a training needs assessment and describes steps to ensure that employees receive appropriate training aligned with their responsibilities, clinical or otherwise. At minimum, this includes training on the ASAM Criteria, DSM-V, Motivational Interviewing, Cognitive Behavioral Therapy, Culturally and Linguistically Appropriate Services (CLAS), and clinical documentation for all direct service staff at the frequency prescribed by DPH-SAPC. Network providers will be monitored at least annually for compliance with this contract requirement.

In addition, DPH-SAPC will be responsible for assessing overall network clinical training needs and coordinating training sessions in alignment with providers' training needs assessment findings. Contracts with the California Institute for Behavioral Health Services and the UCLA-Integrated Substance Abuse Programs serve as the primary vehicles for provision of clinical and program capacity-building training, and technical assistance for its network providers.

Current training topics identified for the DMC-ODS implementation include the following: application of the ASAM Criteria and determination of medical necessity, clinical documentation, and evidence-based practices (Motivational Interviewing, Cognitive Behavioral Therapy, and Medication-Assisted Treatment). Additional trainings topics (e.g., CLAS, data integrity) will also be offered in the future to better ensure a well-trained and capable workforce. The County will use a train-the-trainers approach to build a cadre of highly skilled medical directors and clinical supervisors within the provider network who will then train employees within each provider organization and monitor fidelity to adopted evidence-based practices. To accommodate the diversity and size of the County-contracted SUD provider network and its workforce, training will be continuous throughout the demonstration period and beyond.

11. TECHNICAL ASSISTANCE

What technical assistance will the county need from DHCS?

The County requests technical assistance from the State on the following topics:

- Parental involvement and privacy concerns for minors receiving treatment, and which services are reimbursable (and for how long) if parental consent cannot be obtained.
- Reimbursable services (and the addition of service billing codes) for SUDs under Early Periodic Screening, Diagnosis and Treatment (EPDST).

12. QUALITY ASSURANCE

Describe the quality assurance activities the county will conduct. Include the county monitoring process (frequency and scope), Quality Improvement plan, Quality Improvement committee activities and how counties will comply with CFR 438 requirements. Please also list out the members of the Quality Improvement committee. Also, include descriptions of how each of the quality assurance activities will meet the minimum data requirements.

The County established a *Quality Improvement and Utilization Management (QI/UM) Plan* in consultation with its provider network and stakeholders, and in compliance with DMC-ODS requirements (Attachment 4). The broad objective of the QI/UM program is for patients receiving SUD services to receive effective, coordinated care that is the right service provided at the right time, in the right setting, and at the right intensity and duration.

Quality Improvement Program

The purpose of the QI program is twofold: 1) to establish an infrastructure for quality-focused services through the formation of a number of committees that focus on specific aspects of an organized delivery system of SUD services; and 2) to set standards in areas such as medical necessity criteria, clinical practice (including medication-assisted treatment), and LOC guidelines as founded on the ASAM Criteria. The components of these QI standards will also focus on performance and outcome measures, care coordination, workforce standards, risk management, Quality Improvement Projects (QIP) at the provider level, and a grievance and

appeals process. SUD measures will monitor key quantitative and qualitative characteristics of the system of care including, but not limited to:

- Timeliness of first face-to-face appointment;
- Timeliness of services for urgent conditions;
- Access to afterhours care;
- Responsiveness of the beneficiary access line;
- Strategies to reduce avoidable hospitalizations;
- Coordination of physical and mental health services at the provider level; and
- Assessment of the beneficiaries' experiences.

The QI program will establish various committees including: Quality Improvement/Risk Management (QI/RM), Utilization Management, Research and Data Management, Professional Development, Community Liaison (with subcommittees for providers and consumers), and Cultural Competence. The QI/RM Committee will meet every other month and consist of DPH-SAPC representatives from each major division/unit, including the Director's Office, Office of the Medical Director and Science Officer, Adult and Youth Programs, Contracts, Strategic Planning, Information Systems, Finance, and the evaluation services contractor who will be collaborating with DPH-SAPC on quality assurance and training activities. The QI/RM Committee will work closely with all other committees in order to incorporate feedback into the continuous quality improvement process.

The QI program section of the *Quality Improvement and Utilization Management Plan* (Attachment 4) includes further detail on how DPH-SAPC intends to address the following topics: access to care, workforce, documentation, medical necessity criteria, clinical practice guidelines, levels of care guidelines, recovery support services, case-management/care coordination, performance and outcome measures, peer review quality improvement projects, confidentiality risk management, and complaints/grievances and appeals process. This attachment also describes how these activities will meet the minimum data requirements of the DMC-ODS.

Utilization Management Program

The UM program analyzes how the DPH-SAPC provider network is delivering services and how it is utilizing resources for eligible patients. The various responsibilities of the UM program include: ensuring adherence to established eligibility and medical necessity criteria; ensuring that clinical care and ASAM level of care guidelines are followed; 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; and 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 patients 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 assure fair and consistent UM decision-making
- To focus resources on a timely resolution of identified problems
- To assist in the promotion and maintenance of optimally achievable quality of care
- To educate health care professionals on appropriate and cost-effective use of health care resources.

Provider caseloads for adolescents and adults at each ASAM LOC will be randomly and retrospectively reviewed on at least an annual basis, in addition to the cases that require authorization and pre-authorization. UM staff may also conduct focused chart reviews whenever concerns arise about a particular provider or patient. Such reviews may be conducted onsite and without prior notice to the provider. Reportable incidents are patient safety events that result in death, permanent harm, and/or severe temporary harm, and intervention required to sustain life. Reportable incidents must be investigated by the provider's Risk Management Committee, and must be reported to the SAPC QI/RM Committee immediately.

The UM Program section of the *Quality Improvement and Utilization Management Plan* (Attachment 4) includes further detail on how DPH-SAPC intends to address the following topics: eligibility and medical necessity review process and clinical case review process.

Compliance with CFR 438

The QI/UM plan is in compliance with CFR 438.200, 438.202, and 438.204. The QI/RM Committee that is built into the QI program will conduct periodic reviews to ensure ongoing compliance. DPH-SAPC will ensure compliance with CFR 438 Subpart E by appropriately addressing any quality related concerns identified by the DHCS contracted External Quality Review Organization that will conduct annual reviews of the SUD services provided within this system of care. DPH-SAPC will also conduct the various monitoring processes described above, and comply with data reporting requirements.

13. EVIDENCE-BASED PRACTICES

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

The County will require that its network providers implement and use, at minimum, the evidence-based practices (EBPs) of Cognitive Behavioral Therapy and Motivational Interviewing. In addition, network providers will be encouraged to adopt additional evidence-based practices and promising practices tailored to the needs of each provider's focus patient population. Implementation of these EBPs will be a contract requirement and monitored through the contract compliance monitoring process. Corrective action ranging from technical assistance to disallowance will occur depending on the nature of the deficiency, frequency and/or severity of the findings.

14. ASSESSMENT

Describe how and where counties will assess beneficiaries for medical necessity and ASAM Criteria placement. How will counties ensure beneficiaries receive the correct level of placement?

Beneficiaries will be first engaged in a brief triage assessment by the Beneficiary Access Line or at the SUD provider site to establish the provisional LOC recommendation. The beneficiary will then be assessed by the contracted SUD treatment provider for medical necessity and appropriate LOC based on the ASAM Criteria. SUD treatment providers will be required to have LPHAs determine medical necessity, Clinical staff (e.g., registered interns, certified counselors, LPHAs) will be trained on and required to use the ASAM Criteria for placement decisions, continued service, and transfer/discharge. The County will encourage all providers to use the ASAM Continuum Software (ASAM-CS), which at the present time only pertains to the adult population, although paper-based assessment based on the ASAM Criteria will also be allowable if the tool is pre-approved by the County.

Contract monitoring and the UM program will provide a multi-layered approach to ensuring that beneficiaries are placed at the appropriate LOC. Providers will be required to maintain a record of ASAM assessments. Case reviews conducted as part of UM activities will ensure appropriate LOC placement at the initial assessment, and for purposes of continued service and transfer/discharge.

15. REGIONAL MODEL

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

Los Angeles County will implement a County-specific approach but will coordinate with other Counties in Implementation Phase 2 to promote continuity of care to the extent possible across Counties.

16. MEMORANDUM OF UNDERSTANDING

Submit a signed copy of each Memorandum of Understanding (MOU) between the county and the managed care plans. The MOU must outline the mechanism for sharing information and coordination of service delivery as described in 4(i) of the STCs. If upon submission of an implementation plan, the managed care plan(s) has not signed the MOU(s), the county may explain to the State the efforts undertaken to have the MOU(s) signed and the expected timeline for receipt of the signed MOU(s).

MOUs between the DPH-SAPC, the two Medi-Cal managed care plans (Health Net and LA Care), and DMH are in the process of execution and will be submitted within 90 days of the

approval of the County implementation plan as required. The MOU will include all conditions as required by the State (Attachment 2). DPH-SAPC has already executed MOUs describing care coordination policies and procedures with the health plans and DMH for the Cal MediConnect program.

17. TELEHEALTH SERVICES

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

Some County-operated and contracted SUD providers currently offer telehealth services, including telepsychiatry. DPH-SAPC will encourage all SUD providers to expand or introduce telehealth as an offered service, and will explore telehealth as a means to expand the availability of medication-assisted treatments, physician consultations, and services for special populations, among other services. DPH-SAPC will also explore increased collaboration with DMH and Medi-Cal managed care plans in an effort to expand these services. All telehealth services offered at County-contracted SUD providers will be required to use special equipment and/or software that meets telehealth encryption standards and that can ensure confidentiality. The telehealth equipment will be set up in a private room that is locked and secure.

18. CONTRACTING

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

Review Note: A list of all contracted providers (modality, provider, address) must be submitted to DHCS within 30 days of the waiver implementation date and as new providers are awarded contracts. DHCS will provide the format for the listing of providers.

The County establishes master agreements with qualified community-based SUD service providers through a selective contracting process. Once master agreements are executed with providers that meet County requirements, contracts are established with these legal entities for the provision of specific types of services using a competitive work order solicitation process in which interested providers must demonstrate their capabilities and capacities to provide specific types of services for groups of patients. Using this approach, the County ensures that its network providers each possess the business, clinical, and specific patient populations capacities and competencies to effectively provide the contracted services; and that the service network has the optimal capacity of service providers to meet the needs of the County population. A listing of all contracted providers including information on service modality and provider address is attached as required (see Attachment 3).

Contract Term

All contracts will have a term of three years, with the option to extend on an annual basis dependent upon funding and need for services. SAPC will utilize current contracts to initiate participation in the waiver while developing a new Request for Service Qualifications and associated Work Order Solicitations to expand the number of DMC certified LOCs throughout the County and to more thoroughly incorporate the new contract expectations that come with this system transformation. The new contracts are anticipated to have a five year term with up to five one-year extensions based on provider performance and need. All SUD network providers will be required to be DMC-certified for contracted LOCs by July 2017.

Appeals Process

Under Board Policy No. 5.055 (Services Contract Solicitation Protest), any prospective contractor may request a review of the requirements under a solicitation for a Board-approved services agreement. Additionally, any actual contractor may request a review of a disqualification under such a solicitation. The appeal process will follow the Los Angeles County Protest Policy (available at: http://mylacounty.info/listserver/pcs_contracts/cms1_19157.pdf).

Continuity of Services

Any current SUD provider not awarded a contract, or who is terminated as a contractor, will be notified at least 30 days prior to contract termination. In accordance with existing contract language, such providers shall make immediate and appropriate plans to transfer or refer all current patients to SUD network providers for continuing service in accordance with the patient's needs. Such plans shall be approved by DPH-SAPC before any transfer or referral is completed except in those instances, as determined by SUD provider, where an immediate patient transfer or referral is indicated. In such instances, the SUD provider may make an immediate transfer or referral to the nearest SUD network provider.

19. ADDITIONAL MEDICATION-ASSISTED TREATMENT

If the county chooses to implement additional MAT beyond the requirement for NTP services, describe the MAT and delivery system.

In addition to medications used by Opioid (Narcotic) Treatment Programs (methadone), the County will offer to its beneficiaries all addiction medications approved by the Food and Drug Administration as determined medically necessary. These medication-assisted treatments (MAT) include acamprosate, buprenorphine, disulfiram, naloxone, and naltrexone (oral and extended release formulations). Addiction medications are prescribed and administered by qualified SUD network providers or through coordination with the beneficiaries' Medi-Cal managed care health plan network pharmacy and primary care providers. Currently, within the SAPC network of providers access to MAT occurs via a "hub and spoke" model in which providers with patients who may benefit from MAT refer those patients to one of three MAT "hubs" capable of prescribing MAT. Throughout the demonstration period, DPH-SAPC will explore opportunities to expand access to MAT, either through the expansion of the current MAT hub network, utilizing telehealth, or by facilitating regional networks of providers who collectively fund and share a local MAT prescriber.

20. RESIDENTIAL AUTHORIZATION

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

Initial Authorization: The County will establish written policies and procedures describing required prior authorization for initial admission to residential services within 24 hours of a network provider's prior authorization request submission in compliance with DHCS requirements. 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 residential authorization, with the understanding that authorization denials will result in financial loss whereas authorization approvals will be retroactively reimbursed to the date of admission. An automated tracking system will compile the number, disposition, percentage, and timeliness of requests for pre-authorization.

Continuing Authorization: The County will establish written policies and procedures for processing requests for continuing authorization of residential services. Residential services for all adult populations will require reauthorization after 60-calendar days to assess for appropriate LOC utilization. If a one-time extension is warranted, youth residential services will require reauthorization after 30-calendar days to assess for appropriate LOC utilization. Requests for continuation of residential services must be submitted at least seven calendar days in advance of the end date of current authorization for both adult and youth populations. There will be a maximum residential treatment limit of 90-days for adults and 30-days for adolescents, unless medical necessity warrants a one-time extension of up to 30-days on an annual basis. For adult populations, only two non-continuous 90-day regimens will be authorized in a one-year period. For perinatal and criminal justice populations, a longer length of stay of up to six months on an annual basis may be approved based on medical necessity, but only three months with a one-time 30-day extension of the total episode can be funded under DMC.

Residential patients must receive regular assessments of their progress within these 60- and 30-calendar day residential authorizations for adult and youth populations, respectively. Given the fluid nature of clinical progression, the expectation will be that clinical progress note assessments are performed on a regular basis during residential treatment as clinically warranted and that certain patients will not require the full period of authorized residential services. In these instances, patients must be transitioned to a lower level of care as soon as clinically indicated. Required treatment plan updates every 30-days will help to facilitate these regular case reviews to ensure that patients receive care in the least restrictive setting that is clinically appropriate.

If upon clinical review, either during a focused or random retrospective review, an ongoing residential treatment case is determined to be unnecessary based on the aforementioned considerations, UM Unit will have the authority to terminate/modify the current authorization and to deny ongoing reimbursement for residential services, and require transition to an appropriate lower LOC. In these instances, reimbursement for residential services that have already been provided will be maintained, but future reimbursement for the identified episode

will be denied. Providers will be responsible for ensuring successful care coordination during all level of care transitions. Providers will be required to notify UM staff of residential discharges and to submit a completed discharge summary within 24 hours.

21. ONE YEAR PROVISIONAL PERIOD

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

Review Note: This question only applies to counties participating in the one-year provisional program and only needs to be completed by these counties.

Not applicable for Los Angeles County, as all mandatory requirements are met upon implementation.

County Authorization

Authorization of County Alcohol and Other Drug Program Director:

	Los Angeles	
Wayne K. Sugita, Interim Director Substance Abuse Prevention and Control Department of Public Health	County	Date

YOUTH (12-17) SUBSTANCE USE DISORDER (SUD) BENEFIT PACKAGE					
Level Of Care (LOC)	**ASAM Level**	**DHCS ASAM Description**	**Current DMC LOC**	**Current County LOC**	**Implementation Target Date**
Early Intervention	0.5	Screening, brief intervention, and referral (as needed).	Funded by Health Plans not DMC-ODS		
Outpatient	1	Less than 6 hours of service per week for recovery or motivational enhancement therapies and strategies.	Yes	Yes	Year One
Intensive Outpatient	2.1	Six (6) or more hours of service per week to treat multidimensional instability.	Yes	Yes	Year One
Partial Hospitalization	2.5	20+ hours of service per week for multidimensional instability. No 24-hour care.	Per DHCS not funded under DMC-ODS: SAPC will inquire if and how this is funded.		
Low Intensity Residential	3.1	24-hour structure with available trained personnel and at least 5 hours of clinical service per week. Prepare for outpatient treatment.	No	Yes	Year One
High Intensity Residential Population Specific	3.3	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive and other impairments unable to use full active milieu. Prepare for outpatient treatment.	This is not an ASAM Level of Care for adolescents		
High Intensity Residential Non-Population Specific	3.5	24-hour care with trained counselors to stabilize multidimensional imminent danger for individuals able to use full active milieu. Prepare for outpatient treatment.	Yes (Perinatal)	Yes	Year One
Intensive Inpatient Services Medically Monitored	3.7	24-hour nursing care with physician availability for significant problems with ASAM Dimensions 1, 2, or 3. Includes counselor availability for 16 hours per day.	Per DHCS not funded under DMC-ODS: SAPC will inquire if and how this is funded.		
Intensive Inpatient Services Medically Managed	4.0	24-hour nursing care and daily physician care for severe, unstable problems with ASAM Dimensions 1, 2, or 3. Counseling available to engage patient in treatment.	Per DHCS not funded under DMC-ODS: SAPC will inquire if and how this is funded.		
Ambulatory Withdrawal Management Without Extended On-Site Monitoring	1-WM	Mild withdrawal with daily or less than daily outpatient supervision.	This is not an ASAM Level of Care for adolescents If needed, it is integrated with services in other settings		
Ambulatory Withdrawal Management With Extended On-Site Monitoring	2-WM	Moderate withdrawal with all day withdrawal management and support and supervision. At night patient has supportive family or living situation.	This is not an ASAM Level of Care for adolescents If needed, it is integrated with services in other settings		
Residential Withdrawal Management Clinically Managed	3.2-WM	Moderate withdrawal but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment and recovery.	This is not an ASAM Level of Care for adolescents If needed, it is integrated with services in other settings		
Inpatient Withdrawal Management Clinically Managed	3.7-WM	Severe withdrawal and needs 24-hour nursing care and physician visits. Unlikely to complete withdrawal management without medical monitoring.	This is not an ASAM Level of Care for adolescents If needed, it is integrated with services in other settings		
Inpatient Withdrawal Management Medically Managed and Intensive Services	4-WM	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.	This is not an ASAM Level of Care for adolescents If needed, it is integrated with services in other settings		
Opioid (Narcotic) Treatment Program	1-OTP	Daily or several time weekly opioid agonist medications and counseling available to maintain multidimensional stability for those with severe opioid use disorder.	This is not an ASAM Level of Care for adolescents, however, services are provided in LAC.		
Add'l Medication Assisted Treatment	N/A	Ordering, prescribing, administering, and monitoring all mediations for SUDs. Includes: buprenorphine, disulfiram, methadone, naltrexone, acamprosate, and naloxone.	N/A		
Case Management	N/A	Aid in transition between LOC, communication and coordination of referrals, monitoring to ensure access and progress in services, advocacy and linkages.	No	Yes	Year One
Recovery Services (Post Treatment)	N/A	Individual and group counseling, recovery monitoring, substance abuse assistance, linkages to education, job skills, family support, support groups, ancillary services.	No	Yes	Year One
Physician Consultation	N/A	Communication between addiction medicine physicians/psychiatrists or clinical pharmacists with DMC physicians to address medication and LOC considerations.	No	No	Year One

ADULT (26+) AND YOUNG ADULT (18-25) SUBSTANCE USE DISORDER (SUD) BENEFIT PACKAGE

Level Of Care (LOC)	ASAM Level	DHCS ASAM Description	Current DMC LOC	Current County LOC	Implementation Target Date
Early Intervention	0.5	Screening, brief intervention, and referral (as needed).	Funded by Health Plans not DMC-ODS		
Outpatient	1	Less than 9 hours of service per week for recovery or motivational enhancement therapies and strategies.	Yes	Yes	Year One
Intensive Outpatient	2.1	Nine (9) or more hours of service per week to treat multidimensional instability.	Yes	Yes	Year One
Partial Hospitalization	2.5	20+ hours of service per week for multidimensional instability. No 24-hour care.	Per DHCS not funded under DMC-ODS: SAPC will inquire if and how this is funded.		
Low Intensity Residential	3.1	24-hour structure with available trained personnel and at least 5 hours of clinical service per week. Prepare for outpatient treatment.	No	Yes	Year One
High Intensity Residential Population Specific	3.3	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive and other impairments unable to use full active milieu. Prepare for outpatient treatment.	No	No	Year One
High Intensity Residential Non-Population Specific	3.5	24-hour care with trained counselors to stabilize multidimensional imminent danger for individuals able to use full active milieu. Prepare for outpatient treatment.	Yes (Perinatal)	No	Year One
Intensive Inpatient Services Medically Monitored	3.7	24-hour nursing care with physician availability for significant problems with ASAM Dimensions 1, 2, or 3. Includes counselor availability for 16 hours per day.	Per DHCS not funded under DMC-ODS: SAPC will inquire if and how this is funded.		
Intensive Inpatient Services Medically Managed	4.0	24-hour nursing care and daily physician care for severe, unstable problems with ASAM Dimensions 1, 2, or 3. Counseling available to engage patient in treatment.	Per DHCS not funded under DMC-ODS: SAPC will inquire if and how this is funded.		
Ambulatory Withdrawal Management Without Extended On-Site Monitoring	1-WM	Mild withdrawal with daily or less than daily outpatient supervision.	No	No	Year One
Ambulatory Withdrawal Management With Extended On-Site Monitoring	2-WM	Moderate withdrawal with all day withdrawal management and support and supervision. At night patient has supportive family or living situation.	No	No	Year Three
Residential Withdrawal Management Clinically Managed	3.2-WM	Moderate withdrawal but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment and recovery.	No	No	Year One
Inpatient Withdrawal Management Clinically Managed	3.7-WM	Severe withdrawal and needs 24-hour nursing care and physician visits. Unlikely to complete withdrawal management without medical monitoring.	Per DHCS not funded under DMC-ODS: SAPC will inquire if and how this is funded.		
Inpatient Withdrawal Management Medically Managed and Intensive Services	4-WM	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.	Per DHCS not funded under DMC-ODS: SAPC will inquire if and how this is funded.		
Opioid (Narcotic) Treatment Program	1-OTP	Daily or several time weekly opioid agonist medications and counseling available to maintain multidimensional stability for those with severe opioid use disorder.	Yes	Yes	Year One
Add'l Medication Assisted Treatment	N/A	Ordering, prescribing, administering, and monitoring all mediations for SUDs. Includes: buprenorphine, disulfiram, methadone, naltrexone, acamprosate, and naloxone.	No	Yes (Long-acting Naltrexone)	Year One
Case Management	N/A	Aid in transition between LOC, communication and coordination of referrals, monitoring to ensure access and progress in services, advocacy and linkages.	No	Yes	Year One
Recovery Services (Post Treatment)	N/A	Individual and group counseling, recovery monitoring, substance abuse assistance, linkages to education, job skills, family support, support groups, ancillary services (minimum of one recovery monitoring contact per month for up to six months).	No	Yes	Year One
Physician Consultation	N/A	Communication between addiction medicine physicians/psychiatrists or clinical pharmacists with DMC physicians to address medication and LOC considerations.	No	No	Year One

ATTACHMENT 2

MEMORANDUM OF UNDERSTANDING

By and Between

Name of Managed Care Health Plan

and the

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL

For the

IMPLEMENTATION OF THE
DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

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MEMORANDUM OF UNDERSTANDING

By and Between

Name of Managed Care Health Plan

and the

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL

For the

IMPLEMENTATION OF THE
DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

This Memorandum of Understanding ("MOU") is made and entered into on the _____ day of _____, 2016, by and between Managed Care Health Plan, and the County of Los Angeles Department of Public Health, Substance Abuse Prevention and Control ("DPH-SAPC"), as the county alcohol and drug program administrator in Los Angeles County for the purpose of providing to all Medi-Cal beneficiaries in Los Angeles County, access to all medically necessary specialty substance use disorder ("SUD") treatment services currently covered by Drug Medi-Cal.

I. RECITALS

Whereas, California's Section 1115 "Bridge to Reform" Demonstration Amendment (No. 11-W-00193/9) authorizes the State to test a new paradigm for the organized delivery of health care services for Medicaid eligible individuals with a SUD;

Whereas, the amendment includes a five-year demonstration program, the Drug Medi-Cal Organized Delivery System (DMC-ODS) Pilot that will include a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for SUD treatment services;

Whereas, the DMC-ODS Pilot services shall be available as a Medi-Cal benefit for Medi-Cal eligible individuals who meet the medical necessity criteria and reside in Los Angeles County;

Whereas, the DMC-ODS Pilot is expected to provide the Medi-Cal Beneficiary with access to the care and system interaction needed in order to achieve sustainable recovery;

Whereas, counties participating in the Pilot shall enter into a Memorandum of Understanding (MOU) with selected Medi-Cal managed care plans that enroll beneficiaries served by the DMC-ODS;

Whereas, Managed Care Health Plan has been selected by the DPH-SAPC as one of the managed care plans to ensure collaborative treatment planning, care coordination and effective communication among providers for DMC-ODS services to eligible beneficiaries in Los Angeles County;

NOW, THEREFORE, in consideration of the mutual covenants contained herein, and for good and valuable consideration, the parties agree to the following:

II. PARTIES

DPH-SAPC is the Los Angeles County alcohol and drug program lead agency that will administer the DMC-ODS Pilot in Los Angeles County and ensure that all required services covered under the DMC-ODS Pilot are available and accessible to enrollees of the DMC-ODS in the County.

Managed Care Health Plan, a managed care organization that delivers managed health care services through health plans and government-sponsored managed care plans, and offers behavioral health, substance abuse and employee assistance programs, and managed health care products related to prescription drugs, will ensure collaborative treatment planning, care coordination and effective communication among providers for DMC-ODS services to eligible beneficiaries in Los Angeles County. The Managed Care Health Plan will implement procedures for exchanges of medical information, provide navigation support for patients and caregivers, and facilitate and track referrals between systems.

III. BACKGROUND

The DMC-ODS Pilot program is authorized and financed under the authority of the State's 1115 Bridge to Reform Demonstration Waiver. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and Children's Health Insurance Program (CHIP). The purpose of these demonstrations, which gives states additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as expanding services not typically covered by Medicaid, and using innovative service delivery systems that improve care, increase efficiency, and reduce costs. The section 1115 demonstrations, such as the DMC-ODS pilot, are approved for a five-year period.

The DMC-ODS is a pilot program to test a new paradigm for the organized delivery of health care services for Medicaid eligible individuals with SUD. The DMC-ODS will

demonstrate how organized SUD care increases the success of DMC beneficiaries while decreasing other health care costs. Critical elements of the DMC-ODS Pilot include providing a continuum of care modeled after the ASAM Criteria for SUD services, increased local control and accountability, greater use of resources, evidence-based practices in substance abuse treatment, and increased coordination with other systems of care.

IV. PURPOSE

This MOU sets forth the Parties' mutual understandings, commitments, and protocols regarding how DMC-ODS services will be provided and coordinated toward achieving seamless transitions of care from one level of SUD care to another, including coordination across systems of care, and access to recovery supports and services immediately after discharge, with the goal of sustained engagement and long-term retention in SUD and behavioral health treatment. Among other things, the MOU addresses: 1) the roles and responsibilities of Managed Care Health Plan and DPH-SAPC; 2) how care will be coordinated by and between Managed Care Health Plan and DPH-SAPC; and 3) the process for information exchange between Managed Care Health Plan and DPH-SAPC.

V. DEFINITIONS

42 Code of Federal Regulations (CFR) 455.450
The provisions of Federal law that establish the risk level categories for Medicaid providers and the corresponding screening requirements for each level.

42 Code of Federal Regulations (CFR) 431.107
The provisions of Federal law which set forth State plan requirements that relate to the keeping of records and the furnishing of information by all providers of services (including individual practitioners and groups of practitioners).

42 Code of Federal Regulations (CFR) Part II
The provisions of Federal law which govern the confidentiality of patient alcohol and drug abuse treatment records.

American Society of Addiction Medicine (ASAM)
A professional society representing over 3,600 physicians, clinicians and associated professionals in the field of addiction medicine.

ASAM Criteria
Also known as the ASAM patient placement criteria, provides a multi-dimensional assessment framework for placement determination and the development of comprehensive and individualized treatment plans.

Behavioral Health Services (or "Behavioral Health")
Drug Medi-Cal substance abuse services provided pursuant to Section 51341.1 of Title 22 of the California Code of Regulations and Mental Health Services provided pursuant to Section 51341 of Title 22 of the California Code of Regulations and any substance abuse and mental health benefits available under the Medicare Program.

Behavioral Health Care Management Team ("BHCMT")
The multidisciplinary team that provides care management and care coordination for Medi-Cal services, and authorization for Medicare services to Beneficiaries enrolled in the DMC-ODS Pilot Program.

Behavioral Health Care Plan
The care plan developed by Beneficiary and Beneficiary's Managed Care Health Plan provider that describes the Behavioral Health Services to be provided the Beneficiary.

Beneficiary
An individual who is eligible for Medi-Cal benefits and who is enrolled in DMC-ODS Pilot Program and who receives covered services through Managed Care Health Plan and/or DMC.

California Welfare and Institutions Code, Section 14124.24
Provisions of the State law that sets guidelines and requirements for providers on billing for services provided to probationers and parolees convicted of a nonviolent drug possession offense, and for services provided to indigent individuals not eligible for Medi-Cal.

California Welfare and Institutions Code, Section 14021.51
The provisions of State law that establish the basis for and limitations to reimbursements for narcotic replacement therapy dosing and ancillary services provided by narcotic treatment programs.

Care Coordination
The management of physical, mental and SUD services for Beneficiaries to help ensure that delivered services are well integrated and provided seamlessly to ensure maximum benefit, effectiveness, and safety.

Community Health Centers (CHCs)
Organized as non-profit clinical care providers that operate under comprehensive federal standards, with some types receiving federal funding under Section 330 of the Public Health Service Act and some supported through state and local grants.

Confidentiality of Medical Information Act
A State law, California Civil Code Section 56 et. Seq., which governs the confidentiality of medical information, as defined therein; this law specifies when medical information is required and permitted to be disclosed by health care providers and others.

Determination of DMC-ODS Medical Criteria
As described in the DMC-ODS Standard Terms and Conditions, beneficiaries receiving services through DMC-ODS must be enrolled in Medi-Cal and meet the following medical necessity criteria:

1. Must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders; or be assessed to be at risk for developing substance use disorder (for youth under 21).
2. Must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.
3. If applicable, must meet the ASAM adolescent treatment criteria. Beneficiaries under the age of 21 are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, beneficiaries under age of 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are covered under section 1905(a) Medicaid authority.

Determination of DMC-ODS Medicaid Eligibility and Medical Need
All individuals seeking admission to SUD services can access services by contacting the Access Line which is a dedicated toll-free telephone line, by contacting any network treatment provider, or by going through referrals. The first point of contact, whether Access Line or SUD Provider, will screen to determine Medi-Cal eligibility status. Access Line staff will conduct an initial brief triage assessment based on ASAM Criteria, and place the Beneficiary in a provisional level of care with a contracted SUD Provider. The SUD Provider will determine initial medical necessity through a face-to-face or telehealth review by a Medical Director, licensed physician, or Licensed Practitioner of the Healing Arts. Once medical necessity is established, the SUD Provider will conduct a more intensive psychosocial clinical assessment to establish and/or confirm the appropriate SUD level of care. Residential services require prior authorization of the DPH-SAPC Office of the Medical Director.

Drug Medi-Cal Organized Delivery System Pilot (DMC-ODS Pilot)
The five-year demonstration waiver involving an agreement between the Managed Care Plan (Managed Care Health Plan) and Los Angeles County (DPH-SAPC) for provision of DMC-ODS services to individuals that are enrolled in Medi-Cal, reside in a participating county, and meet the DMC-ODS Program medical necessity criteria.

Diagnostic and Statistical Manual of Mental Disorders (DSM)
The standard classification of mental disorders used by mental health professionals in the United States (U.S.) which contains a listing of diagnostic criteria for every psychiatric disorder recognized by the U.S. healthcare system. Also a necessary tool for collecting and communicating accurate public health statistics about the diagnosis of psychiatric disorders.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
A Medicaid benefit that provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.

Evidence Based Programs (EBP)
Programs that meet the criteria of the National Registry for Evidence Based Programs and Practices (NREPP) for effectiveness and scientific rigor.

Federally Qualified Health Center (FQHC)
A community-based organization that is funded under the Health Center Consolidation Act (Section 330 of the Public Health Service Act), and which provides comprehensive primary care and preventive care, including health, oral, and mental health/substance abuse services to persons of all ages, regardless of their ability to pay or health insurance status.

Health Insurance Portability and Accountability Act (**HIPAA)**
A Federal law, Public Law 104-191 and its implementing regulations, including the Privacy, Security, Breach Notification, and Enforcement Rules at 45 Code of Federal Regulations (C.F.R.) parts 160 and 164, which provide federal protections for individually identifiable health information held by covered entities, as defined therein.

Interdisciplinary Care Team (ICT)
A team composed of medical, behavioral health, and social service providers that collectively manages the medical, cognitive, psychosocial and functional services of Beneficiaries. The ICT also includes a representative from the BHCMT.

Licensed Practitioner of the Healing Arts (LPHA)[1]
Professional staff must be licensed, registered, certified, or recognized under California State scope of practice statues, provide services within their scope of practice and recive supervision required under their scope of practice laws. LPHA includes the following professional categories:

- Physician
- Licensed Clinical Psychologist
- Licensed Clinical Social Worker
- Licensed Marriage and Family Therapist
- Licensed Professional Clinical Counselor
- Registered Nurse
- Nurse Practitioner
- Physician Assistant
- Registered Pharmacist
- Licensed eligible practitioner under the supervision of licensed clinicians

[1] CCR, Title 9, Chapter 11, Section 1830.215 and Section J (4e) Non-Hospital Chart Review-EPSDT Reviews FY 06-07

Local Mental Health Plan ("LMHP")
The Los Angeles County Department of Mental Health that is the local county agency that has responsibility for administering public and specialty mental health services.

Long Term Services and Supports ("LTSS")
Those services and supports described in Welfare and Institutions Code section 141861, subdivision (b).

Medi-Cal
California's Medicaid health care program of medical assistance benefits under Title XIX of the Social Security Act.

Primary Care Provider ("PCP")
A person licensed by the applicable State licensing board who has primary health care responsibility for the Beneficiary through Managed Care Health Plan in the DMC-ODS Pilot Program.

Protected Health Information (PHI)
Individually identifiable health information as defined by 45 C.F.R. Section 160.103.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)
An evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.

State Department of Health Care Services (DHCS)
The California department that has responsibility for administering statewide, health care services funded by Medi-Cal.

Substance Use Disorder (SUD)
The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5), defines SUD as mild, moderate, or severe to indicate the level of severity, by the number of diagnostic criteria met by an individual. SUDs occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.

VI. APPLICABLE DOCUMENTS

Addenda I, II, IIA, IIB, III, and IIIA are attached to and form part of this MOU. In the event of any conflict or inconsistency in the definition or interpretation of any word, responsibility, or contents or description of task or responsibility between the MOU and the addendum, or between addenda, such conflict or inconsistency shall be resolved in a manner that advances the purpose and intent of this MOU. Addenda to this Agreement are as follows:

Addendum I
Drug Medi-Cal Organized Delivery System Coordination of Care Policies and Procedures "Applicable Solely to Los Angeles County. This addendum sets forth the policies and coordination of care procedures that the Parties and their applicable related entities will follow for the provision of DMC-ODS Services to Beneficiaries.

Addendum II
DMC-ODS Flow Chart. This addendum provides the flow process of DMC-ODS eligible individuals into the SUD continuum of services.

Addendum IIA
Benefits Package for Youth. This identifies the SUD services that constitute the DMC-ODS continuum of care for eligible youth DMC-ODS beneficiaries in Los Angeles County.

Addendum IIB
Benefits Package for Adults. This identifies the SUD services that constitute the DMC-ODS continuum of care for eligible adult DMC-ODS beneficiaries in Los Angeles County.

Addendum III
Exchange of Information, Including PHI, Related to the Beneficiaries in the DMC-ODS. This addendum sets forth how the Parties and their applicable related entities will share information to coordinate care of DMC-ODS Beneficiaries.

Addendum IIIA
Managed Care Health Plan Beneficiary Data Exchange Protocol. This addendum describes the data exchange protocol for coordinating physical health primary care and SUD care among Common Members.

VII. ROLES AND RESPONSIBILITIES

A. DPH-SAPC

DPH-SAPC will be responsible for ensuring all DMC-ODS SUD Providers are licensed and/or certified for SUD services as required by the DMC-ODS Pilot Program.

DPH-SAPC will be responsible for implementing a system of care that provides comprehensive SUD services for youth and adults consistent with the ASAM Criteria for levels of care. (See Addendum IIA, Benefits Package for Youth and Addendum IIB, Benefits Package for Adults)

DPH-SAPC will be responsible for the following:

1. Developing and contracting with a Managed Care Health Plan provider network that includes, but is not limited to, DPH-SAPC providers.
2. Serving as lead and focal point for all Behavioral Health Services coordination activities between Managed Care Health Plan providers and LMHP, and DPH-SAPC.
3. Participating in BHCMTs.
4. Processing Drug Medi-Cal Behavioral Health Services claims payment to Managed Care Health Plan network providers that include, but are not limited to, DPH-SAPC providers.

B. Managed Care Health Plan

Managed Care Health Plan shall ensure Behavioral Health Services and care coordination needs for Beneficiaries with SUD are available through its network of providers.

C. Care Management Teams

At the point of care, clinical integration between DPH-SAPC providers and Managed Care Health Plan providers shall include:

1. Comprehensive substance use, physical, and mental health screening, including ASAM Level 0.5 SBIRT services;
2. Beneficiary engagement and participation in an integrated care program that integrates physical and behavioral health care services to beneficiaries as needed;
3. Shared development of care plans by the Beneficiary, caregivers, and all concerned providers;
4. Collaborative treatment planning with managed care;
5. Beneficiary access to needed medical, educational, social, prevocational, vocational, rehabilitative, and other community services;
6. Care coordination and effective communication among providers in network;
7. Facilitation and tracking of referrals between and across systems; and
8. Navigation support for Beneficiaries and caregivers.

To ensure the Medi-Cal services are coordinated into a seamless system of care, Managed Care Health Plan, LMHP, and DPH-SAPC, shall establish three (3) interagency care management teams for behavioral health composed of, but not limited to, representatives from each of the entities.

The interagency care management teams are responsible, as described below, for ensuring the health, mental health, and substance abuse and LTSS services are easily accessible and coordinated for Beneficiaries:

1. Program Administration Team ("PAT") has the following shared responsibilities:
   - Develop algorithms, and policies and procedures to assist the BHCMT in its day-to-day operations.
   - Identify systemic and programmatic issues and provide recommendations for resolution of problem areas.
   - Conduct program evaluation.
   - Resolve disputes between Managed Care Health Plan and DPH-SAPC.
   - Identify and resolve provider relations issues.

2. Behavioral Health Care Management Team ("BHCMT") led by Managed Care Health Plan has the following responsibilities:
   - Provide input for to the algorithms developed by PAT. Develop individual behavioral health care plans.
   - Coordinate care between physical health, mental health, and substance abuse providers.
   - Monitor clinical progress.
   - Reassess individual service needs.
   - Refer and link to appropriate services.
   - Resolve disputes between Managed Care Health Plan and DPH-SAPC.

3. Interdisciplinary Care Team ("ICT") Managed Care Health Plan is responsible for facilitating ICT's to provide care management services to Beneficiaries, that present with complex and multiple health, mental health, and substance abuse, LTSS agencies, and other community agencies as appropriate and as permitted by law.

For further guidance regarding the role of and processes applicable to the Care Management Teams refer to Addenda I and II to this MOU.

D. Referrals and Criteria

To ensure that DMC-ODS services are coordinated into a seamless system of care for purposes of referring Beneficiaries to SUD services, Managed Care Health Plan and DPH-SAPC agree to the following protocols, as further described in Addenda I, II, IIA, IIB, III, and IIIA to this MOU.

1. Referral Process for DMC-ODS
   1.1. The DMC-ODS shall have a "no wrong door" approach to services access, with multiple entry points including, but not limited to, Beneficiary self-referrals to Access Line or Beneficiary accessing SUD Provider directly, and Managed Care Health Plan providers contacting Access Line or referring Beneficiary directly to SUD Provider.

1.2. All incoming referrals or requests for Behavioral Health Services shall be screened to determine Behavioral Health need by Managed Care Health Plan provider. Based on Behavioral Health need, Managed Care Health Plan provider will refer and link Beneficiaries to a DMC-ODS SUD Provider, either through the Access Line or directly to the DPH-SAPC SUD Provider.

2. Referral Process for non-Behavioral Health Services

2.1 DPH-SAPC shall identify Beneficiaries that need physical health care services and refer these Beneficiaries to the Managed Care Health Plan in the manner described in Addenda I and II attached to this MOU.

3. Determination of DPH-SAPC Service Criteria

3.1 The criteria for provision of Drug Medi-Cal substance use treatment services are set forth in Section 51341.1 of Title 22 of the California Code of Regulations.

E. Dispute Resolution Related to Reimbursement for Services

1. First Level Disputes: All "First Level Disputes" shall be submitted to the BHCMT for resolution. First Level Disputes may include, but are not limited to, disagreements regarding authorization for or reimbursement of Medi-Cal services.

2. Second Level Disputes: If the BHCMT cannot resolve a First Level Dispute to the satisfaction of either or both parties, the dispute shall be submitted to the PAT within mutually agreed upon timeframes. The PAT shall inform the BHCMT of its decision. ("Second Level Dispute").

3. Third Level Disputes: If the PAT cannot resolve a Second Level Dispute to the satisfaction of either party, the dispute shall be addressed by executive management from DPH-SAPC and Managed Care Health Plan. The executive management shall review the dispute and inform the PAT of its decision. ("Third Level Dispute")

4. If resolution cannot be reached at the executive management level within agreed upon timeframes, Managed Care Health Plan and DPH-SAPC agree to follow the resolution of dispute process in accordance with Title 9, CCR, Sections 1810.370, 1850.505 and 1850.525.

VIII. COORDINATION OF CARE

A. Point of Contact for Clinical Issues

1. Managed Care Health Plan contact staff is_____
2. The LMHP contact staff is the LMHP Medical Director.
3. DPH-SAPC contact staff is the designated DPH-SAPC Program Director.

B. Care Coordination Activities

1. Managed Care Health Plan shall conduct a Health Risk Assessment that includes Behavioral Health Screenings for all Medi-Cal Beneficiaries enrolled with Managed Care Health Plan. Managed Care Health Plan will refer Beneficiaries with specific substance abuse and mental health findings from screenings to the PCP for potential linkage to a substance abuse provider and/or mental health provider.
2. At the point of care to ensure clinical integration between DMC-ODS and Managed Care Health Plan provider, a comprehensive substance use, physical and mental health screening including the ASAM Level 0.5 SBIRT services shall be conducted on Beneficiary.
3. The ICT or member thereof shall refer Beneficiaries to the Managed Care Health Plan or DPH-SAPC if the PCP or Beneficiary believes that substance abuse services beyond the scope of practice of the PCP are required.
4. The PCP, DPH-SAPC SUD Provider, Beneficiary, and the ICT shall collaboratively develop a Behavioral Health Care Plan for the Beneficiary.
5. As permitted by 42 C.F.R. Part 2, HIPAA and other applicable privacy laws, the DPH-SAPC SUD Provider and PCP shall share PHI as needed for purpose of care coordination in accordance with the Exchange of Data MOU attached hereto as Addendum III and to the extent permitted by law.
6. DPH-SAPC SUD Providers shall submit to the Beneficiary's PCP, written documentation that contains treatment coordination information in accordance with Addendum III to the extent permitted by law.
7. Managed Care Health Plan PCP shall submit to the Beneficiary's substance abuse provider, written documentation that contains treatment coordination information in accordance with Addendum III to the extent permitted by law.
8. Managed Care Health Plan shall establish a process for reviewing and updating the Behavioral Health Care Plan as clinically indicated, such as following a hospitalization, a significant change in health or well-being, in level of care, or a request for change of provider, and for coordinating with the DPH-SAPC provider when necessary.
9. The DPH-SAPC and Managed Care Health Plan providers may participate in case conferencing and conduct regular meetings to review the care coordination process.
10. Managed Care Health Plan shall coordinate with DPH-SAPC to perform an annual review analysis and evaluation of the effectiveness of the care

management program to identify actions to implement and improve the quality of care and delivery of services.

11. Managed Care Health Plan shall develop procedures and coordinate direct transfers between inpatient SUD services and inpatient medical services and involve the appropriate clinical staff for the purpose of care management and care coordination.

C. Case Consultation

In accordance with Addendum III and to the extent permitted by 42 C.F.R. Part 2, HIPAA and other applicable privacy laws, DPH-SAPC and Managed Care Health Plan shall establish processes that facilitate consultation and coordination of SUD and medical treatment and care plans.

1. DPH-SAPC SUD Providers shall provide information, education, and consultation to Managed Care Health Plan PCP regarding substance use related issues to improve coordination of care and care management.
2. Managed Care Health Plan PCP shall provide information, education, and consultation to DPH-SAPC SUD Providers on medical and mental health issues to improve coordination of care and care management.
3. Consultation and communication between Managed Care Health Plan and DPH-SAPC providers may be facilitated by various means including, but not limited to:
    a. Direct consultation and communication – telephonic, e-mail, telepsychiatry/telemedicine, e-consult.
    b. Facilitated case conference by the ICT concerning care management planning.

IX. FUNDING

This MOU is a non-financial agreement.

X. EXCHANGE OF INFORMATION

Addenda III and IIIA of this MOU sets forth the understanding of the parties regarding the exchange of data to coordinate care for Beneficiaries, including protocols governing the secure and legally permissible exchange of information to ensure coordination of SUD, physical health, mental health, ancillary, and other services.

A. The parties understand and agree that each party has obligations under the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA"), as amended by subtitle D, Privacy, of the Health Information Technology for Economic and Clinical Health ("HITECH") Act, as further implemented by the Omnibus HIPAA Rule, with

respect to the confidentiality, privacy, and security of patients' health information, both internally and externally, including the training of staff and the establishment of proper procedures for the release of such information, including, when required, the use of appropriate authorizations as specified under HIPAA. The disclosure of data, including without limitation PHI, from Managed Care Health Plan to DPH-SAPC, are for the purposes for Managed Care Health Plan payment/health care operations and/or the DPH-SAPC's treatment, payment or health care operations in their capacity as Covered Entities and/or to the extent applicable in their capacity as Health Oversight Agencies (as such capitalized terms are defined in HIPAA).

B. Each party acknowledges that it may have additional obligations under other State or Federal laws that may impose on that party additional restrictions with respect to the sharing of information, including but not limited to the Confidentiality of Medical Information Act, Welfare and Institutions Code 5328 et.seq., and 42 C.F.R. Part 2.

C. Each party acknowledges that it will comply with consent requirements pursuant to Article 5.7 (commencing with Section 14186) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code related to Long-Term Services and Supports Integration.

D. Addenda III and IIIA of this MOU sets forth the understanding of the parties regarding the exchange of data to coordinate care for Beneficiaries, including protocols governing the secure and legally permissible exchange of information to ensure coordination of physical health, mental health services, and substance abuse services.

XI. INDEMNIFICATION

Managed Care Health Plan and DPH-SAPC shall indemnify, defend and hold harmless each other, their elected and appointed directors, officers, employees, and agents from and against any demands, claims, damages, liability, loss, actions, fees, costs, and expenses, including reasonable attorneys' fees, or any damage whatsoever, including but not limited to death or injury to any person and damage to any property, resulting from the misconduct, negligent acts, errors or omissions by the other party or any of its directors, officers, employees, agents, successor or assigns related to this MOU, its terms and conditions, including without limitation a breach or violation of any State or Federal privacy and/or security laws, regulations and guidance relating to the disclosure of PHI, personally identifiable information or other confidential information of a party hereunder. The terms of this Article shall survive termination of this MOU.

XII. INSURANCE COVERAGE

General Provisions for all Insurance Coverage: Without limiting either party's indemnification of the other, and during the pendency of this MOU, each party shall provide and maintain at its own expense, insurance coverage sufficient for liabilities which may arise from or relate to this MOU.

Commercial General Liability insurance (providing scope of coverage equivalent to ISO policy form CG 00 01), naming the County and its Agents as an additional insured, with limits of not less than:

General Aggregate:	$2 million
Products/Completed Operations Aggregate:	$1 million
Personal and Advertising Injury:	$1 million
Each Occurrence:	$1 million

Sexual Misconduct Liability
Insurance covering actual or alleged claims for sexual misconduct and/or molestation with limits of not less than $2 million per claim and $2 million aggregate, and claims for negligent employment, investigation, supervision, training or retention of, or failure to report to proper authorities, a person(s) who committed any act of abuse, molestation, harassment, mistreatment or maltreatment of a sexual nature.

Professional Liability/Errors and Omissions
Insurance covering Contractor's liability arising from or related to this Contract, with limits of not less than $1 million per claim and $3 million aggregate. Further, Contractor understands and agrees it shall maintain such coverage for a period of not less than three (3) years following this Agreement's expiration, termination or cancellation.

XIII. TERM

This MOU is effective _____ ("Effective Date") and shall continue in effect as long as necessary to implement the DMC-ODS Pilot or until _____, whichever date is earlier. The term of this MOU may be extended by the parties upon their mutual agreement.

XIV. TERMINATION

Either party may terminate this MOU with or without cause upon thirty (30) days written notice to the other party. This MOU may be terminated immediately upon the mutual written agreement of the parties. This MOU shall terminate upon: (i) the termination of the MOU between the Federal Centers for Medicare and Medicaid Services (CMS) and the State of California DHCS effective _____; (ii)

termination of the three way agreement by and among Managed Care Health Plan, CMS and DHCS; or (iii) either party may terminate this MOU upon a material breach if such breach has not been cured within thirty (30) days of receipt of non-breaching party's written notice on the breach.

XV. MISCELLANEOUS TERMS

A. **No Third Party Beneficiaries**: Nothing in this MOU shall confer upon any person other than the parties, any rights, remedies, obligations, or liabilities whatsoever.

B. **Regulatory References**: Statutory and/or regulatory references in this MOU shall mean the section as in effect is amended.

C. **Interpretation**: Any ambiguity in this MOU shall be resolved in favor of a meaning that permits the parties to comply with the requirements of the DMC ODS Pilot Program.

D. **Supervising Circumstances**: Neither Managed Care Health Plan nor DPH-SAPC shall be deemed in violation of any provision of this MOU if it is prevented from performing any of its obligations by reason of: (a) severe weather and storms; (b) earthquakes or other natural occurrences; (c) strikes of labor unrest; (d) power failures; (e) nuclear or other civil or military emergencies; (f) acts of legislative, judicial, executive, or administrative authorities; or (g) any other circumstances that are not within it reasonable control. The Supervening Circumstances shall not apply to obligations imposed under applicable laws and regulations or obligations to pay.

E. **Amendment:** This MOU may be amended by mutual written agreement of the parties. Notwithstanding the foregoing, amendments required to comply with State or Federal laws or regulations, requirements of regulatory agencies, or requirements of accreditation agencies, including without limitation, changes required to comply with the DMC-ODS Pilot shall not require the consent of DPH-SAPC and/or Managed Care Health Plan and shall be effective immediately on the effective date of the requirement.

F. **Assignment:** Neither this MOU, nor any of a party's rights or obligations hereunder, is assignable by either party without the prior written consent of the other party which consent shall not be unreasonably withheld.

G. **Confidentiality:** Managed Care Health Plan and DPH-SAPC agree to hold Beneficiary health information and records in accordance with HIPAA and applicable privacy laws, and 42 C.F.R. Part 2. The parties acknowledge that DPH-SAPC is governed by the Public Records Act, Government Code Section 6520 et. seq., (the "PRA"). Pursuant to the PRA, documents provided to DPH-

SAPC may be deemed "public records" as that term is defined in the PRA and, subject to the exceptions set forth therein, may be subject to public disclosure. Consistent with the provisions of the PRA, DPH-SAPC shall not disclose documents provided by Managed Care Health Plan which are excepted from the disclosure requirements of the PRA and which are clearly marked or otherwise identified as confidential by Managed Care Health Plan, including, without limitation, the exceptions applicable to corporate financial records and proprietary information including trade secrets. In the event DPH-SAPC is required to defend an action on a PRA request for any document provided by Managed Care Health Plan to DPH-SAPC in connection with the subject matter of this Agreement, Managed Care Health Plan agrees to defend and indemnify the County from all costs and expenses, including reasonable attorney's fees, in any action or liability arising from the defense of such action. Nothing in this section shall be construed to prevent DPH-SAPC from disclosing any document if such disclosure is required by law, or by an order issued by a court of competent jurisdiction.

H. **Governing Law:** This MOU shall be governed by and construed and enforced in accordance with the laws of the State of California, except to the extent such laws conflict with or are preempted by any Federal law, in which case such Federal law shall govern.

I. **Notice:** Notices regarding the breach, term, termination or renewal of this MOU shall be given in writing in accordance with this Section 15.9 and shall be deemed given five (5) days following deposit in the U.S. mail, postage prepaid. If sent by hand delivery, overnight courier, or facsimile, notices shall be deemed given upon documentation of delivery. All notices shall be addressed as follows:

Managed Care Health Plan
_____
_____
_____

With a copy to:

Substance Abuse Prevention and Control
Los Angeles County Department of Public Health
Unit #34, 3rd Floor, A-9 East Building,
1000 South Fremont Avenue, Alhambra, California 91803
Attn: Wesley L. Ford, Director

The addresses to which notices are to be sent may be changed by written notice given in accordance with this Section.

J. **Severability:** If any provision of this MOU is rendered invalid or unenforceable by any local, State, or Federal law, rule or regulation, or declared null and void

by any court of competent jurisdiction, the remainder of this MOU shall remain in full force and effect.

K. **Waiver of Obligations:** The waiver of any obligation or breach of this MOU by either party shall not constitute a continuing waiver of any obligation or subsequent breach of either the same or any other provision(s) of this MOU. Further, any such waiver shall not be construed to be a waiver on the part of such party to enforce strict compliance in the future and to exercise any right or remedy related thereto.

L. **Status as Independent Entities:** None of the provisions of this MOU is intended to create, nor shall be deemed or construed to create any relationship between Managed Care Health Plan and DPH-SAPC other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this MOU. Neither Managed Care Health Plan, DPH-SAPC, nor any of their respective agents, employees, or representatives shall be construed to be the agent, employee or representative of the other.

M. **Entire Agreement:** This MOU represents the entire agreement between the parties hereto with respect to the subject matter hereof and supersedes any and all other agreements, either oral or written, between the parties with respect to the subject matter hereof, and no other agreement, statement or promise relating to the subject matter of this MOU shall be valid or binding.

N. **Counterparts:** This MOU may be executed in counterparts and by facsimile or PDF signature, all of which taken together constitute a single agreement between the parties. Each signed counterpart, including a signed counterpart reproduced by reliable means (such as facsimile and PDF), will be considered as legally effective as an original signature.

IN WITNESS WHEREOF, the parties have executed this MOU on the date first written.

By: _____ Date: _____
Managed Care Health Plan
President

By: _____ Date: _____
Cynthia A. Harding, M.P.H.
Interim Director
Los Angeles County Department of Public Health

Drug Medi-Cal Organized Delivery System
Coordination of Care Policies and Procedures
Applicable Solely to Los Angeles County

I. POLICY

1. There is no "wrong door" to enter the DMC-ODS system of care in Los Angeles County. Referrals will be accepted from all sources that will include but will not be limited to County Access Center, other County agency, Provider, Community, Caregiver, and Beneficiary (Self).

2. Managed Care Health Plan and DPH SAPC are responsible for providing eligible beneficiaries with seamless access to all medically necessary substance use disorder (SUD) treatment and recovery services covered by the DMC-ODS Pilot.

3. Managed Care Health Plan will coordinate with DPH SAPC and its Los Angeles County SUD providers to ensure DMC-ODS enrollees have seamless access to these services.

4. Managed Care Health Plan and DPH SAPC will ensure coordination of SUD care with physical health services, mental health services, and long-term services and supports.

II. DEFINITIONS

1. **Addiction** is a primary, chronic, neurobiological disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, continued use despite harm, and craving. (Authority – Substance Abuse and Mental Health Services Administration, A Treatment Improvement Protocol 54, and the American Society of Addiction Medicine)

2. **ASAM** means the American Society of Addiction Medicine which developed the ASAM Criteria, also known as the ASAM patient placement criteria. These criteria are the most widely used and comprehensive set of guidelines for placement, continued stay, and transfer/discharge of patients with addiction and co-occurring conditions.

3. **BH** means Behavioral Health, which includes mental health and substance use disorder services**.**

4. **Behavioral Health Care Management Team (BHCMT)** Multidisciplinary team that provides care management, care coordination and authorization for reimbursement of Medicare services to Beneficiaries enrolled in the Pilot.

5. **Behavioral Health Care Plan** The care plan developed by a Beneficiary and the Beneficiary's Behavioral Health Care Management Team that describes the authorized services to the Beneficiary.

6. **BHP** means Behavioral Health Providers.

7. **Care Coordination** refers to the management of services for beneficiaries to help ensure that delivered services are well-integrated to provide maximum benefit, effectiveness, and safety.

8. **DMH** means County Department of Mental Health.

9. **DPH** means County Department of Public Health.

10. **DPH-SAPC** means County Department of Public Health, Substance Abuse Prevention and Control.

11. **DHS** means County Department of Health Services.

12. **Health Plan, "The Plan," or "Plan"** refers to Managed Care Health Plan.

13. **Interdisciplinary Care Team (ICT)** refers to a team composed of medical, behavioral health, and social service providers that collectively manages the medical, cognitive, psychosocial and functional services of beneficiaries with complex needs.

14. **LMHP** refers to the Los Angeles County Department of Mental Health (DMH) which is the local county agency that has the responsibility for administering public mental health services.

15. **LTSS** means Long Term Services and Supports, which includes Institutional Long Term Care and Community Based Long Term Services and Supports.

16. **Primary Care** means a basic level of health care usually rendered in ambulatory setting by general practitioners, family practitioners, internists, obstetricians, pediatricians, and mid- level practitioners. Primary care emphasizes caring for the member's general health needs as opposed to a specialist focusing on specific needs. This means providing care for the majority of health care problems, including, but not limited to, preventive services, acute and chronic conditions, and psychosocial issues.

17. **Primary Care Provider (PCP)** means a person responsible for supervising, coordinating, and providing initial and primary care to patients, initiating referrals, and maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner. The medical home is where care is accessible, continuous, comprehensive, and culturally competent. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN).

18. **Program Administration Team (PAT)** refers to a team composed of staff from Managed Care Health Plan, DMH, and DPH-SAPC that provides program oversight of the Behavioral Health Care Management Team.

19. **Substance Use Disorder Treatment Services** are outpatient, intensive outpatient, residential, withdrawal management, opioid (narcotic) treatment program, and recovery support services that are made available to persons with substance use disorders. Types of services, as described in Title 22, Section 51341.1, Drug Medi-Cal Substance Abuse Services; the California Health and Safety Code, Section 11752.1 (l) and the State of California Alcohol and/or Other Drug Program Certification Standards, include assessment, screening, evaluation, crisis intervention, individual, group, and family counseling, case-management, collateral, vocational, detoxification, medication assisted treatment services, recovery support, and education services on tuberculosis and sexually transmitted diseases.

20. **Substance Use Disorder Provider** means an entity/organization contracted with Los Angeles County DPH-SAPC and is certified or licensed to provide SUD treatment services. Individuals providing counseling services must be registered, certified or licensed in accordance with the California Code of Regulations, Title 9, Division 4, Chapter 8, commencing with Section 13000, and DPH-SAPC contract requirements.

21. **Specialty Mental Health Service** means Medi-Cal specialty mental health services and health plans and Counties will follow the medical necessity criteria for specialty mental health 1915b waiver services described in Title 9, California Code of Regulations (CCR), Sections 1820.205, 1830.205, and 1830.210. These criteria can be summarized as the following:

    a. **Diagnosis -** One or more of the specified Medi-Cal included Diagnostic and Statistical Manual of Mental Disorders;

    b. **Impairment -** Significant impairment or probability of deterioration of an important area of life functioning, or for children a probability the child will not progress appropriately;

c. **Intervention Services -** must address the impairment, be expected to significantly improve the condition, and the condition is not responsive to physical health care based treatment.

III. PROCEDURE

1. The DMC-ODS Pilot has a "no wrong door" approach to service access. There will be multiple entry paths for eligible Beneficiaries to access DMC-ODS Pilot services. Referrals may come from all sources, including the Access Line, Medi-Cal managed care health plans, other County departments, criminal justice and juvenile justice agencies, child dependency system, community-based human service agencies, families, and self. Sources of referrals will also be educated on expeditiously referring DMC-ODS cases to Managed Care Health Plan's toll free numbers.

2. Calls will be screened and triaged to establish Medi-Cal eligibility and determine DMC-ODS service needs, and refer and link Beneficiaries to DPH-SAPC SUD Providers. The screening and assessments will be conducted using guidelines developed by the Program Administration Team (PAT).
    a. If the Beneficiary does not require DMC-ODS services and needs other medical services, s/he is referred to the Managed Care Health Plan's member services department.
    b. If the Beneficiary does require DMC-ODS services, appropriate authorization by DPH-SAPC will be obtained and referral will be done.
    c. In case of Crisis, the caller will be appropriately directed to emergency services.

3. Beneficiaries that are enrolled in the DMC-ODS Pilot may walk in or present to a DPH-SAPC SUD Provider to receive a brief triage assessment, using a DPH-SAPC authorized tool, to determine the appropriate level of care. Where indicated, the Beneficiary would then receive a more intensive biopsychosocial clinical assessment, using a DPH-SAPC authorized tool, and enroll in services. The SUD Provider must secure prior authorization from DPH-SAPC for residential treatment (ASAM 3.1, 3.3, 3.5), and any withdrawal management and/or medication-assisted treatment to be provided to minors; prior authorization is not required for other ASAM levels of care included in the benefit package.
    a. If the Beneficiary is in need of emergent, urgent or routine SUD services. Beneficiaries experiencing a SUD crisis will be immediately referred to emergency services.
        1) An emergency (SUD) is defined as an emergent situation in which the Beneficiary is in need of assessment and treatment in a safe and therapeutic setting, is a danger to himself or others, exhibits acute onset of psychosis, exhibits severe thought disorganization, or exhibits significant clinical deterioration in a chronic behavioral condition including symptoms of

intoxication or withdrawal.
2) Emergency SUD services will be provided in accordance with the symptoms listed above.
3) The use of 911 services will be incorporated as necessary.

b. If the Beneficiary is in need of non-urgent SUD or additional services, the providers will determine the Beneficiary's Care Management level based on guidelines developed by DPH-SAPC.

4. Care Management (CM) level determination includes the following:
   a. **DMC-ODS SUD Services for Adults**
      1) Outpatient Services (ASAM Level 1)
      2) Intensive Outpatient Treatment (ASAM Level 2.1)
      3) Residential Treatment
         i. Clinically Managed Low-Intensity (ASAM Level 3.1)
         ii. Clinically Managed Population-Specific High-Intensity (ASAM Level 3.3)
         iii. Clinically Managed High-Intensity (ASAM Level 3.5)
      4) Withdrawal Management
         i. Ambulatory Withdrawal Management without Extended On-site (ASAM Level 1-WM)
         ii. Ambulatory Withdrawal Management with Extended On-site (ASAM Level 2-WM)
         iii. Clinically Managed Residential Withdrawal Management (ASAM Level 3.2-WM)
      5) Medication Assisted Treatment
         i. Narcotic Treatment Programs (ASAM Level OTP)
         ii. Addiction Medications with Concurrent Outpatient or Residential Treatment
      6) Recovery Support
   b. **DMC-ODS SUD Services for Adolescents**
      1) Outpatient Services (ASAM Level 1)
      2) Intensive Outpatient Treatment (ASAM Level 2.1)
      3) Residential Treatment
         i. Clinically Managed Low-Intensity (ASAM Level 3.1)
         ii. Clinically Managed High-Intensity (ASAM Level 3.5)
      4) Recovery Support (Post-Discharge)
   c. Beneficiaries that do not meet criteria for DMC-ODS services will be referred and linked back to Managed Care health Plan provider network by the BHCMT.

5. Referral Process for non-BH Care Services
   a. Managed Care Health Plan and DPH-SAPC will follow referral workflows and levels of care developed by the PAT.
   b. Beneficiaries with co-occurring medical conditions or with need for other ancillary or medical services may be referred by the providers to the ICT

that is developed by the Managed Care Health Plan for coordinating all care requirements of the Beneficiary.

c. Any DPH-SAPC SUD Provider may identify SUD Beneficiaries that need physical and mental health care services and refer the Beneficiaries to the BHCMT care manager.

d. Managed Care Health Plan's BHCMT care manager will identify the Primary Care Physician (PCP) assigned to the Beneficiary and refer and link the Beneficiary to the PCP for health care services as needed.

IV. STRUCTURAL CONSIDERATIONS FOR DMC-ODS CARE COORDINATION

1. Care Management Teams
   a. PAT will have the following shared responsibilities:
      1) Develop guidelines and policies and procedures to assist the Behavioral Health Care Management Team in its day-to-day operations.
      2) Identify systemic and programmatic issues and provide recommendations for resolution of problem areas.
      3) Program evaluation.
      4) Resolve disputes between Managed Care Health Plan and the DPH-SAPC.
      5) Identify and resolve issues between Managed Care Health Plan and DPH provider relations.
   b. Behavioral Health Care Management Team (BHCMT) will have the following shared responsibilities:
      1) Authorize reimbursement based upon developed guidelines by PAT.
      2) Develop a behavioral health care plan.
      3) Coordinate care between physical health and substance abuse providers through the ICT.
      4) Monitor clinical progress.
      5) Reassess service needs.
      6) Refer and link to appropriate services.
      7) Serve as the liaison to the ICT as needed.
   c. ICT will be facilitated by Managed Care Health Plan to provide needed care management services to all beneficiaries. The team will include health care staff, substance abuse, and other community agencies as appropriate. DPH-SAPC will provide consultation to the team and ensure SUD needs are addressed.

V. CARE COORDINATION

1. Care Coordination Activities
   a. Managed Care Health Plan will conduct a Health Risk Assessment for all Beneficiaries enrolled in the DMC-ODS Pilot that also includes SUD

screenings. When possible, Managed Care Health Plan will coordinate this initial assessment with DPH-SAPC. Managed Care Health Plan will refer Beneficiaries with specific substance abuse findings from the screening to the PCP for linkage to a DMC-ODS Access Line or directly to SUD Provider.

b. Managed Care Health Plan will refer Beneficiaries through the toll free County Access Number to the BHCMT if services required are outside the scope of the PCP or if the Beneficiary requests services from the DPH-SAPC.
c. The BHCMT will work with the Beneficiary and providers to develop a SUD service plan that will become part of the Beneficiary's overall individual care plan created by the ICT.
d. Whenever possible, signed consent will be secured from the Beneficiary to share PHI with the SUD Provider and the PCP for the purpose of care coordination.
e. SUD Provider will submit written documentation that contains treatment coordination information to the Beneficiary's PCP within thirty (30) days after the initial visit, annually, and when there are significant changes in diagnosis, medications or other aspects of the care plan.
f. Managed Care Health Plan will have a process for reviewing and updating the care plan as clinically indicated, such as following a hospitalization, significant change in health or well-being, change in level of care or request for change of provider, and for coordinating with the SUD Provider when necessary.
g. Managed Care Health Plan provider, SUD Provider, and the Beneficiary will work closely together to develop an individual treatment plan.
h. If needed, Managed Care Health Plan will secure a signed consent from the Beneficiary to share PHI with another provider for care coordination purposes.
i. Managed Care Health Plan will have a process for reviewing and updating the treatment plan as clinically indicated, such as following a hospitalization, significant change in health or well-being, change in level of care or request for change of provider, and for coordinating with other providers when and where necessary.
j. Managed Care Health Plan providers and DPH-SAPC providers may participate in case conferencing as needed and conduct regular meetings to review the care coordination process.

2. Exchange of Information
    a. Refer to Addendum III for the details on Exchange of Information.

VI. AUTHORITY

1. California Code of Regulations, Title 9, Division 4, Chapter 8 commencing with Section 13000

2. Department of Health Care Services (DHCS) Agreement 04-36069, and Amendments thereof, Exhibit A, Attachment 11, Case Management and Coordination of Care, 5. Specialty Mental Health
3. Department of Health Care Services (DHCS) Agreement 04-36069, and Amendments thereof, Exhibit A, Attachment 10, Scope of Services, 7. Services for All Members, D. Mental Health Services
4. MMCD Policy letter 00-01
5. Title 9, CCR, Chapter 11, Division 1, Section(s): 1810.231; 1810.247; 1810.350; 1810.405; 1810.415; 1820.100; 1820.205; 1820.225; 1830.205; 1830.205(b)(1); 1830.210; 1850.210(I); 1850.505
6. Title 22, CCR, Chapter 3, Article 4, Section(s) 51305; 51311; 51313; 51183
7. Title 22, Section 51341.1, Drug Medi-Cal Substance Abuse Services; the California Health and Safety Code, Section 11752.1 (l) and the State of California Alcohol and/or Other Drug Program Certification Standards
8. Welfare and Institutions Code Section 5600.3; and 14016.5

VII. REFERENCE

Memorandum of Understanding by and between Managed Care Health Plan and the Los Angeles County Department of Public Health, Substance Abuse Prevention and Control on the Implementation of the Drug Medi-Cal Organized Delivery System Waiver.

This is a placeholder for Addendum II, DMC-ODS Flowchart.

YOUTH (12-17) SUBSTANCE USE DISORDER (SUD) BENEFIT PACKAGE					
Level Of Care (LOC)	**ASAM Level**	**DHCS ASAM Description**	**Current DMC LOC**	**Current County LOC**	**Implementation Target Date**
Early Intervention	0.5	Screening, brief intervention, and referral (as needed).	Funded by Health Plans not DMC-ODS		
Outpatient	1	Less than 6 hours of service per week for recovery or motivational enhancement therapies and strategies.	Yes	Yes	Year One
Intensive Outpatient	2.1	Six (6) or more hours of service per week to treat multidimensional instability.	Yes	Yes	Year One
Partial Hospitalization	2.5	20+ hours of service per week for multidimensional instability. No 24-hour care.	Per DHCS not funded under DMC-ODS: SAPC will inquire if and how this is funded.		
Low Intensity Residential	3.1	24-hour structure with available trained personnel and at least 5 hours of clinical service per week. Prepare for outpatient treatment.	No	Yes	Year One
High Intensity Residential Population Specific	3.3	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive and other impairments unable to use full active milieu. Prepare for outpatient treatment.	This is not an ASAM Level of Care for adolescents		
High Intensity Residential Non-Population Specific	3.5	24-hour care with trained counselors to stabilize multidimensional imminent danger for individuals able to use full active milieu. Prepare for outpatient treatment.	Yes (Perinatal)	Yes	Year One
Intensive Inpatient Services Medically Monitored	3.7	24-hour nursing care with physician availability for significant problems with ASAM Dimensions 1, 2, or 3. Includes counselor availability for 16 hours per day.	Per DHCS not funded under DMC-ODS: SAPC will inquire if and how this is funded.		
Intensive Inpatient Services Medically Managed	4.0	24-hour nursing care and daily physician care for severe, unstable problems with ASAM Dimensions 1, 2, or 3. Counseling available to engage patient in treatment.	Per DHCS not funded under DMC-ODS: SAPC will inquire if and how this is funded.		
Ambulatory Withdrawal Management Without Extended On-Site Monitoring	1-WM	Mild withdrawal with daily or less than daily outpatient supervision.	This is not an ASAM Level of Care for adolescents If needed, it is integrated with services in other settings		
Ambulatory Withdrawal Management With Extended On-Site Monitoring	2-WM	Moderate withdrawal with all day withdrawal management and support and supervision. At night patient has supportive family or living situation.	This is not an ASAM Level of Care for adolescents If needed, it is integrated with services in other settings		
Residential Withdrawal Management Clinically Managed	3.2-WM	Moderate withdrawal but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment and recovery.	This is not an ASAM Level of Care for adolescents If needed, it is integrated with services in other settings		
Inpatient Withdrawal Management Clinically Managed	3.7-WM	Severe withdrawal and needs 24-hour nursing care and physician visits. Unlikely to complete withdrawal management without medical monitoring.	This is not an ASAM Level of Care for adolescents If needed, it is integrated with services in other settings		
Inpatient Withdrawal Management Medically Managed and Intensive Services	4-WM	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.	This is not an ASAM Level of Care for adolescents If needed, it is integrated with services in other settings		
Opioid (Narcotic) Treatment Program	1-OTP	Daily or several time weekly opioid agonist medications and counseling available to maintain multidimensional stability for those with severe opioid use disorder.	This is not an ASAM Level of Care for adolescents, however, services are provided in LAC.		
Add'l Medication Assisted Treatment	N/A	Ordering, prescribing, administering, and monitoring all mediations for SUDs. Includes: buprenorphine, disulfiram, methadone, naltrexone, acamprosate, and naloxone.	N/A		
Case Management	N/A	Aid in transition between LOC, communication and coordination of referrals, monitoring to ensure access and progress in services, advocacy and linkages.	No	Yes	Year One
Recovery Services (Post Treatment)	N/A	Individual and group counseling, recovery monitoring, substance abuse assistance, linkages to education, job skills, family support, support groups, ancillary services.	No	Yes	Year One
Physician Consultation	N/A	Communication between addiction medicine physicians/psychiatrists or clinical pharmacists with DMC physicians to address medication and LOC considerations.	No	No	Year One

ADULT (26+) AND YOUNG ADULT (18-25) SUBSTANCE USE DISORDER (SUD) BENEFIT PACKAGE					
Level Of Care (LOC)	**ASAM Level**	**DHCS ASAM Description**	**Current DMC LOC**	**Current County LOC**	**Implementation Target Date**
Early Intervention	0.5	Screening, brief intervention, and referral (as needed).	Funded by Health Plans not DMC-ODS		
Outpatient	1	Less than 9 hours of service per week for recovery or motivational enhancement therapies and strategies.	Yes	Yes	Year One
Intensive Outpatient	2.1	Nine (9) or more hours of service per week to treat multidimensional instability.	Yes	Yes	Year One
Partial Hospitalization	2.5	20+ hours of service per week for multidimensional instability. No 24-hour care.	Per DHCS not funded under DMC-ODS: SAPC will inquire if and how this is funded.		
Low Intensity Residential	3.1	24-hour structure with available trained personnel and at least 5 hours of clinical service per week. Prepare for outpatient treatment.	No	Yes	Year One
High Intensity Residential Population Specific	3.3	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive and other impairments unable to use full active milieu. Prepare for outpatient treatment.	No	No	Year One
High Intensity Residential Non-Population Specific	3.5	24-hour care with trained counselors to stabilize multidimensional imminent danger for individuals able to use full active milieu. Prepare for outpatient treatment.	Yes (Perinatal)	No	Year One
Intensive Inpatient Services Medically Monitored	3.7	24-hour nursing care with physician availability for significant problems with ASAM Dimensions 1, 2, or 3. Includes counselor availability for 16 hours per day.	Per DHCS not funded under DMC-ODS: SAPC will inquire if and how this is funded.		
Intensive Inpatient Services Medically Managed	4.0	24-hour nursing care and daily physician care for severe, unstable problems with ASAM Dimensions 1, 2, or 3. Counseling available to engage patient in treatment.	Per DHCS not funded under DMC-ODS: SAPC will inquire if and how this is funded.		
Ambulatory Withdrawal Management Without Extended On-Site Monitoring	1-WM	Mild withdrawal with daily or less than daily outpatient supervision.	No	No	Year One
Ambulatory Withdrawal Management With Extended On-Site Monitoring	2-WM	Moderate withdrawal with all day withdrawal management and support and supervision. At night patient has supportive family or living situation.	No	No	Year Three
Residential Withdrawal Management Clinically Managed	3.2-WM	Moderate withdrawal but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment and recovery.	No	No	Year One
Inpatient Withdrawal Management Clinically Managed	3.7-WM	Severe withdrawal and needs 24-hour nursing care and physician visits. Unlikely to complete withdrawal management without medical monitoring.	Per DHCS not funded under DMC-ODS: SAPC will inquire if and how this is funded.		
Inpatient Withdrawal Management Medically Managed and Intensive Services	4-WM	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.	Per DHCS not funded under DMC-ODS: SAPC will inquire if and how this is funded.		
Opioid (Narcotic) Treatment Program	1-OTP	Daily or several time weekly opioid agonist medications and counseling available to maintain multidimensional stability for those with severe opioid use disorder.	Yes	Yes	Year One
Add'l Medication Assisted Treatment	N/A	Ordering, prescribing, administering, and monitoring all mediations for SUDs. Includes: buprenorphine, disulfiram, methadone, naltrexone, acamprosate, and naloxone.	No	Yes (Long-acting Naltrexone)	Year One
Case Management	N/A	Aid in transition between LOC, communication and coordination of referrals, monitoring to ensure access and progress in services, advocacy and linkages.	No	Yes	Year One
Recovery Services (Post Treatment)	N/A	Individual and group counseling, recovery monitoring, substance abuse assistance, linkages to education, job skills, family support, support groups, ancillary services (minimum of one recovery monitoring contact per month for up to six months).	No	Yes	Year One
Physician Consultation	N/A	Communication between addiction medicine physicians/psychiatrists or clinical pharmacists with DMC physicians to address medication and LOC considerations.	No	No	Year One

Exchange of Information, Including PHI, Related to the Beneficiaries in the Drug Medi-Cal Organized Delivery System

1. Purpose

This addendum addresses how DPH-SAPC and Managed Care Health Plan will share information to coordinate care of Beneficiaries with substance use disorder (SUD). Individuals with mental disorders have substantially higher morbidity and mortality associated with physical health problems than the general public. For many of these individuals, accessing physical healthcare services independently is a challenge and their SUD service provider functions as their primary connection to the overall healthcare system.

In order to coordinate care for such Beneficiaries, the parties must identify those Beneficiaries who are enrollees of Managed Care Health Plan and clients of DPH-SAPC Providers ("Common Members"). This Addendum documents how the parties will share information to: (a) identify Common Members in compliance with the requirements of all applicable Federal and State laws and regulations; and (b) provide coordinated care to the Common Members pursuant to the DMC-ODS Waiver Program.

2. Data Matching

Performing a data match to identify Common Members and transmitting the results to the entities providing services to the Common Members helps achieve two important results:

a. The matched data can help alert healthcare providers to ongoing SUD needs and interventions in Common Members. These SUD needs and interventions may have impact on their physical healthcare, and providing the information may facilitate consultation and collaboration between health and SUD providers that can improve the health status and treatment outcomes of those served.

b. Results of this match would also provide DPH-SAPC with information that would allow DPH-SAPC SUD Providers to more efficiently and effectively facilitate access to much needed physical healthcare services for Common Members by identifying available primary care resources.

3. Protocols Governing the Exchange of Information

a. To the extent allowed by the Health Insurance Portability and Accountability Act (HIPAA) and applicable State and Federal privacy laws and 42 C.F.R. Part 2, Managed Care Health Plan shall provide to DPH-SAPC the data

described in Addendum IIIA, Managed Care Health Plan Beneficiary Data Exchange Protocol ("Protocol"). DPH-SAPC shall use this data solely to determine whether Beneficiaries are Common Members.

i. For those Beneficiaries who are determined to be Common Members, DPH-SAPC and Managed Care Health Plan shall use the data for the purposes of coordinating care.

ii. For those Beneficiaries who are determined to be Common Members, DPH-SAPC and Managed Care Health Plan shall not use the data for any other purposes, and shall return it to Managed Care Health Plan and remove it from all Systems where the data was used or stored.

b. Managed Care Health Plan and DPH-SAPC have reviewed the attached Protocol and agree that the data described in the Protocol complies with HIPAA's minimum necessary standard.

c. The parties shall comply with the HIPAA Security Rule in transmitting, receiving and maintaining Protected Health Information (PHI) exchanged in accordance with the Protocol.

4. HIPAA Obligations of the Parties

a. Managed Care Health Plan and DPH-SAPC acknowledge that each is a covered entity under HIPAA, and each acknowledges their independent obligations to comply with HIPAA.

b. Each party represents that it has implemented reasonable safeguards to protect the privacy and security of PHI, including electronic PHI, received from or transmitted by the other party and to prevent unpermitted uses or disclosures of such PHI.

5. Business Associate-Obligations

a. The parties acknowledge that for the purposes of conducting the data matching, DPH-SAPC shall be acting in the capacity of a Business Associate of Managed Care Health Plan, with respect to the receipt of PHI for Beneficiaries who are not Common Members.

b. The parties shall enter into a Business Associate Agreement for the data matching requirements.

c. Upon completion of the data matching, DPH-SAPC shall not retain any PHI for Managed Care Health Plan Beneficiaries who are not Common Members. Such PHI shall be destroyed or returned in accordance with the terms of the Business Associate Agreement.

Managed Care Health Plan Beneficiary Data Exchange Protocol

1. Background

This document describes the data exchange protocol for the purpose of coordinating physical health primary care and specialty substance use disorder care among Common Members. In the event of an inconsistency between this Protocol and Addendum III. Addendum III shall govern.

2. Data Exchange-data Matching

Demographic Data. DPH-SAPC will provide a secured location for Managed Care Health Plan to place a data file of individuals identified as Beneficiaries, initially in the form of a flat text file or an X12 834 file, on an interval agreed upon by DPH-SAPC and Managed Care Health Plan. The data file, referred to as the DMC-ODS file, at a minimum shall contain the following demographic identifying elements:

- Member First Name
- Member Last Name
- Member Social Security Number
- Member CIN
- Member Date of Birth
- Member Residence Address
- Member Residence City
- Member Residence State
- Member Residence Zip
- Member Gender
- Member Ethnicity
- Member Race
- Managed Care Health Plan Internal Member Number
- Primary Care Physician Name
- Primary Care Physician Contact Phone Number
- Primary Care Physician Address

Match Details. Upon receipt of the DMC-ODS file, DPH-SAPC shall load the data to the Department of Public Health ("DPH") Enterprise Data Warehouse. DPH-SAPC shall maintain a historical table of DMC-ODS beneficiaries and their respective eligibility information. DPH-SAPC shall conduct a match of concomitant Beneficiaries between Managed Care Health Plan and the Department of Mental Health (DMH), on an interval agreed upon by both parties. DPH-SAPC will use the health plan's DMC-ODS enrollment file to identify common beneficiaries who are enrolled in Managed Care Health Plan and receiving substance abuse services at DPH-SAPC. DPH-SAPC will provide the Managed Care Health Plan with a file representing these common beneficiaries. DPH-SAPC will include Beneficiary and substance abuse provider contact information.

3. Data Exchange – Care Coordination

a. Managed Care Health Plan Usage. Upon completion of the match, with Common Member's consent in compliance to 42 C.F.R. Part 2 in place, DPH-SAPC shall extract and provide (as described below), Common Members who currently have an open and active episode in the DPH Integrated System (IS) or successor DPH electronic health record (EHR) to Managed Care Health Plan in the form of a flat text file or an X12 834 file. DPH-SAPC will, at minimum, provide the following elements:

- Admission Data of Episode
- Last SUD Contact Date
- SUD Provider ID
- SUD Provider Name
- SUD Provider Address
- SUD Provider Contact Phone Number
- SUD Provider Primary Contact Name
- Current Diagnosis(es) (ICD-10 or other applicable codes)

The response data file will be placed on a secure server administered and maintained by the DPH-SAPC. Managed Care Health Plan will retrieve the file for the purposes of coordinating Common Members care.

Managed Care Health Plan shall not use or disclose the information for any other purpose.

b. DPH-SAPC Usage. In addition to the demographic data provided pursuant to Section 2.1, Managed Care Health Plan will provide the following data elements for Common Members to DPH-SAPC in the form of a flat text file or an X12 834 file:

- Current Diagnosis(es) (ICD-10 or other applicable codes)

After processing the Beneficiary data, DPH-SAPC will upload the PCP and other pertinent information for Common Members to the DPH EHR or successor DPH EHR. DPH-SAPC Providers will then be able to access the data via the IS or successor DPH EHR. The information will be displayed as supplemental detail in order to facilitate coordination of care with Primary Care Providers. Access to the IS or successor DMH EHR is controlled via user credentials.

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LEVEL OF CARE	AGES SERVED	DMC*	AGENCY NAME	FACILITY ADDRESS
OUTPATIENT BY POPULATION SERVED				
Outpatient Treatment	Youth Only	No	Alcoholism Council of Antelope Valley/NCA	311 East Avenue K-4, Lancaster, CA 93535
Outpatient Treatment	Youth Only	No	Asian American Drug Abuse Program, Inc.	13931 South Van Ness Avenue, Suite 202, Gardena, CA 90249
Outpatient Treatment	Youth Only	No	Child and Family Center	21545 Centre Pointe Parkway, Santa Clarita, CA 91350
Outpatient Treatment	Youth Only	No	Children's Hospital of Los Angeles	5000 Sunset Boulevard, Suite 701, Los Angeles, CA 90027
Outpatient Treatment	Youth Only	No	Didi Hirsch Psychiatric Service	12420 Venice Boulevard, Suite 200, Los Angeles, CA 90066
Outpatient Treatment	Youth Only	No	Helpline Youth Counseling, Inc.	14181 Telegraph Road., Whittier CA, 90604
Outpatient Treatment	Youth Only	No	SPIRITT Family Services, Inc.	1505 South Sunflower Avenue, Glendora, CA 91740
Outpatient Treatment	Youth/Adults	Yes	Behavioral Health Services, Inc.	3421 East Olympic Boulevard, Los Angeles, CA 90023
Outpatient Treatment	Youth/Adults	Yes	Behavioral Health Services, Inc.	4099 North Mission Road, Los Angeles, CA 90032
Outpatient Treatment	Youth/Adults	Yes	California Hispanic Commission on Alcohol and Drug Abuse, Inc.	3316-3320 West Beverly Boulevard, Montebello, CA 90640
Outpatient Treatment	Youth/Adults	Yes	Pacific Clinics	2550 East Foothill Boulevard, Pasadena, CA 91107
Outpatient Treatment	Youth/Adults	Yes	Pacific Clinics	790 East Bonita Avenue, Pomona, CA 91767
Outpatient Treatment	Youth/Adults	Yes	Phoenix Houses of Los Angeles, Inc.	11600 Eldridge Avenue, Lake View Terrace, CA 91342
Outpatient Treatment	Youth/Adults	Yes	Shields for Families, Inc.	2620 Industry Way, Suites A & B, Lynwood, CA 90262
Outpatient Treatment	Youth/Adults	No	Special Services for Groups, Inc.	5849 South Crocker Street, Los Angeles, CA 90003
Outpatient Treatment	Youth/Adults	Yes	SPIRITT Family Services, Inc.	147 South Sixth Avenue, La Puente, CA 91746
Outpatient Treatment	Youth/Adults	Yes	SPIRITT Family Services, Inc.	2000 South Tyler Avenue, El Monte, CA 91733
Outpatient Treatment	Youth/Adults	Yes	Tarzana Treatment Centers, Inc.	18700 Oxnard Street, Tarzana, CA 91356
Outpatient Treatment	Youth/Adults	Yes	Tarzana Treatment Centers, Inc.	44443 North 10th Street, Lancaster, CA 93534
Outpatient Treatment	Adults Only	Yes	Alcoholism Center for Women, Inc.	1147 South Alvarado Street, Los Angeles, CA 90006
Outpatient Treatment	Adults Only	No	Asian American Drug Abuse Program, Inc.	1088 South La Brea Avenue, Los Angeles, CA 90019
Outpatient Treatment	Adults Only	No	Asian American Drug Abuse Program, Inc.	11101 South Main Street, Los Angeles, CA 90061
Outpatient Treatment	Adults Only	No	Asian American Drug Abuse Program, Inc.	1900 Atlantic Ave., Long Beach, CA 90806
Outpatient Treatment	Adults Only	No	Asian American Drug Abuse Program, Inc.	4920 South Avalon Boulevard, Los Angeles, CA 90011
Outpatient Treatment	Adults Only	No	Asian American Drug Abuse Program, Inc.	520 North La Brea Avenue, Inglewood, CA 90302
Outpatient Treatment	Adults Only	Yes	Avalon-Carver Community Center	4920 South Avalon Boulevard, Los Angeles, CA 90011
Outpatient Treatment	Adults Only	No	Behavioral Health Services, Inc.	1318 North Avalon Boulevard, Suite A, Wilmington, CA 90744
Outpatient Treatment	Adults Only	Yes	Behavioral Health Services, Inc.	1318 North Avalon Boulevard, Wilmington, CA 90744
Outpatient Treatment	Adults Only	Yes	Behavioral Health Services, Inc.	1334 Post Avenue, Torrance, CA 90501
Outpatient Treatment	Adults Only	Yes	Behavioral Health Services, Inc.	15519 South Crenshaw Boulevard, Gardena, CA 90249

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LEVEL OF CARE	AGES SERVED	DMC*	AGENCY NAME	FACILITY ADDRESS
Outpatient Treatment	Adults Only	No	Behavioral Health Services, Inc.	1775 Chestnut Avenue, Long Beach, CA 90813
Outpatient Treatment	Adults Only	Yes	Behavioral Health Services, Inc.	2180 West Valley Boulevard, Pomona, CA 91768
Outpatient Treatment	Adults Only	No	Behavioral Health Services, Inc.	2180 West Valley Boulevard, Pomona, CA 91768
Outpatient Treatment	Adults Only	No	Behavioral Health Services, Inc.	2501 Atlantic Avenue, Long Beach, CA 90806
Outpatient Treatment	Adults Only	No	Behavioral Health Services, Inc.	4201 Long Beach Blvd, Ste 300/304, Long Beach, CA 90807
Outpatient Treatment	Adults Only	Yes	Behavioral Health Services, Inc.	590 West 8th Street, San Pedro, CA 90731
Outpatient Treatment	Adults Only	Yes	Behavioral Health Services, Inc.	6838 Sunset Boulevard, Hollywood, CA 90028
Outpatient Treatment	Adults Only	Yes	Bienstar (DBA: Substance Abuse Specialists, Inc.)	14515 Hamlin Street, Van Nuys, CA 91411
Outpatient Treatment	Adults Only	Yes	California Hispanic Commission on Alcohol and Drug Abuse, Inc.	11046 Valley Mall, El Monte, CA 91731
Outpatient Treatment	Adults Only	Yes	California Hispanic Commission on Alcohol and Drug Abuse, Inc.	2309 Daly Street, Los Angeles, CA 90031
Outpatient Treatment	Adults Only	No	Cambodian Association of America	1318A and 1314B North Avalon Blvd, Wilmington, CA 90744
Outpatient Treatment	Adults Only	No	Cambodian Association of America	1334 Post Avenue, Torrance, CA 90501
Outpatient Treatment	Adults Only	No	Cambodian Association of America	2501 Atlantic Avenue, Long Beach, CA 90806
Outpatient Treatment	Adults Only	No	Cambodian Association of America	590 West 8th Street, San Pedro, CA 90731
Outpatient Treatment	Adults Only	No	Canon Human Services, Inc.	9705 South Holmes Avenue, Los Angeles, CA 90002
Outpatient Treatment	Adults Only	Yes	Center for Integrated Family and Health Services	540 South Eremland Drive, Suite A, Covina, CA 91723
Outpatient Treatment	Adults Only	No	Children's Hospital of Los Angeles	1157 South Berendo Street, Los Angeles, California 90006
Outpatient Treatment	Adults Only	No	Children's Hospital of Los Angeles	1215 West 15th Street, Los Angeles, California 90026
Outpatient Treatment	Adults Only	No	Children's Hospital of Los Angeles	1339 West 120th Street, Los Angeles, CA 90059
Outpatient Treatment	Adults Only	No	Children's Hospital of Los Angeles	147 North Occidental Boulevard., Los Angeles CA, 90026
Outpatient Treatment	Adults Only	No	Children's Hospital of Los Angeles	1521 North Highland Avenue, Los Angeles, CA 90028
Outpatient Treatment	Adults Only	No	Children's Hospital of Los Angeles	155 North Occidental Boulevard, Los Angeles, CA 90026
Outpatient Treatment	Adults Only	No	Children's Hospital of Los Angeles	1575 West 2nd Street, Los Angeles, CA 90026
Outpatient Treatment	Adults Only	No	Children's Hospital of Los Angeles	2140 West Olympic Boulevard, Suite 101, Los Angeles, California 90017
Outpatient Treatment	Adults Only	No	Children's Hospital of Los Angeles	2755 West 15th Street, Los Angeles, California 90006
Outpatient Treatment	Adults Only	No	Children's Hospital of Los Angeles	3435 West Temple Street, Los Angeles, California 90026
Outpatient Treatment	Adults Only	No	Children's Hospital of Los Angeles	3939 Tracey Street, Los Angeles, CA 90027
Outpatient Treatment	Adults Only	Yes	CLARE Foundation, Inc.	1020 Pico Boulevard, Santa Monica, CA 90405
Outpatient Treatment	Adults Only	Yes	Clinica Monsenor Oscar A. Romero	2032 Marengo Street, Los Angeles, CA 90033
Outpatient Treatment	Adults Only	Yes	CRI-HELP, Inc.	2029 Keith Street, Los Angeles, CA 90031
Outpatient Treatment	Adults Only	Yes	CRI-HELP, Inc.	8330 Lankershim Boulevard, North Hollywood, CA 91605
Outpatient Treatment	Adults Only	Yes	Didi Hirsch Psychiatric Service	323 North Prairie Avenue, Inglewood, CA 90301

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LEVEL OF CARE	AGES SERVED	DMC*	AGENCY NAME	FACILITY ADDRESS
Outpatient Treatment	Adults Only	Yes	Divine Healthcare Services, Inc.	405 West Manchester Blvd., Suite A, Inglewood, CA 90301
Outpatient Treatment	Adults Only	Yes	Eggleston Youth Centers (DBA: Eggleston Substance Abuse and Education Program)	13001 Ramona Boulevard, Suites E & J, Irwindale, CA 91706
Outpatient Treatment	Adults Only	No	El Proyecto del Barrio	9140 Van Nuys Boulevard #211, Panorama City, CA 91402
Outpatient Treatment	Adults Only	Yes	Eldorado Community Service Center	5200 San Gabriel Place, Suites B & C, Pico Rivera, CA 90660
Outpatient Treatment	Adults Only	Yes	Ettie Lee Homes, Inc.	160 East Holt Avenue, Suite B, Pomona, CA 91767
Outpatient Treatment	Adults Only	Yes	Families for Children, Inc.	2504 Westchester Boulevard, Inglewood, CA 90305
Outpatient Treatment	Adults Only	Yes	Grandview Foundation, Inc.	1230 North Marengo Avenue, Pasadena, CA 91103
Outpatient Treatment	Adults Only	Yes	HACC, Inc. (DBA: Harbor Area Substance Abuse Treatment Center)	599 West 9th Street, San Pedro, CA 90731
Outpatient Treatment	Adults Only	Yes	Helping Kids to Recover, Inc.	13305 South San Pedro Street, Los Angeles, CA 90061
Outpatient Treatment	Adults Only	Yes	Helping Kids to Recover, Inc.	14500 Larch Avenue, Building 17-2, Lawndale, CA 90260
Outpatient Treatment	Adults Only	Yes	Helping Kids to Recover, Inc.	2606 North Central Avenue, Compton, CA 90222
Outpatient Treatment	Adults Only	Yes	Helping Kids to Recover, Inc.	601 South Acacia Avenue, Compton, CA 90220
Outpatient Treatment	Adults Only	Yes	Helping Kids to Recover, Inc.	637 East Albertoni Street, Carson, CA 90746
Outpatient Treatment	Adults Only	Yes	Helpline Youth Counseling, Inc.	12440 East Firestone Blvd., Suite 1000, Norwalk, CA 90650
Outpatient Treatment	Adults Only	Yes	His Sheltering Arms, Inc.	11101 South Main Street, Los Angeles, CA 90061
Outpatient Treatment	Adults Only	Yes	Holy Addiction Care Center, Inc.	111 North Glendale Blvd., Suite B., Los Angeles CA, 90026
Outpatient Treatment	Adults Only	Yes	Homeless Health Care Los Angeles, Inc.	2330 West Beverly Boulevard, Los Angeles, CA 90057
Outpatient Treatment	Adults Only	No	I-ADARP, Inc.	8330 Lankershim Boulevard, North Hollywood, CA 91601
Outpatient Treatment	Adults Only	Yes	JWCH Institute, Inc.	1218 East Compton Boulevard, Compton, CA 90221
Outpatient Treatment	Adults Only	Yes	JWCH Institute, Inc.	522 South San Pedro Street, Los Angeles, CA 90013
Outpatient Treatment	Adults Only	Yes	Los Angeles Centers for Alcohol and Drug Abuse	10400 Orr & Day Road, Santa Fe Springs, CA 90670
Outpatient Treatment	Adults Only	Yes	Los Angeles Centers for Alcohol and Drug Abuse	10800 Benavon Street, Whittier, CA 90606
Outpatient Treatment	Adults Only	No	Los Angeles Centers for Alcohol and Drug Abuse	1088 South La Brea Avenue, Los Angeles, CA 90019
Outpatient Treatment	Adults Only	Yes	Los Angeles Centers for Alcohol and Drug Abuse	11015 Bloomfield Avenue, Santa Fe Springs, CA 90670
Outpatient Treatment	Adults Only	Yes	Los Angeles Centers for Alcohol and Drug Abuse	12417 East Philadelphia Street, Whittier, CA 90601
Outpatient Treatment	Adults Only	Yes	Los Angeles Centers for Alcohol and Drug Abuse	14421 Whittier Boulevard, Whittier, CA 90605
Outpatient Treatment	Adults Only	Yes	Los Angeles Centers for Alcohol and Drug Abuse	15301 Youngwood Drive, Whittier, CA 90605
Outpatient Treatment	Adults Only	No	Los Angeles Centers for Alcohol and Drug Abuse	204 Hampton Drive., Venice CA, 90291
Outpatient Treatment	Adults Only	No	Los Angeles Centers for Alcohol and Drug Abuse	3323 Washington Boulevard., Los Angeles CA, 90018
Outpatient Treatment	Adults Only	Yes	Los Angeles Centers for Alcohol and Drug Abuse	470 East 3rd Street, Suites A & B, Los Angeles, CA 90013
Outpatient Treatment	Adults Only	No	Los Angeles Centers for Alcohol and Drug Abuse	520 North La Brea, Inglewood, CA 90302

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LEVEL OF CARE	AGES SERVED	DMC*	AGENCY NAME	FACILITY ADDRESS
Outpatient Treatment	Adults Only	No	Los Angeles Centers for Alcohol and Drug Abuse	5723 Whittier Boulevard, Los Angeles, CA 90022
Outpatient Treatment	Adults Only	Yes	Los Angeles Centers for Alcohol and Drug Abuse	5777 Lockheed Avenue, Whittier, CA 90606
Outpatient Treatment	Adults Only	Yes	Los Angeles Centers for Alcohol and Drug Abuse	9401 South Painter Avenue, Whittier, CA 90605
Outpatient Treatment	Adults Only	Yes	Los Angeles Centers for Alcohol and Drug Abuse	9800 South Mills Avenue, Whittier, CA 90604
Outpatient Treatment	Adults Only	Yes	Matrix Institute on Addictions	1849 Sawtelle Boulevard, Suite 100, Los Angeles, CA 90025
Outpatient Treatment	Adults Only	Yes	Matrix Institute on Addictions	20350 Ventura Blvd., Suite 230, Woodland Hills, CA 91364
Outpatient Treatment	Adults Only	Yes	Matrix Institute on Addictions	233 West Baseline Road, La Verne, CA 91750
Outpatient Treatment	Adults Only	Yes	Matrix Institute on Addictions	5220 W. Washington Blvd., Suite 200, Los Angeles, CA 90016
Outpatient Treatment	Adults Only	Yes	Maxin Health Care Services, Inc.	3756 Santa Rosalia Drive, Suite 326A, Los Angeles, CA 90008
Outpatient Treatment	Adults Only	Yes	Medi-Cure Health Services, Inc.	3756 Santa Rosalia Drive, Suite 417, Los Angeles, CA 90008
Outpatient Treatment	Adults Only	Yes	Motivational Recovery Services, Inc.	2116-2118 Central Avenue., Los Angeles CA, 90011
Outpatient Treatment	Adults Only	No	National Council on Alcoholism and Drug Dependence - Long Beach Area	4201 Long Beach Blvd., Ste 300/304, Long Beach, CA 90807
Outpatient Treatment	Adults Only	Yes	National Council on Alcoholism and Drug Dependence - San Fernando Valley	24460 Lyons Avenue, Santa Clarita, CA 91321
Outpatient Treatment	Adults Only	Yes	National Council on Alcoholism and Drug Dependence - San Fernando Valley	6166 Vesper Avenue, Van Nuys, CA 91411
Outpatient Treatment	Adults Only	No	National Council on Alcoholism and Drug Dependence - San Gabriel and Pomona Valleys	4626 North Grand Avenue, Covina, CA 91724
Outpatient Treatment	Adults Only	Yes	New Hope Drug & Alcohol Treatment Program, Inc.	1841 West Imperial Highway, Los Angeles, CA 90047
Outpatient Treatment	Adults Only	Yes	Pacific Clinics	1020 South Arroyo Parkway, Pasadena, CA 91105
Outpatient Treatment	Adults Only	No	Pacific Clinics	1134 South Barranca Avenue, Glendora, CA 91741
Outpatient Treatment	Adults Only	Yes	Pacific Clinics	1160 South Grand Avenue, Glendora, CA 91740
Outpatient Treatment	Adults Only	Yes	Pacific Clinics	11721 E. Telegraph Road, Ste A, Santa Fe Springs, CA 90670
Outpatient Treatment	Adults Only	Yes	Pacific Clinics	11741 Telegraph Road, Bldg. G, Santa Fe Springs, CA 90670
Outpatient Treatment	Adults Only	No	Pacific Clinics	11741 Telegraph Road, Unit G, Santa Fe Springs, CA 90670
Outpatient Treatment	Adults Only	No	Pacific Clinics	1200 North Gordon Street, Pomona, CA 91768
Outpatient Treatment	Adults Only	No	Pacific Clinics	13000 Clarkdale Avenue, Norwalk, CA 90650
Outpatient Treatment	Adults Only	Yes	Pacific Clinics	13001 Ramona Boulevard, Suite H and I, Irwindale, CA 91706
Outpatient Treatment	Adults Only	No	Pacific Clinics	13177 Ramona Boulevard, #C, Irwindale, CA 91706
Outpatient Treatment	Adults Only	No	Pacific Clinics	2131 Loma Avenue, El Monte, CA 91732
Outpatient Treatment	Adults Only	Yes	Pacific Clinics	2500 Wilshire Boulevard Suite 704, Los Angeles, CA 90057
Outpatient Treatment	Adults Only	No	Pacific Clinics	2900 Parkway Drive, El Monte, CA 91732

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Outpatient Treatment	Adults Only	No	Pacific Clinics	2980 Santa Anita Avenue, Altadena, CA 91001
Outpatient Treatment	Adults Only	No	Pacific Clinics	3053 La Corona Avenue, Altadena, CA 91001
Outpatient Treatment	Adults Only	No	Pacific Clinics	3082 Thurin Avenue, Altadena, CA 91001
Outpatient Treatment	Adults Only	No	Pacific Clinics	3569 Lexington Avenue, El Monte, CA 91731
Outpatient Treatment	Adults Only	No	Pacific Clinics	3656 Monterosa Avenue, Altadena, CA 91001
Outpatient Treatment	Adults Only	No	Pacific Clinics	4876 East Gleason Street, Los Angeles, CA 90022
Outpatient Treatment	Adults Only	No	Pacific Clinics	5050 Kings Row, All Classrooms, El Monte, CA 91732
Outpatient Treatment	Adults Only	Yes	Pacific Clinics	581 North Claremont Place, Pomona, CA 91767
Outpatient Treatment	Adults Only	No	Pacific Clinics	605 North Park Avenue, Pomona, California 91768
Outpatient Treatment	Adults Only	Yes	Pacific Clinics	66 Hurlbut Street, Pasadena, CA 91105
Outpatient Treatment	Adults Only	No	Pacific Clinics	701 North Huntington Boulevard, Pomona, CA 91768
Outpatient Treatment	Adults Only	Yes	Pacific Clinics	735 South Soto Street, Los Angeles, CA 90023
Outpatient Treatment	Adults Only	No	Pacific Clinics	751 North Vineland Avenue, La Puente, CA 91746
Outpatient Treatment	Adults Only	No	Pacific Clinics	755 North Ardilla Avenue, La Puente, CA 91746
Outpatient Treatment	Adults Only	No	Pacific Clinics	7600 East Graves Avenue, Rosemead, CA 91770
Outpatient Treatment	Adults Only	Yes	Pacific Lodge Youth Services, Inc.	22030 Sherman Way, Suite #215, Canoga Park, CA 91303
Outpatient Treatment	Adults Only	No	People Coordinated Services of Southern California	3021 South Vermont Avenue, Los Angeles, CA 90007
Outpatient Treatment	Adults Only	Yes	Phoenix Houses of Los Angeles, Inc.	503 Ocean Front Walk, Venice, CA 90291
Outpatient Treatment	Adults Only	Yes	Plaza Community Center	5255 Pomona Boulevard, Suites 2 & 5, Los Angeles, CA 90022
Outpatient Treatment	Adults Only	Yes	Principles, Inc.	1450 North Lake Avenue, Room 218, Pasadena, CA 91104
Outpatient Treatment	Adults Only	No	Principles, Inc.	333 South Central Avenue, Los Angeles, CA 90013
Outpatient Treatment	Adults Only	Yes	Principles, Inc.	333 South Central Avenue, Los Angeles, CA 90013
Outpatient Treatment	Adults Only	No	Prototypes, Centers for Innovation in Health, Mental Health, and Social Services	11001 Valley Mall, Suite 300, El Monte, CA 91731
Outpatient Treatment	Adults Only	No	Prototypes, Centers for Innovation in Health, Mental Health, and Social Services	1460 North Lake Avenue, Pasadena, CA 91104
Outpatient Treatment	Adults Only	No	Prototypes, Centers for Innovation in Health, Mental Health, and Social Services	605 South Myrtle Avenue, Monrovia, CA 91016
Outpatient Treatment	Adults Only	Yes	Prototypes, Centers for Innovation in Health, Mental Health, and Social Services	831 East Arrow Highway, Pomona, CA 91767
Outpatient Treatment	Adults Only	Yes	Safe Refuge (Formerly: Substance Abuse Foundation of Long Beach, Inc.)	3125 East 7th Street, Long Beach, CA 90804

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LEVEL OF CARE	AGES SERVED	DMC*	AGENCY NAME	FACILITY ADDRESS
Outpatient Treatment	Adults Only	No	Safe Refuge (Formerly: Substance Abuse Foundation of Long Beach, Inc.)	3137-3139 East Seventh Street, Long Beach, CA 90804
Outpatient Treatment	Adults Only	No	San Fernando Valley Community Mental Health Center, Inc.	5950 Cedros Street., Van Nuys CA, 91411
Outpatient Treatment	Adults Only	No	Santa Anita Family Services	206 East Las Tunas Drive, Unit 12, San Gabriel, CA 91776
Outpatient Treatment	Adults Only	No	Santa Anita Family Services	605 South Myrtle Avenue, Monrovia, CA 91016
Outpatient Treatment	Adults Only	No	Santa Anita Family Services	716 North Citrus Avenue, Covina, CA 91723
Outpatient Treatment	Adults Only	Yes	Shields for Families, Inc.	1009 North Avalon Boulevard, Wilmington, CA 90744
Outpatient Treatment	Adults Only	Yes	Shields for Families, Inc.	10901 South Vermont Avenue, Los Angeles, CA 90044
Outpatient Treatment	Adults Only	Yes	Shields for Families, Inc.	11705 Deputy Yamamoto Place, Suite A, Lynwood, CA 90262
Outpatient Treatment	Adults Only	Yes	Shields for Families, Inc.	12021 S. Wilmington Avenue, Lot C, Los Angeles, CA 90059
Outpatient Treatment	Adults Only	Yes	Shields for Families, Inc.	1500 East Kay Street, Compton, CA 90221
Outpatient Treatment	Adults Only	No	Shields for Families, Inc.	3209 North Alameda Street, Suite D, Compton, CA 90262
Outpatient Treatment	Adults Only	No	Social Model Recovery Systems, Inc.	1245 East Walnut Suite117, Pasadena, CA 91106
Outpatient Treatment	Adults Only	No	Social Model Recovery Systems, Inc.	3131 Santa Anita Avenue, Suite 112B, El Monte, CA 91733
Outpatient Treatment	Adults Only	Yes	Social Model Recovery Systems, Inc.	4610 Santa Anita Avenue, El Monte, CA 91731
Outpatient Treatment	Adults Only	No	South Bay Human Services Coalition	2370 West Carson Street, Suite 136, Torrance, CA 90501
Outpatient Treatment	Adults Only	No	Southern California Alcohol and Drug Programs, Inc.	10155 Colima Road, Whittier, CA 90604
Outpatient Treatment	Adults Only	No	Southern California Alcohol and Drug Programs, Inc.	11500 Paramount Boulevard, Downey, CA 90241
Outpatient Treatment	Adults Only	No	Southern California Alcohol and Drug Programs, Inc.	12322 Clearglen Avenue, Apartment 1, Whittier, CA 90604
Outpatient Treatment	Adults Only	No	Southern California Alcohol and Drug Programs, Inc.	6635 Florence Avenue, Suite 101, Bell Gardens CA, 90201
Outpatient Treatment	Adults Only	No	Southern California Alcohol and Drug Programs, Inc.	6635 Florence Avenue, Suite 102, Bell Gardens, CA 90201
Outpatient Treatment	Adults Only	No	Southern California Alcohol and Drug Programs, Inc.	9047 Washington Boulevard, Pico Rivera, CA 90660
Outpatient Treatment	Adults Only	Yes	Southwest Care, Inc.	2930 West Imperial Highway, Suite 511, Inglewood, CA 90303
Outpatient Treatment	Adults Only	No	Special Services for Groups, Inc.	1218 East Compton Boulevard., Compton CA, 90221
Outpatient Treatment	Adults Only	No	Special Services for Groups, Inc.	200 North Long Beach Boulevard, Compton, CA 90221
Outpatient Treatment	Adults Only	No	Special Services for Groups, Inc.	5715 South Broadway Avenue, Los Angeles, CA 90037
Outpatient Treatment	Adults Only	No	SPIRITT Family Services, Inc.	8000 Painter Avenue, Whittier, CA 90602
Outpatient Treatment	Adults Only	No	Sunrise Community Counseling Center	537 South Alvarado Street, Los Angeles, CA 90057
Outpatient Treatment	Adults Only	Yes	Tarzana Treatment Centers, Inc.	18646 Oxnard Street, Tarzana, CA 91356
Outpatient Treatment	Adults Only	No	Tarzana Treatment Centers, Inc.	2101-45 Magnolia Avenue, Long Beach, CA 90806
Outpatient Treatment	Adults Only	No	Tarzana Treatment Centers, Inc.	22110 Roscoe Boulevard, Suite 204, Canoga Park, CA 91304
Outpatient Treatment	Adults Only	Yes	Tarzana Treatment Centers, Inc.	44447 North 10th Street, Lancaster, CA 93534
Outpatient Treatment	Adults Only	No	Tarzana Treatment Centers, Inc.	44459 10th Street West, Lancaster, CA 93534

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LEVEL OF CARE	AGES SERVED	DMC*	AGENCY NAME	FACILITY ADDRESS
Outpatient Treatment	Adults Only	Yes	Tarzana Treatment Centers, Inc.	5190 Atlantic Avenue, Long Beach, CA 90805
Outpatient Treatment	Adults Only	No	Tarzana Treatment Centers, Inc.	6911 Hayvenhurst Avenue, Suite 101, Van Nuys, CA 91406
Outpatient Treatment	Adults Only	Yes	Tarzana Treatment Centers, Inc.	7101 Baird Avenue, Reseda, CA 91335
Outpatient Treatment	Adults Only	Yes	The New You Center, Inc.	1030 West Florence Avenue, Los Angeles, CA 90044
Outpatient Treatment	Adults Only	Yes	Valley Women's Center, Inc.	22110 Roscoe Boulevard, Suite 204, Canoga Park, CA 91304
Outpatient Treatment	Adults Only	No	Watts Healthcare Corporation	8005 South Figueroa Street, Los Angeles, CA 90003
Outpatient Treatment	Adults Only	Yes	You Can Health Services	600 West Manchester Blvd., Suite 5, Los Angeles, CA 90044
Outpatient Treatment (Perinatal)	Adults Only	Yes	Alcoholism Center for Women, Inc.	1147 South Alvarado Street, Los Angeles, CA 90006
Outpatient Treatment (Perinatal)	Adults Only	Yes	Clinica Monsenor Oscar A. Romero	2032 Marengo Street, Los Angeles, CA 90033
Outpatient Treatment (Perinatal)	Adults Only	No	El Proyecto del Barrio	9140 Van Nuys Boulevard #211, Panorama City, CA 91402
Outpatient Treatment (Perinatal)	Adults Only	Yes	Families for Children, Inc.	2504 Westchester Boulevard, Inglewood, CA 90305
Outpatient Treatment (Perinatal)	Adults Only	Yes	Hannah's First Step Treatment Center	5900 S. Eastern Avenue, Suite 186., Los Angeles CA, 90040
Outpatient Treatment (Perinatal)	Adults Only	Yes	His Sheltering Arms, Inc.	11101 South Main Street, Los Angeles, CA 90061
Outpatient Treatment (Perinatal)	Adults Only	No	Los Angeles Biomedical Research Institute at Harbor-UCLA Medical Center	1124 West Carson Street - Building N33, Torrance, CA 90502
Outpatient Treatment (Perinatal)	Adults Only	Yes	Los Angeles Centers for Alcohol and Drug Abuse	11015 Bloomfield Avenue, Santa Fe Springs, CA 90670
Outpatient Treatment (Perinatal)	Adults Only	Yes	Los Angeles Centers for Alcohol and Drug Abuse	470 East 3rd Street, Suites A & B, Los Angeles, CA 90013
Outpatient Treatment (Perinatal)	Adults Only	No	Mela Counseling Services Center, Inc.	5721 Whittier Boulevard, Los Angeles, CA 90022
Outpatient Treatment (Perinatal)	Adults Only	No	Mela Counseling Services Center, Inc.	5723 Whittier Boulevard, Los Angeles, CA 90022
Outpatient Treatment (Perinatal)	Adults Only	No	National Council on Alcoholism and Drug Dependence - Long Beach Area	4201 Long Beach Blvd., Ste. 300/304, Long Beach, CA 90807
Outpatient Treatment (Perinatal)	Adults Only	Yes	National Council on Alcoholism and Drug Dependence - San Fernando Valley	24460 Lyons Avenue, Santa Clarita, CA 91321
Outpatient Treatment (Perinatal)	Adults Only	Yes	National Council on Alcoholism and Drug Dependence - San Fernando Valley	6166 Vesper Avenue, Van Nuys, CA 91411
Outpatient Treatment (Perinatal)	Adults Only	Yes	Plaza Community Center	5255 Pomona Boulevard, Suites 2 & 5, Los Angeles, CA 90022
Outpatient Treatment (Perinatal)	Adults Only	Yes	Prototypes, Centers for Innovation in Health, Mental Health, and Social Services	831 East Arrow Highway, Pomona, CA 91767
Outpatient Treatment (Perinatal)	Adults Only	Yes	Safe Refuge (Formerly: Substance Abuse Foundation of Long Beach, Inc.)	3125 East 7th Street, Long Beach, CA 90804
Outpatient Treatment (Perinatal)	Adults Only	No	Shields for Families, Inc.	11601 South Western Avenue, Los Angeles, CA 90047
Outpatient Treatment (Perinatal)	Adults Only	Yes	Shields for Families, Inc.	10901 South Vermont Avenue, Los Angeles, CA 90044
Outpatient Treatment (Perinatal)	Adults Only	Yes	Shields for Families, Inc.	11705 Deputy Yamamoto Place, Suite A, Lynwood, CA 90262

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Outpatient Treatment (Perinatal)	Adults Only	Yes	Shields for Families, Inc.	12021 S. Wilmington Avenue, Lot C, Los Angeles, CA 90059
Outpatient Treatment (Perinatal)	Adults Only	Yes	Shields for Families, Inc.	1500 East Kay Street, Compton, CA 90221
Outpatient Treatment (Perinatal)	Adults Only	Yes	Shields for Families, Inc.	2620 Industry Way, Suites A, Lynwood, CA 90262
Outpatient Treatment (Perinatal)	Adults Only	Yes	Shields for Families, Inc.	1009 North Avalon Boulevard, Wilmington, CA 90744
Outpatient Treatment (Perinatal)	Adults Only	No	Southern California Alcohol and Drug Programs, Inc.	11500 Paramount Boulevard, Downey, CA 90241
Outpatient Treatment (Perinatal)	Adults Only	Yes	Southwest Care, Inc.	2930 West Imperial Highway, Suite 511, Inglewood, CA 90303
Outpatient Treatment (Perinatal)	Adults Only	No	Tarzana Treatment Centers, Inc.	18549 Roscoe Boulevard, Northridge, CA 91324
Outpatient Treatment (Perinatal)	Adults Only	No	Tarzana Treatment Centers, Inc.	18646 Oxnard Street, Tarzana, CA 91356
Outpatient Treatment (Perinatal)	Adults Only	No	Tarzana Treatment Centers, Inc.	2101-45 Magnolia Avenue, Long Beach, CA 90806
Outpatient Treatment (Perinatal)	Adults Only	No	Tarzana Treatment Centers, Inc.	44459 10th Street West, Lancaster, CA 93534
Outpatient Treatment (Perinatal)	Adults Only	No	Tarzana Treatment Centers, Inc.	5190 Atlantic Avenue, Long Beach, CA 90805
Outpatient Treatment (Perinatal)	Adults Only	No	Tarzana Treatment Centers, Inc.	7101 Baird Avenue, Reseda, CA 91335
Outpatient Treatment (Perinatal)	Adults Only	Yes	The New You Center, Inc.	1030 West Florence Avenue, Los Angeles, CA 90044
Outpatient Treatment (Perinatal)	Adults Only	Yes	Valley Women's Center, Inc.	22110 Roscoe Boulevard, Suite 204, Canoga Park, CA 91304
INTENSIVE OUTPATIENT BY POPULATION SERVED				
Intensive Outpatient Treatment	Adults Only	Yes	Alcoholism Center for Women, Inc.	1147 South Alvarado Street, Los Angeles, CA 90006
Intensive Outpatient Treatment	Adults Only	No	Asian American Drug Abuse Program, Inc.	520 North La Brea Avenue, Inglewood, CA 90302
Intensive Outpatient Treatment	Adults Only	No	Behavioral Health Services, Inc.	1318 North Avalon Boulevard, Suite A, Wilmington, CA 90744
Intensive Outpatient Treatment	Adults Only	No	Behavioral Health Services, Inc.	1334 Post Avenue, Torrance, CA 90501
Intensive Outpatient Treatment	Adults Only	No	Behavioral Health Services, Inc.	15519 South Crenshaw Boulevard, Gardena, CA 90249
Intensive Outpatient Treatment	Adults Only	No	Behavioral Health Services, Inc.	2180 West Valley Boulevard, Pomona, CA 91768
Intensive Outpatient Treatment	Adults Only	No	Behavioral Health Services, Inc.	2180 West Valley Boulevard, Pomona, CA 91768
Intensive Outpatient Treatment	Adults Only	No	Behavioral Health Services, Inc.	4201 Long Beach Blvd., Ste 300/304, Long Beach, CA 90807
Intensive Outpatient Treatment	Adults Only	No	Behavioral Health Services, Inc.	520 North La Brea Avenue #209, Inglewood, CA 90302
Intensive Outpatient Treatment	Adults Only	No	Behavioral Health Services, Inc.	590 West 8th Street, San Pedro, CA 90731
Intensive Outpatient Treatment	Adults Only	No	Behavioral Health Services, Inc.	6838 Sunset Boulevard, Hollywood, CA 90028
Intensive Outpatient Treatment	Adults Only	No	Cambodian Association of America	1318A/1314B North Avalon Boulevard, Wilmington, CA 90744
Intensive Outpatient Treatment	Adults Only	No	Cambodian Association of America	15519 Crenshaw Boulevard, Gardena, CA 90249
Intensive Outpatient Treatment	Adults Only	No	Cambodian Association of America	1775 Chestnut Avenue, Long Beach, CA 90813
Intensive Outpatient Treatment	Adults Only	Yes	Clinica Monsenor Oscar A. Romero	2032 Marengo Street, Los Angeles, CA 90033
Intensive Outpatient Treatment	Adults Only	Yes	CRI-HELP, Inc.	2029 Keith Street, Los Angeles, CA 90031
Intensive Outpatient Treatment	Adults Only	Yes	CRI-HELP, Inc.	8330 Lankershim Boulevard, North Hollywood, CA 91605
Intensive Outpatient Treatment	Adults Only	Yes	Divine Healthcare Services, Inc.	405 West Manchester Blvd., Suite A, Inglewood, CA 90301

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LEVEL OF CARE	AGES SERVED	DMC*	AGENCY NAME	FACILITY ADDRESS
Intensive Outpatient Treatment	Adults Only	Yes	Eggleston Youth Centers (DBA: Eggleston Substance Abuse and Education Program)	13001 Ramona Boulevard, Suites E & J, Irwindale, CA 91706
Intensive Outpatient Treatment	Adults Only	Yes	Ettie Lee Homes, Inc.	160 East Holt Avenue, Suite B, Pomona, CA 91767
Intensive Outpatient Treatment	Adults Only	Yes	Families for Children, Inc.	2504 Westchester Boulevard, Inglewood, CA 90305
Intensive Outpatient Treatment	Adults Only	Yes	Hannah's First Step Treatment Center	5900 S. Eastern Avenue, Suite 186, Los Angeles CA, 90040
Intensive Outpatient Treatment	Adults Only	Yes	Helping Kids to Recover, Inc.	637 E. Albertoni Street, Ste 200, 201, 203, Carson, CA 90746
Intensive Outpatient Treatment	Adults Only	Yes	Holy Addiction Care Center, Inc.	111 North Glendale Blvd., Suite B., Los Angeles CA, 90026
Intensive Outpatient Treatment	Adults Only	Yes	Homeless Health Care Los Angeles, Inc.	2330 West Beverly Boulevard, Los Angeles, CA 90057
Intensive Outpatient Treatment	Adults Only	No	JWCH Institute, Inc.	1218 East Compton Boulevard, Compton, CA 90221
Intensive Outpatient Treatment	Adults Only	No	Los Angeles Centers for Alcohol and Drug Abuse	1088 South La Brea Avenue, Los Angeles, CA 90019
Intensive Outpatient Treatment	Adults Only	No	Los Angeles Centers for Alcohol and Drug Abuse	11015 Bloomfield Avenue, Santa Fe Springs, CA 90670
Intensive Outpatient Treatment	Adults Only	No	Los Angeles Centers for Alcohol and Drug Abuse	470 East 3rd Street, Suites A & B, Los Angeles, CA 90013
Intensive Outpatient Treatment	Adults Only	No	Los Angeles Centers for Alcohol and Drug Abuse	520 North La Brea, Inglewood, CA 90302
Intensive Outpatient Treatment	Adults Only	No	Los Angeles Centers for Alcohol and Drug Abuse	5723 Whittier Boulevard, Los Angeles, CA 90022
Intensive Outpatient Treatment	Adults Only	Yes	Matrix Institute on Addictions	1849 Sawtelle Boulevard, Suite 100, Los Angeles, CA 90025
Intensive Outpatient Treatment	Adults Only	Yes	Matrix Institute on Addictions	20350 Ventura Blvd., Suite 230, Woodland Hills, CA 91364
Intensive Outpatient Treatment	Adults Only	Yes	Matrix Institute on Addictions	233 West Baseline Road, La Verne, CA 91750
Intensive Outpatient Treatment	Adults Only	Yes	Matrix Institute on Addictions	5220 W. Washington Blvd., Suite 200, Los Angeles, CA 90016
Intensive Outpatient Treatment	Adults Only	Yes	Maxin Health Care Services, Inc.	3756 Santa Rosalia Drive, Suite 326A, Los Angeles, CA 90008
Intensive Outpatient Treatment	Adults Only	Yes	Medi-Cure Health Services, Inc.	3756 Santa Rosalia Drive, Suite 417, Los Angeles, CA 90008
Intensive Outpatient Treatment	Adults Only	Yes	New Hope Drug & Alcohol Treatment Program, Inc.	1841 West Imperial Highway, Los Angeles, CA 90047
Intensive Outpatient Treatment	Adults Only	No	Phoenix Houses of Los Angeles, Inc.	503 Ocean Front Walk, Venice, CA 90291
Intensive Outpatient Treatment	Adults Only	No	Prototypes, Centers for Innovation in Health, Mental Health, and Social Services	1460 North Lake Avenue, Pasadena, CA 91104
Intensive Outpatient Treatment	Adults Only	Yes	Prototypes, Centers for Innovation in Health, Mental Health, and Social Services	831 East Arrow Highway, Pomona, CA 91767
Intensive Outpatient Treatment	Adults Only	Yes	Safe Refuge (Formerly: Substance Abuse Foundation of Long Beach, Inc.)	3125 East 7th Street, Long Beach, CA 90804
Intensive Outpatient Treatment	Adults Only	No	Safe Refuge (Formerly: Substance Abuse Foundation of Long Beach, Inc.)	3137-3139 East Seventh Street, Long Beach, CA 90804
Intensive Outpatient Treatment	Adults Only	No	Shields for Families, Inc.	11705 Deputy Yamamoto Place, Suite A, Lynwood, CA 90262
Intensive Outpatient Treatment	Adults Only	Yes	Shields for Families, Inc.	12021 S. Wilmington Avenue, Lot C, Los Angeles, CA 90059
Intensive Outpatient Treatment	Adults Only	No	Shields for Families, Inc.	1500 East Kay Street, Compton, CA 90221

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Intensive Outpatient Treatment	Adults Only	Yes	Shields for Families, Inc.	2620 Industry Way, Suites A, Lynwood, CA 90262
Intensive Outpatient Treatment	Adults Only	No	Social Model Recovery Systems, Inc.	1245 East Walnut Suite117, Pasadena, CA 91106
Intensive Outpatient Treatment	Adults Only	No	Social Model Recovery Systems, Inc.	3131 Santa Anita Avenue, Suite 112B, El Monte, CA 91733
Intensive Outpatient Treatment	Adults Only	No	Southern California Alcohol and Drug Programs, Inc.	11500 Paramount Boulevard, Downey, CA 90241
Intensive Outpatient Treatment	Adults Only	Yes	Southwest Care, Inc.	2930 West Imperial Highway, Suite 511, Inglewood, CA 90303
Intensive Outpatient Treatment	Adults Only	Yes	Tarzana Treatment Centers, Inc.	18646 Oxnard Street, Tarzana, CA 91356
Intensive Outpatient Treatment	Adults Only	Yes	Tarzana Treatment Centers, Inc.	44447 North 10th Street, Lancaster, CA 93534
Intensive Outpatient Treatment	Adults Only	No	Tarzana Treatment Centers, Inc.	44459 10th Street West, Lancaster, CA 93534
Intensive Outpatient Treatment	Adults Only	Yes	Tarzana Treatment Centers, Inc.	5190 Atlantic Avenue, Long Beach, CA 90805
Intensive Outpatient Treatment	Adults Only	Yes	Tarzana Treatment Centers, Inc.	7101 Baird Avenue, Reseda, CA 91335
Intensive Outpatient Treatment	Adults Only	Yes	Tarzana Treatment Centers, Inc.	907 West Lancaster Boulevard, Lancaster, CA 93534
Intensive Outpatient Treatment	Adults Only	Yes	The New You Center, Inc.	1030 West Florence Avenue, Los Angeles, CA 90044
Intensive Outpatient Treatment	Adults Only	Yes	You Can Health Services	600 West Manchester Blvd., Suite 5, Los Angeles, CA 90044
Intensive Outpatient Treatment (Perinatal)	Adults Only	Yes	Asian American Drug Abuse Program, Inc.	1088 South La Brea Avenue, Los Angeles, CA 90019
Intensive Outpatient Treatment (Perinatal)	Adults Only	Yes	Alcoholism Center for Women, Inc.	1147 South Alvarado Street, Los Angeles, CA 90006
Intensive Outpatient Treatment (Perinatal)	Adults Only	No	Asian American Drug Abuse Program, Inc.	520 North La Brea Avenue, Inglewood, CA 90302
Intensive Outpatient Treatment (Perinatal)	Adults Only	Yes	Clinica Monsenor Oscar A. Romero	2032 Marengo Street, Los Angeles, CA 90033
Intensive Outpatient Treatment (Perinatal)	Adults Only	No	El Proyecto del Barrio	9140 Van Nuys Boulevard #211, Panorama City, CA 91402
Intensive Outpatient Treatment (Perinatal)	Adults Only	Yes	Hannah's First Step Treatment Center	5900 S. Eastern Avenue, Suite 186, Los Angeles CA, 90040
Intensive Outpatient Treatment (Perinatal)	Adults Only	Yes	Helping Kids to Recover, Inc.	637 E. Albertoni Street, Ste. 200, 201, 203, Carson, CA 90746
Intensive Outpatient Treatment (Perinatal)	Adults Only	No	Los Angeles Biomedical Research Institute at Harbor-UCLA Medical Center	1124 West Carson Street - Building N33, Torrance, CA 90502
Intensive Outpatient Treatment (Perinatal)	Adults Only	No	Mela Counseling Services Center, Inc.	5721 Whittier Boulevard, Los Angeles, CA 90022
Intensive Outpatient Treatment (Perinatal)	Adults Only	No	Mela Counseling Services Center, Inc.	5723 Whittier Boulevard, Los Angeles, CA 90022
Intensive Outpatient Treatment (Perinatal)	Adults Only	No	National Council on Alcoholism and Drug Dependence - Long Beach Area	4201 Long Beach Blvd., Ste. 300/304, Long Beach, CA 90807
Intensive Outpatient Treatment (Perinatal)	Adults Only	Yes	Plaza Community Center	5255 Pomona Boulevard, Suites 2 & 5, Los Angeles, CA 90022
Intensive Outpatient Treatment (Perinatal)	Adults Only	Yes	Prototypes, Centers for Innovation in Health, Mental Health, and Social Services	831 East Arrow Highway, Pomona, CA 91767
Intensive Outpatient Treatment (Perinatal)	Adults Only	Yes	Safe Refuge (Formerly: Substance Abuse Foundation of Long Beach, Inc.)	3125 East 7th Street, Long Beach, CA 90804
Intensive Outpatient Treatment (Perinatal)	Adults Only	Yes	Shields for Families, Inc.	12021 S. Wilmington Avenue, Lot C, Los Angeles, CA 90059
Intensive Outpatient Treatment (Perinatal)	Adults Only	Yes	Shields for Families, Inc.	1500 East Kay Street, Compton, CA 90221

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Intensive Outpatient Treatment (Perinatal)	Adults Only	Yes	Southwest Care, Inc.	2930 West Imperial Highway, Suite 511, Inglewood, CA 90303
Intensive Outpatient Treatment (Perinatal)	Adults Only	No	Tarzana Treatment Centers, Inc.	18549 Roscoe Boulevard, Northridge, CA 91324
Intensive Outpatient Treatment (Perinatal)	Adults Only	Yes	Tarzana Treatment Centers, Inc.	18646 Oxnard Street, Tarzana, CA 91356
Intensive Outpatient Treatment (Perinatal)	Adults Only	No	Tarzana Treatment Centers, Inc.	2101-45 Magnolia Avenue, Long Beach, CA 90806
Intensive Outpatient Treatment (Perinatal)	Adults Only	Yes	Tarzana Treatment Centers, Inc.	44447 North 10th Street, Lancaster, CA 93534
Intensive Outpatient Treatment (Perinatal)	Adults Only	Yes	Tarzana Treatment Centers, Inc.	5190 Atlantic Avenue, Long Beach, CA 90805
Intensive Outpatient Treatment (Perinatal)	Adults Only	No	Tarzana Treatment Centers, Inc.	7101 Baird Avenue, Reseda, CA 91335
Intensive Outpatient Treatment (Perinatal)	Adults Only	Yes	The New You Center, Inc.	1030 West Florence Avenue, Los Angeles, CA 90044
RESIDENTIAL PROGRAMS BY POPULATION SERVED				
Residential Treatment	Youth Only	No	Asian American Drug Abuse Program, Inc.	5825 West Olympic Boulevard, Los Angeles, CA 90036
Residential Treatment	Youth/Adults	No	California Hispanic Commission on Alcohol and Drug Abuse, Inc.	328 North Avenue 59, Los Angeles, CA 90042
Residential Treatment	Youth/Adults	No	California Hispanic Commission on Alcohol and Drug Abuse, Inc.	524 North Avenue 54, Los Angeles, CA 90042
Residential Treatment	Youth/Adults	No	Phoenix Houses of Los Angeles, Inc.	11600 Eldridge Avenue, Lake View Terrace, CA 91342
Residential Treatment	Youth/Adults	No	Tarzana Treatment Centers, Inc.	44447 N. 10th Street West, Building A, Lancaster, CA 93534
Residential Treatment	Adults Only	No	Alcoholism Center for Women, Inc.	1135 South Alvarado Street, Los Angeles, CA 90006
Residential Treatment	Adults Only	No	American Indian Changing Spirits	2120 Williams Street, Building 1, Long Beach, CA 90810
Residential Treatment	Adults Only	No	Asian American Drug Abuse Program, Inc.	11101 South Main Street, Los Angeles, CA 90061
Residential Treatment	Adults Only	No	Asian American Drug Abuse Program, Inc.	5318 South Crenshaw Boulevard, Los Angeles, CA 90043
Residential Treatment	Adults Only	No	Beacon House Association of San Pedro (The)	1003 South Beacon Street, San Pedro, CA 90731
Residential Treatment	Adults Only	No	Beacon House Association of San Pedro (The)	132 West 10th Street, San Pedro, CA 90731
Residential Treatment	Adults Only	No	Behavioral Health Services, Inc.	12917 Cerise Avenue, Hawthorne, CA 90250
Residential Treatment	Adults Only	No	Behavioral Health Services, Inc.	1775 Chestnut Avenue, Long Beach, CA 90813
Residential Treatment	Adults Only	No	Behavioral Health Services, Inc.	2120 Williams Street, Building 1, Long Beach, CA 90810
Residential Treatment	Adults Only	No	Behavioral Health Services, Inc.	2120 Williams Street, Building 2, Long Beach CA, 90810
Residential Treatment	Adults Only	No	Behavioral Health Services, Inc.	2180 West Valley Blvd., Pomona, CA 91768
Residential Treatment	Adults Only	No	Behavioral Health Services, Inc.	2501 West El Segundo Boulevard, Hawthorne, CA 90250
Residential Treatment	Adults Only	No	Behavioral Health Services, Inc.	341 East 6th Street, Long Beach, CA 90802
Residential Treatment	Adults Only	No	Behavioral Health Services, Inc.	351 East 6th Street, Long Beach, CA 90802-1402
Residential Treatment	Adults Only	No	Behavioral Health Services, Inc.	431 West 9th Street, Long Beach, CA 90813
Residential Treatment	Adults Only	No	Behavioral Health Services, Inc.	615 Elm Avenue, Long Beach, CA 90802
Residential Treatment	Adults Only	No	California Hispanic Commission on Alcohol and Drug Abuse, Inc.	2436 Wabash Avenue, Los Angeles, CA 90033
Residential Treatment	Adults Only	No	California Hispanic Commission on Alcohol and Drug Abuse, Inc.	327 North St. Louis Street, Los Angeles, CA 90033
Residential Treatment	Adults Only	No	California Hispanic Commission on Alcohol and Drug Abuse, Inc.	530 North Avenue 54, Los Angeles, CA 90042

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Residential Treatment	Adults Only	No	Cambodian Association of America	12917 Cerise Avenue, Hawthorne, CA 90250
Residential Treatment	Adults Only	No	Cambodian Association of America	2501 West El Segundo Boulevard, Hawthorne, CA 90250
Residential Treatment	Adults Only	No	Cambodian Association of America	615 Elm Avenue, Long Beach, CA 90802
Residential Treatment	Adults Only	No	Canon Human Services, Inc.	9705 South Holmes Avenue, Los Angeles, CA 90002
Residential Treatment	Adults Only	No	Casa de las Amigas	160 North El Molino Avenue, Pasadena, CA 91101
Residential Treatment	Adults Only	No	Chabad of California, Inc.	5675 West Olympic Boulevard, Los Angeles, CA 90036
Residential Treatment	Adults Only	No	CLARE Foundation, Inc.	844 Pico Boulevard, Santa Monica, CA 90405
Residential Treatment	Adults Only	No	CLARE Foundation, Inc.	905 and 907 West Pico Boulevard, Santa Monica, CA 90405
Residential Treatment	Adults Only	No	CRI-HELP, Inc.	11027 Burbank Boulevard, North Hollywood, CA 91601
Residential Treatment	Adults Only	No	CRI-HELP, Inc.	2010 North Lincoln Park Avenue, Los Angeles, CA 90031
Residential Treatment	Adults Only	No	Didi Hirsch Psychiatric Service	11643 Glenoaks Boulevard, Pacoima, CA 91331
Residential Treatment	Adults Only	No	Grandview Foundation, Inc.	1230 North Marengo Avenue, Pasadena, CA 91103
Residential Treatment	Adults Only	No	Grandview Foundation, Inc.	225 Grandview Street, Pasadena, CA 91104
Residential Treatment	Adults Only	No	His Sheltering Arms, Inc.	11101 South Main Street, Los Angeles, CA 90061
Residential Treatment	Adults Only	No	Homeless Health Care Los Angeles, Inc.	4445 Burns Avenue, Los Angeles, CA 90029
Residential Treatment	Adults Only	No	House of Hope Foundation, Inc.	221 West 9th Street, San Pedro, CA 90731
Residential Treatment	Adults Only	No	House of Hope Foundation, Inc.	223 West 9th Street, San Pedro, CA 90731
Residential Treatment	Adults Only	No	House of Hope Foundation, Inc.	225 West 9th Street, San Pedro, CA 90731
Residential Treatment	Adults Only	No	House of Hope Foundation, Inc.	227 West 9th Street, San Pedro, CA 90731
Residential Treatment	Adults Only	No	House of Hope Foundation, Inc.	229 West 9th Street, San Pedro, CA 90731
Residential Treatment	Adults Only	No	House of Hope Foundation, Inc.	235 West 9th Street, San Pedro, CA 90731
Residential Treatment	Adults Only	No	House of Hope Foundation, Inc.	917 Palos Verdes Street, Unit C, San Pedro, CA 90731
Residential Treatment	Adults Only	No	House of Hope Foundation, Inc.	917 Palos Verdes Street, Unit D, San Pedro, CA 90731
Residential Treatment	Adults Only	No	JWCH Institute, Inc.	303 East 52nd Street, Los Angeles, CA 90011
Residential Treatment	Adults Only	No	Little House	9718 Harvard Street, Bellflower, CA 90706
Residential Treatment	Adults Only	No	Live Again Recovery Home, Inc.	38215 N. San Francisquito Canyon Road, Saugus, CA 91350
Residential Treatment	Adults Only	No	Los Angeles Centers for Alcohol and Drug Abuse	10425 Painter Avenue, Santa Fe Springs, CA 90670
Residential Treatment	Adults Only	No	Mary Lind Recovery Centers	360 South Westlake Avenue, Los Angeles, CA 90057
Residential Treatment	Adults Only	No	Mary Lind Recovery Centers	4439, 4445, and 4455 Burns Avenue, Los Angeles, CA 90029
Residential Treatment	Adults Only	No	National Council on Alcoholism and Drug Dependence - Long Beach Area	1003 South Beacon Street, San Pedro, CA 90731
Residential Treatment	Adults Only	No	National Council on Alcoholism and Drug Dependence - Long Beach Area	431 West 9th Street, Long Beach, CA 90813

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Residential Treatment	Adults Only	No	New Way Foundation, Inc.	207 North Victory Boulevard, Burbank, CA 91502
Residential Treatment	Adults Only	No	Palm House, Inc.	2515 East Jefferson Street, Carson, CA 90810
Residential Treatment	Adults Only	No	People Coordinated Services of Southern California	1319 South Manhattan Place, Los Angeles, CA 90019
Residential Treatment	Adults Only	No	People Coordinated Services of Southern California	4771 South Main Street, Los Angeles, CA 90037
Residential Treatment	Adults Only	No	Phoenix Houses of Los Angeles, Inc.	503 Ocean Front Walk, Venice, CA 90291
Residential Treatment	Adults Only	No	Principles, Inc.	1680 North Fair Oaks Avenue, Pasadena, CA 91103
Residential Treatment	Adults Only	No	Prototypes, Centers for Innovation in Health, Mental Health, and Social Services	1000 North Alameda Street, Suite 390, Los Angeles, CA 90012
Residential Treatment	Adults Only	No	Prototypes, Centers for Innovation in Health, Mental Health, and Social Services	2180 West Valley Boulevard, Floors 100, 300, & 400, Pomona, CA 91768
Residential Treatment	Adults Only	No	Prototypes, Centers for Innovation in Health, Mental Health, and Social Services	845 East Arrow Highway, Pomona, CA 91767
Residential Treatment	Adults Only	No	Safe Refuge (Formerly: Substance Abuse Foundation of Long Beach, Inc.)	3111 - 3113 East 7th Street, Long Beach, CA 90804
Residential Treatment	Adults Only	No	Safe Refuge (Formerly: Substance Abuse Foundation of Long Beach, Inc.)	3115 - 3119 East 7th Street, Long Beach, CA 90804
Residential Treatment	Adults Only	No	Safe Refuge (Formerly: Substance Abuse Foundation of Long Beach, Inc.)	3125 East 7th Street, Long Beach, CA 90804
Residential Treatment	Adults Only	No	Safe Refuge (Formerly: Substance Abuse Foundation of Long Beach, Inc.)	3131 East 7th Street Apt.1, 3, 4, 5, 6, Long Beach, CA 90804
Residential Treatment	Adults Only	No	Safe Refuge (Formerly: Substance Abuse Foundation of Long Beach, Inc.)	718 Freeman Avenue, Long Beach, CA 90804
Residential Treatment	Adults Only	No	Safe Refuge (Formerly: Substance Abuse Foundation of Long Beach, Inc.)	719 Obispo Avenue, Apt. 1-10, Long Beach, CA 90804
Residential Treatment	Adults Only	No	Safe Refuge (Formerly: Substance Abuse Foundation of Long Beach, Inc.)	727-729 Obispo Avenue, Long Beach, CA 90804
Residential Treatment	Adults Only	No	Safe Refuge (Formerly: Substance Abuse Foundation of Long Beach, Inc.)	728, 728A, & 728 1/2 Freeman Avenue, Long Beach, CA 90804
Residential Treatment	Adults Only	No	Salvation Army, A California Corporation	3107 South Grand Avenue, Los Angeles, CA 90007
Residential Treatment	Adults Only	No	Salvation Army, A California Corporation	5600 Rickenbacker Road, City of Bell, CA 90201
Residential Treatment	Adults Only	No	Shields for Families, Inc.	801 West 70th Street, Los Angeles, CA 90044
Residential Treatment	Adults Only	No	Social Model Recovery Systems, Inc.	17719 East Cypress Street, Covina, CA 91722
Residential Treatment	Adults Only	No	Social Model Recovery Systems, Inc.	17727 East Cypress Street, Covina, CA 91722

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Residential Treatment	Adults Only	No	Social Model Recovery Systems, Inc.	23701 East Fork Road, Azusa, CA 91702
Residential Treatment	Adults Only	No	Social Model Recovery Systems, Inc.	3426 Cogswell Road., El Monte CA, 91732
Residential Treatment	Adults Only	No	Social Model Recovery Systems, Inc.	3430 Cogswell Road, El Monte, CA 91732
Residential Treatment	Adults Only	No	Social Model Recovery Systems, Inc.	453 South Indiana Street, Los Angeles, CA 90063
Residential Treatment	Adults Only	No	Southern California Alcohol and Drug Programs, Inc.	10501, 10505, 10511, 10517, and 10519 Mills Avenue, Whittier, CA 90604
Residential Treatment	Adults Only	No	Southern California Alcohol and Drug Programs, Inc.	11501 Dolan Avenue, Downey, CA 90241
Residential Treatment	Adults Only	No	Southern California Alcohol and Drug Programs, Inc.	12322 Clearglen Avenue, Apartment 2, Whittier, CA 90604
Residential Treatment	Adults Only	No	Southern California Alcohol and Drug Programs, Inc.	12322 Clearglen Avenue, Apartment 3, Whittier, CA 90604
Residential Treatment	Adults Only	No	Southern California Alcohol and Drug Programs, Inc.	12322 Clearglen Avenue, Apartment 4, Whittier, CA 90604
Residential Treatment	Adults Only	No	Southern California Alcohol and Drug Programs, Inc.	16322 7/8 Cornuta Avenue, Bellflower, CA 90706
Residential Treatment	Adults Only	No	Special Services for Groups, Inc.	303 East 52nd Street, Los Angeles, CA 90011
Residential Treatment	Adults Only	No	Special Services for Groups, Inc.	4052 South Budlog Avenue, Los Angeles, CA 90037
Residential Treatment	Adults Only	No	Tarzana Treatment Centers, Inc.	11027 Burbank Boulevard, North Hollywood, CA 91601
Residential Treatment	Adults Only	No	Tarzana Treatment Centers, Inc.	11643 Glenoaks Boulevard, Pacoima, CA 91331
Residential Treatment	Adults Only	No	Tarzana Treatment Centers, Inc.	18646 Oxnard Street, Tarzana, CA 91356
Residential Treatment	Adults Only	No	Tarzana Treatment Centers, Inc.	2101 Magnolia Avenue, Long Beach, CA 90806
Residential Treatment	Adults Only	No	Tarzana Treatment Centers, Inc.	44447 N. 10th Street West, Building B., Lancaster CA, 93534
Residential Treatment	Adults Only	No	Tarzana Treatment Centers, Inc.	44447 N. 10th Street West, Building C., Lancaster CA, 93534
Residential Treatment	Adults Only	No	Van Ness Recovery House	1919 North Beachwood Drive, Los Angeles, CA 90068
Residential Treatment	Adults Only	No	Volunteers of America of Los Angeles	4969 Sunset Boulevard, Los Angeles, CA 90027
Residential Treatment	Adults Only	No	Volunteers of America of Los Angeles	515 East 6th Street, 9th Floor, Los Angeles, CA 90021
Residential Treatment	Adults Only	No	Watts Healthcare Corporation	8005 South Figueroa Street, Los Angeles, CA 90003
Residential Treatment (Perinatal)	Adults Only	No	Behavioral Health Services, Inc.	12917 Cerise Avenue, Hawthorne, CA 90250
Residential Treatment (Perinatal)	Adults Only	No	Behavioral Health Services, Inc.	2180 West Valley Blvd., Pomona, CA 91768
Residential Treatment (Perinatal)	Adults Only	No	Behavioral Health Services, Inc.	341 East 6th Street, Long Beach, CA 90802
Residential Treatment (Perinatal)	Adults Only	No	Behavioral Health Services, Inc.	351 East 6th Street, Long Beach, CA 90802-1402
Residential Treatment (Perinatal)	Adults Only	No	Behavioral Health Services, Inc.	615 Elm Avenue, Long Beach, CA 90802
Residential Treatment (Perinatal)	Adults Only	No	His Sheltering Arms, Inc.	112 West 111th Street, Los Angeles, CA 90061
Residential Treatment (Perinatal)	Adults Only	No	National Council on Alcoholism and Drug Dependence - Long Beach Area	431 West 9th Street, Long Beach, CA 90813
Residential Treatment (Perinatal)	Adults Only	No	Prototypes, Centers for Innovation in Health, Mental Health, and Social Services	1000 North Alameda Street, Suite 390, Los Angeles, CA 90012

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Residential Treatment (Perinatal)	Adults Only	No	Prototypes, Centers for Innovation in Health, Mental Health, and Social Services	845 East Arrow Highway, Pomona, CA 91767
Residential Treatment (Perinatal)	Adults Only	No	Watts Healthcare Corporation	8005 South Figueroa Street, Los Angeles, CA 90003
Residential Treatment (Perinatal)	Adults Only	No	Social Model Recovery Systems, Inc.	453 South Indiana Street, Los Angeles, CA 90063
Residential Treatment (Perinatal)	Adults Only	No	Southern California Alcohol and Drug Programs, Inc.	10603 Downey Avenue, Downey, CA 90241
Residential Treatment (Perinatal)	Adults Only	No	Southern California Alcohol and Drug Programs, Inc.	10615 Downey Avenue, Downey, CA 90241
Residential Treatment (Perinatal)	Adults Only	No	Southern California Alcohol and Drug Programs, Inc.	10621 Downey Avenue, Downey, CA 90241
WITHDRAWAL MANAGEMENT PROGRAMS BY POPULATION SERVED				
Residential Medical Detox	Adults Only	No	Behavioral Health Services, Inc.	1775 Chestnut Avenue, Long Beach, CA 90813
Residential Medical Detox	Adults Only	No	Behavioral Health Services, Inc.	2180 West Valley Boulevard, Pomona, CA 91768
Residential Medical Detox	Adults Only	No	Principles, Inc.	1680 North Fair Oaks Avenue, Pasadena, CA 91103
Residential Medical Detox	Adults Only	No	Tarzana Treatment Centers, Inc.	18646 Oxnard Street, Tarzana, CA 91356
OPIOID (NARCOTIC) TREATMENT PROGRAMS BY POPULATION SERVED				
Narcotic Treatment Program	Adults Only	Yes	Addiction Research and Treatment, Inc.	11315 South Atlantic Avenue, Lynwood, CA 90262
Narcotic Treatment Program	Adults Only	Yes	Addiction Research and Treatment, Inc.	15229 East Amar Road, La Puente, CA 91744
Narcotic Treatment Program	Adults Only	Yes	Addiction Research and Treatment, Inc.	1926 West Beverly Boulevard, Los Angeles, CA 90057
Narcotic Treatment Program	Adults Only	Yes	Addiction Research and Treatment, Inc.	4920 South Avalon Boulevard, Los Angeles, CA 90011
Narcotic Treatment Program	Adults Only	Yes	AEGIS Treatment Centers, LLC	1050 North Garey Avenue, Pomona, CA 91767
Narcotic Treatment Program	Adults Only	Yes	AEGIS Treatment Centers, LLC	11041 East Valley Boulevard, El Monte, CA 91731
Narcotic Treatment Program	Adults Only	Yes	AEGIS Treatment Centers, LLC	1322 North Avalon Boulevard, Wilmington, CA 90744
Narcotic Treatment Program	Adults Only	Yes	AEGIS Treatment Centers, LLC	14240 East Imperial Highway, La Mirada, CA 90638
Narcotic Treatment Program	Adults Only	Yes	AEGIS Treatment Centers, LLC	1450 North Lake Avenue, Suite 150, Pasadena, CA 91104
Narcotic Treatment Program	Adults Only	Yes	AEGIS Treatment Centers, LLC	1825 East Thelborn Street, West Covina, CA 91790
Narcotic Treatment Program	Adults Only	Yes	AEGIS Treatment Centers, LLC	614 W. Manchester Blvd., Ste 103-105, Inglewood, CA 90301
Narcotic Treatment Program	Adults Only	Yes	Altamed Health Services Corporation	1701 Zonal Avenue, Los Angeles, CA 90033
Narcotic Treatment Program	Adults Only	Yes	American Health Services, LLC	21505 Norwalk Boulevard, Hawaiian Gardens, CA 90716
Narcotic Treatment Program	Adults Only	Yes	American Health Services, LLC	2720 E. Palmdale Blvd., Suites 128/129, Palmdale, CA 93550
Narcotic Treatment Program	Adults Only	Yes	American Health Services, LLC	5015 West Pico Boulevard, Los Angeles, CA 90019
Narcotic Treatment Program	Adults Only	Yes	American Health Services, LLC	6265 Sepulveda Boulevard, Suite 9 & 10, Van Nuys, CA 91411
Narcotic Treatment Program	Adults Only	Yes	American Health Services, LLC	717 Lincoln Boulevard, Venice, CA 90291
Narcotic Treatment Program	Adults Only	No	BAART Behavioral Health Services, Inc.	1926 West Beverly Boulevard, Los Angeles, CA 90057
Narcotic Treatment Program	Adults Only	No	BAART Behavioral Health Services, Inc.	4920 South Avalon Boulevard, Los Angeles, CA 90011

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Narcotic Treatment Program	Adults Only	Yes	Eldorado Community Service Center	24625 Arch Street, Newhall, CA 91321
Narcotic Treatment Program	Adults Only	Yes	Eldorado Community Service Center	4023 Marine Avenue, Lawndale, CA 90260
Narcotic Treatment Program	Adults Only	Yes	Eldorado Community Service Center	4450 West Century Boulevard, Inglewood, CA 90304
Narcotic Treatment Program	Adults Only	Yes	Eldorado Community Service Center	5200 San Gabriel Place, Suites B & C, Pico Rivera, CA 90660
Narcotic Treatment Program	Adults Only	Yes	Matrix Institute on Addictions	5220 West Washington Boulevard, Suite 101, Los Angeles, CA 90016
Narcotic Treatment Program	Adults Only	Yes	Narcotic Addiction Treatment Agency, Inc.	8741 Laurel Canyon Boulevard, Sun Valley, CA 91352
Narcotic Treatment Program	Adults Only	Yes	Narcotic Prevention Association, Inc.	942 South Atlantic Blvd., Suite 100, Los Angeles, CA 90022
Narcotic Treatment Program	Adults Only	Yes	Tarzana Treatment Centers, Inc.	18646 Oxnard Street, Tarzana, CA 91356
Narcotic Treatment Program	Adults Only	No	Tarzana Treatment Centers, Inc.	2101 Magnolia Avenue, Long Beach, CA 90806
Narcotic Treatment Program	Adults Only	No	Tarzana Treatment Centers, Inc.	44459 10th Street West, Lancaster, CA 93534
Narcotic Treatment Program	Adults Only	No	Tarzana Treatment Centers, Inc.	5190 Atlantic Avenue, Long Beach, CA 90805
Narcotic Treatment Program	Adults Only	No	Tarzana Treatment Centers, Inc.	7101 Baird Avenue, Reseda, CA 91335
Narcotic Treatment Program	Adults Only	Yes	Tavarua Health Services	8207 Whittier Boulevard, Pico Rivera, CA 90660
Narcotic Treatment Program	Adults Only	Yes	Tavarua Medical Rehabilitation Services (DBA: Asuza Medical and Mental Health Services)	474 South Citrus Avenue, Azusa, CA 91702
Narcotic Treatment Program	Adults Only	Yes	The Pajo Corporation	11900 Avalon Boulevard, Suite 200, Los Angeles, CA 90061
Narcotic Treatment Program	Adults Only	Yes	The Pajo Corporation	2080 Century Park East, Suite 1210, Century City, CA 90067
Narcotic Treatment Program	Adults Only	Yes	Transcultural Health Development, Inc.	117 East Harry Bridges Boulevard, Wilmington, CA 90744
Narcotic Treatment Program	Adults Only	Yes	West County Medical Clinic	100 East Market Street, Long Beach, CA 90805
Narcotic Treatment Program	Adults Only	Yes	West County Medical Corporation	2272 Pacific Avenue, Suite A, Long Beach, CA 90806
Narcotic Treatment Program	Adults Only	Yes	Western Pacific Med-Corp	11321 Camarillo Street, North Hollywood, CA 91602
Narcotic Treatment Program	Adults Only	Yes	Western Pacific Med-Corp	11902 Rosecrans Boulevard, Norwalk, CA 90650
Narcotic Treatment Program	Adults Only	Yes	Western Pacific Med-Corp	14332 Victory Boulevard, Van Nuys, CA 91401
Narcotic Treatment Program	Adults Only	Yes	Western Pacific Med-Corp	45335 Sierra Highway, Lancaster, CA 93534
Narcotic Treatment Program	Adults Only	Yes	Western Pacific Med-Corp	4544 San Fernando Road, Suite 201, Glendale, CA 91204
Narcotic Treatment Program	Adults Only	Yes	Western Pacific Med-Corp	7232 Canby Avenue, Suites 4,5,6, Reseda, CA 91335
Narcotic Treatment Program	Adults Only	Yes	Western Pacific Med-Corp	9462 Van Nuys Boulevard, Panorama City, CA 91402
Narcotic Treatment Program (Perinatal)	Adults Only	Yes	Addiction Research and Treatment, Inc.	11315 South Atlantic Avenue, Lynwood, CA 90262
Narcotic Treatment Program (Perinatal)	Adults Only	Yes	Addiction Research and Treatment, Inc.	15229 East Amar Road, La Puente, CA 91744
Narcotic Treatment Program (Perinatal)	Adults Only	Yes	Addiction Research and Treatment, Inc.	1926 West Beverly Boulevard, Los Angeles, CA 90057
Narcotic Treatment Program (Perinatal)	Adults Only	Yes	Addiction Research and Treatment, Inc.	4920 South Avalon Boulevard, Los Angeles, CA 90011
RECOVERY RESIDENCES BY POPULATION SERVED				
Alcohol and Drug Free Living Center	Adults Only	No	Asian American Drug Abuse Program, Inc.	2547 Bronson Avenue, Los Angeles, CA 90016

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Alcohol and Drug Free Living Center	Adults Only	No	Behavioral Health Services, Inc.	10419 South Budlong Avenue, Los Angeles, CA 90044
Alcohol and Drug Free Living Center	Adults Only	No	Behavioral Health Services, Inc.	11717 Crenshaw Boulevard, Inglewood, CA 90303
Alcohol and Drug Free Living Center	Adults Only	No	Behavioral Health Services, Inc.	11719 Crenshaw Boulevard, Inglewood, CA 90303
Alcohol and Drug Free Living Center	Adults Only	No	Behavioral Health Services, Inc.	1608 1/2 West 218th Street, Torrance, CA 90501
Alcohol and Drug Free Living Center	Adults Only	No	Behavioral Health Services, Inc.	1775 Chestnut Avenue, Long Beach, CA 90813
Alcohol and Drug Free Living Center	Adults Only	No	Behavioral Health Services, Inc.	1835 Chestnut Ave. Apartment A/D, Long Beach, CA 90813
Alcohol and Drug Free Living Center	Adults Only	No	Behavioral Health Services, Inc.	2180 West Valley Boulevard, Pomona, CA 91768
Alcohol and Drug Free Living Center	Adults Only	No	Behavioral Health Services, Inc.	2501 West El Segundo Boulevard, Hawthorne, CA 90250
Alcohol and Drug Free Living Center	Adults Only	No	Behavioral Health Services, Inc.	341 East 6th Street, Long Beach, CA 90802
Alcohol and Drug Free Living Center	Adults Only	No	Behavioral Health Services, Inc.	604 Verde Vista Avenue, Pomona, CA 91767
Alcohol and Drug Free Living Center	Adults Only	No	Behavioral Health Services, Inc.	615 Elm Avenue, Long Beach, CA 90802
Alcohol and Drug Free Living Center	Adults Only	No	CRI-HELP, Inc.	4819 Gambier Street, El Sereno, CA 90032
Alcohol and Drug Free Living Center	Adults Only	No	CRI-HELP, Inc.	4944 Barstow Street, Los Angeles, CA 90032
Alcohol and Drug Free Living Center	Adults Only	No	CRI-HELP, Inc.	5640 Case Avenue, North Hollywood, CA 91601
Alcohol and Drug Free Living Center	Adults Only	No	National Council on Alcoholism and Drug Dependence - Long Beach Area	431 West 9th Street, Long Beach, CA 90813
Alcohol and Drug Free Living Center	Adults Only	No	Phoenix Houses of Los Angeles, Inc.	4601 Pickford, Los Angeles, CA 90019
Alcohol and Drug Free Living Center	Adults Only	No	Principles, Inc.	1680 North Fair Oaks Avenue, Pasadena, CA 91103
Alcohol and Drug Free Living Center	Adults Only	No	Principles, Inc.	2659-61 Nina Street, Pasadena, CA 91107
Alcohol and Drug Free Living Center	Adults Only	No	Principles, Inc.	38 Penn Street, Pasadena, CA 91103
Alcohol and Drug Free Living Center	Adults Only	No	Safe Refuge (Formerly: Substance Abuse Foundation of Long Beach, Inc.)	1035 Redondo Avenue, Long Beach, CA 90804
Alcohol and Drug Free Living Center	Adults Only	No	Safe Refuge (Formerly: Substance Abuse Foundation of Long Beach, Inc.)	1040-1044 Redondo Avenue, Long Beach, CA 90804
Alcohol and Drug Free Living Center	Adults Only	No	Safe Refuge (Formerly: Substance Abuse Foundation of Long Beach, Inc.)	1085 Obispo Avenue, Long Beach, CA 90804
Alcohol and Drug Free Living Center	Adults Only	No	Safe Refuge (Formerly: Substance Abuse Foundation of Long Beach, Inc.)	2825 East Seventh Street, Long Beach, CA 90804
Alcohol and Drug Free Living Center	Adults Only	No	Safe Refuge (Formerly: Substance Abuse Foundation of Long Beach, Inc.)	3116 East Seventh Street, Long Beach, CA 90804
Alcohol and Drug Free Living Center	Adults Only	No	Special Services for Groups, Inc.	1111 West 59th Street, Los Angeles, CA 90044
Alcohol and Drug Free Living Center	Adults Only	No	Special Services for Groups, Inc.	1113 West 59th Street, Los Angeles, CA 90047
Alcohol and Drug Free Living Center	Adults Only	No	Special Services for Groups, Inc.	1137 West 60th Place, Los Angeles, CA 90047

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Alcohol and Drug Free Living Center	Adults Only	No	Special Services for Groups, Inc.	1147 West 37th Place, Los Angeles, CA 90007
Alcohol and Drug Free Living Center	Adults Only	No	Special Services for Groups, Inc.	1301 North Willowbrook, Compton, CA 90222
Alcohol and Drug Free Living Center	Adults Only	No	Special Services for Groups, Inc.	1311 West 65th Street, Los Angeles, CA 90047
Alcohol and Drug Free Living Center	Adults Only	No	Special Services for Groups, Inc.	1627 West 82nd Street, Los Angeles, CA 90047
Alcohol and Drug Free Living Center	Adults Only	No	Special Services for Groups, Inc.	1629 West 82nd Street, Los Angeles, CA 90047
Alcohol and Drug Free Living Center	Adults Only	No	Special Services for Groups, Inc.	5430-5432 South Wilton Place, Los Angeles, CA 90062
Alcohol and Drug Free Living Center	Adults Only	No	Tarzana Treatment Centers, Inc.	1253 Loma Vista Drive, Long Beach, CA 90813
Alcohol and Drug Free Living Center	Adults Only	No	Tarzana Treatment Centers, Inc.	18317 Arminta Street, Reseda, CA 91335
Alcohol and Drug Free Living Center	Adults Only	No	Tarzana Treatment Centers, Inc.	18350 Lorne Street, Reseda, CA 91335
Alcohol and Drug Free Living Center	Adults Only	No	Tarzana Treatment Centers, Inc.	18418 Arminta Street, Reseda, CA 91335
Alcohol and Drug Free Living Center	Adults Only	No	Tarzana Treatment Centers, Inc.	18822 Valerio Street, Reseda, CA 91335
Alcohol and Drug Free Living Center	Adults Only	No	Tarzana Treatment Centers, Inc.	19139 Friar Street, Reseda, CA 91335
Alcohol and Drug Free Living Center	Adults Only	No	Tarzana Treatment Centers, Inc.	19155 Kittridge Street, Reseda, CA 91335
Alcohol and Drug Free Living Center	Adults Only	No	Tarzana Treatment Centers, Inc.	19827 Arminta Street, Reseda, CA 91335
Alcohol and Drug Free Living Center	Adults Only	No	Tarzana Treatment Centers, Inc.	20436 Gilmore Street, Winnetka, CA 91306
Alcohol and Drug Free Living Center	Adults Only	No	Tarzana Treatment Centers, Inc.	425 West 10th Street, Long Beach, CA 90815
Alcohol and Drug Free Living Center	Adults Only	No	Tarzana Treatment Centers, Inc.	44404 3rd Street East, Lancaster, CA 93534
Alcohol and Drug Free Living Center	Adults Only	No	Tarzana Treatment Centers, Inc.	44561 Leatherwood, Lancaster, CA 93534
Alcohol and Drug Free Living Center	Adults Only	No	Tarzana Treatment Centers, Inc.	44656 North 10th Street West, Lancaster, CA 93534
Alcohol and Drug Free Living Center	Adults Only	No	Tarzana Treatment Centers, Inc.	6422 Belmar Avenue, Reseda, CA 91335
Alcohol and Drug Free Living Center	Adults Only	No	Tarzana Treatment Centers, Inc.	7319 Calvin, Reseda, CA 91335
Alcohol and Drug Free Living Center	Adults Only	No	Tarzana Treatment Centers, Inc.	7319 Kelvin Avenue, Winnetka, CA 91306
Alcohol and Drug Free Living Center	Adults Only	No	Tarzana Treatment Centers, Inc.	8018 Quartz Avenue, Winnetka, CA 91306
Alcohol and Drug Free Living Center	Adults Only	No	Tarzana Treatment Centers, Inc.	8044 Darby Place, Reseda, CA 91335
Alcohol and Drug Free Living Center	Adults Only	No	Tarzana Treatment Centers, Inc.	809 West Avenue H-4, Lancaster, CA 93534
Perinatal Satellite Housing	Adults Only	No	Asian American Drug Abuse Program, Inc.	2547 Bronson Avenue, Los Angeles, CA 90016
Perinatal Satellite Housing	Adults Only	No	Asian American Drug Abuse Program, Inc.	4654 West 18th Street, Los Angeles, CA 90019
Perinatal Satellite Housing	Adults Only	No	Behavioral Health Services, Inc.	12917 Cerise Avenue, Hawthorne, CA 90250
Perinatal Satellite Housing	Adults Only	No	Behavioral Health Services, Inc.	2180 West Valley Blvd., Pomona, CA 91768
Perinatal Satellite Housing	Adults Only	No	Behavioral Health Services, Inc.	341 East 6th Street, Long Beach, CA 90802
Perinatal Satellite Housing	Adults Only	No	California Hispanic Commission on Alcohol and Drug Abuse, Inc.	5331 Via San Delarro, Los Angeles, CA 90022
Perinatal Satellite Housing	Adults Only	No	National Council on Alcoholism and Drug Dependence - Long Beach Area	427 West 9th Street, Long Beach, CA 90813

Department of Public Health, Substance Abuse Prevention and Control
SUD Provider Network as of January 1, 2016

LEVEL OF CARE	AGES SERVED	DMC*	AGENCY NAME	FACILITY ADDRESS
Perinatal Satellite Housing	Adults Only	No	Prototypes, Centers for Innovation in Health, Mental Health, and Social Services	845 East Arrow Highway, Pomona, CA 91767
Perinatal Satellite Housing	Adults Only	No	Shields for Families, Inc.	1415 East Alondra Boulevard, Compton, CA 90221
Perinatal Satellite Housing	Adults Only	No	Shields for Families, Inc.	840 West Imperial Highway, Los Angeles, CA 90044
Perinatal Satellite Housing	Adults Only	No	Southern California Alcohol and Drug Programs, Inc.	13916 Trumbal Street, Whittier, CA 90604
Perinatal Satellite Housing	Adults Only	No	Tarzana Treatment Centers, Inc.	44561 Leatherwood, Lancaster, CA 93534
Perinatal Satellite Housing	Adults Only	No	Tarzana Treatment Centers, Inc.	44656 North 10th Street West, Lancaster, CA 93534
Perinatal Satellite Housing	Adults Only	No	Watts Healthcare Corporation	524 West 121st Street, Los Angeles, CA 90044

*** This column indicates whether the facility site listed provides DMC services.**

Los Angeles County, Department of Public Health
Substance Abuse Prevention and Control

QUALITY IMPROVEMENT / UTILIZATION MANAGEMENT PROGRAM PLAN

COUNTY OF LOS ANGELES
Public Health
Substance Abuse Prevention and Control

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Substance Abuse Prevention and Control (SAPC) is a division of the Department of Public Health, and is responsible for leading and facilitating the delivery of a full spectrum of prevention, treatment, recovery support services for substance use disorders (SUD) across Los Angeles County.

Key organizational objectives are to develop a comprehensive, coordinated, and integrated continuum of care for the treatment of SUD that is accessible, evidence-based, effective, and sustainable. The Quality Improvement / Utilization Management (QI/UM) program plan describes the goals, scope, structure and operations of the SAPC QI/UM program, and pertains to all providers who have contracts with SAPC to provide SUD services in Los Angeles County.

The broad objective of the QI/UM program is for patients receiving SUD services to receive effective, coordinated care that is the right service provided at the right time, in the right setting, and at the right intensity and duration. Guiding principles include:

- Supporting providers to help patients achieve recovery, stability, and functional improvement.
- Ensuring timely access to high quality, evidence-based, medically necessary SUD services in the most appropriate setting.
- Ensuring effective and efficient utilization of SUD services and resources.
- Facilitating and coordinating care between physical health, mental health, and SUD services.
- Ensuring the provision of services that are age-specific and developmentally, culturally, and linguistically appropriate.
- Involving patient support systems (e.g., family members, significant others), when clinically appropriate.
- Assessing, monitoring, and analyzing clinical performance and outcome measures to identify and promote opportunities to improve service delivery, patient outcomes, and overall organizational and provider performance.

Establishing a committee structure within the SAPC will address the needs of the QI/UM program and better coordinate activities in order to meet organizational objectives. These committees include:

- Quality Improvement / Risk Management Committee
- Utilization Management Committee
- Research and Data Management Committee
- Professional Development Committee
- Community Liaison Committee
    - Provider Sub-Committee
    - Consumer Sub-Committee
- Cultural Competence Committee

The remainder of this document includes brief overviews of both the QI and the UM programs. This executive summary does not include the same detail as the QI/UM program plan. If questions or concerns arise after reading this summary, please refer to the full QI/UM plan for additional details. If the full plan does not address the question/concern, please contact the SAPC.

QUALITY IMPROVEMENT PROGRAM

The purpose of the Quality Improvement (QI) program is to ensure that the provision of SUD services aligns with the SAPC's organizational mission and goals. Further the QI program will ensure that services follow a standard of clinical practice consistent with medical necessity, best practice, and level of care guidelines described by the American Society of Addiction Medicine (ASAM).

The QI program will implement two models in order to achieve these objectives:

1) *Continuous Quality Improvement (CQI) Model:* The CQI model is a respected quality improvement model that employs a patient-centered philosophy and a long-term approach to quantify what a system should do.

2) *Chronic Care Model (CCM):* The CCM identifies the essential elements of a health care system that encourage high-quality care. Elements include the community, health system, self-management support, delivery system design, decision support and clinical information systems.

Access to Care: One of the central goals of SAPC is to ensure that access to SUD services in Los Angeles County is timely (a Beneficiary Access Line will be established to facilitate more expedient and easier access to services), broad (Los Angeles County provides the majority of the levels of care noted in the ASAM Criteria), and evidence-based (providers will be expected to use a minimum of two evidence-based practices).

Workforce: As a result of the expansion of Medi-Cal, the SUD treatment population is expected to increase significantly. To address the workforce needs of this expanded population, Los Angeles County will work with provider agencies to provide trainings to enhance the quality and capabilities of the current workforce, while also exploring opportunities to expand their number. A diverse workforce in terms of discipline and cultural background will be crucial in order to address the varied needs of the SUD treatment population. Ensuring reasonable caseloads, continuing education, and career ladders as means for professional growth will also be critical in ensuring quality, individualized care, and workforce retention.

Documentation: Increased focus on quality and a biopsychosocial model of care in the SUD field requires that health records (paper-based or electronic) be credible and complete. Los Angeles County requires that SUD treatment providers create initial documentation based on the ASAM Criteria. In addition, progress notes must follow one of four formats: SOAP, GIRP, SIRP, or BIRP. The SOAP (Subjective, Objective, Assessment and Plan), GIRP (Goals, Intervention, Response and Plan), SIRP (Situation, Intervention, Response and Progress), and the BIRP (Behavior, Intervention, Response and Plan) are specific methods of documentation that describe the format and content of progress notes to ensure communication and monitoring of patient interactions. The full QI/UM plan provides additional details concerning the characteristics of each type of note (e.g., progress notes, treatment plans, assessment information, summary of progress, etc.)

Clinical Practice Guidelines and Evidence Based Practices (EBP): The QI program also includes descriptions of the medical necessity criteria (patients must have a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders [DSM] for a SUD and meet the ASAM criteria definition), clinical practice guidelines, the appropriate utilization of medication-assisted treatments (MAT) and evidence based practices or EBPs (e.g., motivational interviewing, cognitive behavioral therapy, relapse

prevention, trauma informed treatment, psychoeducation). SUD providers are at a minimum expected to implement the two EBPs of Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT).

Cultural Competency: Research indicates that lack of cultural competency in the design and delivery of services can result in poor outcomes in areas such as access, engagement, receptivity to treatment, help-seeking behaviors, treatment goals, and family response. Culturally competent care is an essential component to treatment. SAPC will promote cultural competency by coordinating trainings designed to educate providers and administrators about various aspects of cultural sensitivity, with the goal of better engaging patients of diverse backgrounds and needs.

Special Populations: In addition to focusing on specific practices to treat SUD, the QI program also offers guidance on treatment for patients with more complex and specialized needs such as patients with co-occurring disorders, pregnant and postpartum patients, adolescents, transition age youth, older adults, patients involved in the criminal justice system, homeless populations, and lesbian/gay/bisexual/transgender/questioning patients. Although some EBP have been shown to be effective when treating these populations, other clinical practices require further research (e.g., some types medication assisted treatment for adolescents). Furthermore, these populations may have special needs (e.g., history of trauma, developmental needs, co-occurring mental health conditions) that may hinder the patient's progress if not addressed as a part of treatment. Training and/or technical assistance will be necessary to ensure that staff who treat these populations have the skills to provide the best types of interventions given the patient's age, health, and other unique characteristics.

Level of Care: Level of care determinations should be based on the ASAM Criteria, which helps to organize the assessment and clinical formulation in a manner that increases the likelihood that a patient will receive the right service, at the right time, in the right setting, for the right duration. Referral to a specific level of care must be based on a comprehensive and individualized assessment of the patient, with the primary goal of placing the patient at the most appropriate level of care. In general, the preferable and most appropriate level of care is one that is the least intensive while still safely meeting the unique treatment objectives of the patient.

Recovery Support Services: Recovery support services (RSS) refer to non-clinical services that foster health and resilience in individuals and families by helping them to navigate systems of care, and reduce barriers to employment, housing, education, and other life goals. They incorporate a broad range of support and social services that facilitate recovery, wellness, and linkage to and coordination among service providers. Similar to how patients see their primary care provider for periodic health checkups even when healthy, RSS can be viewed as aftercare or continuity of care in SUD treatment. The frequency of RSS is dependent on patient need, preference, and stage of recovery.

Case Management/Care Coordination: Research suggests two main reasons why case management is effective as an adjunct to SUD treatment: 1) retention in treatment is associated with better outcomes, and a principal goal of case management is to keep patients engaged in treatment and moving toward recovery; and 2) a patient may be more likely to succeed in treatment when other problems are addressed concurrently with substance abuse. Case management and care coordination are critical aspects of treatment.

Performance and Outcomes: The QI plan includes performance and outcome measures, quality improvement projects, and a peer review process for counselors and clinicians, with the goal of

establishing an educational and evaluative mechanism for providers to contribute to the identification of opportunities to improve care and services. Confidentiality and risk management are also addressed.

Complaints/Grievances and Appeals: A complaint/grievance and/or appeals process is available for patients, their authorized representative, or providers ("involved parties") who are dissatisfied with elements of care including, but not limited to, services, treatment, or authorization denials regarding eligibility, services, or level of care decisions. Involved parties may contact QI/UM staff in these instances to discuss their concerns. Concerns that are not adequately addressed can be elevated to formal grievances or appeals. The procedure and timetables for submitting for these processes is outlined in the full QI/UM plan.

UTILIZATION MANAGEMENT PROGRAM

The Utilization Management (UM) program helps to ensure quality services by monitoring adherence to the guidelines established within the Quality Improvement program, including processes involving eligibility and medical necessity criteria, as well as appropriate clinical care and level of care utilization.

In summary, the purpose of the UM program is to achieve the following objectives for patients and providers:

- 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.
- Assure fair and consistent UM decision-making.
- Focus resources on a timely resolution of identified problems.
- Assist in the promotion and maintenance of optimally achievable quality of care.
- Educate health care professionals on appropriate and cost-effective use of health resources.

Initial screenings should occur at the point of first contact between a patient and the SUD system of care, whether via the Beneficiary Access Line or at the treatment provider site. Medical necessity determinations, on the other hand, will occur at the provider site via a face-to-face review or telehealth. Treatment providers should verify initial DMC-ODS eligibility and insurance status prior to the provision of services. For patients who are determined to be eligible for Medi-Cal but not enrolled, treatment providers must make efforts to enroll patients and facilitate the enrollment process.

The initial DMC-ODS eligibility determination may be performed by trained support staff and/or registered or certified SUD counselors, however medical necessity determinations must be performed by a Medical Director, licensed physician, or Licensed Practitioner of the Health Arts (LPHA): physician, registered nurse, nurse practitioner, physician assistant, licensed/waivered psychologist, licensed/waivered/registered social worker, licensed/waivered/registered marriage and family therapist, licensed/waivered/registered Licensed Professional Clinical Counselor.

Ongoing DMC-ODS eligibility will be determined by medical necessity assessment at least every six months through the reauthorization process for all SUD services other than Narcotic Treatment Program services, which will involve an annual reauthorization process. During the reauthorization process, the Medical Director, licensed physician, or LPHA at the provider agency will be required to justify ongoing eligibility for services by submitting a completed Authorization Request Form, current treatment plan, assessment information, progress notes, and laboratory test results (if available).

Utilization Management staff will review clinical cases from SAPC contracted providers, including both adolescent and adult patients. The purpose of these case reviews is to establish an ongoing monitoring program to ensure appropriate and quality care, as well as appropriate utilization of services across the SUD service continuum.

Treatment provider caseloads for adults and adolescents at each ASAM level of care will be randomly and retrospectively reviewed on at least an annual basis, in addition to the cases that require authorization and pre-authorization (described below). These case reviews are independent from SAPC contract monitoring activities, and the quantity of these reviews will occur at County discretion. Utilization Management staff may also conduct focused, retrospective chart reviews whenever concerns arise about a particular provider or patient. Such reviews may be conducted on site and without prior notice to the provider. As needed, Utilization Management and Contracts staff will confer on cases to determine the most appropriate responding SAPC entity. These cases will then be addressed, as appropriate.

The following methods of review are utilized by UM staff:
- *Prospective Review* - A prospective review occurs prior to the delivery of services.
- *Concurrent Review* - A concurrent review examines ongoing care to evaluate medical necessity, and the quality and appropriateness of care.
- *Retrospective Review* – A retrospective review examines various aspects of previously provided services.

Services requiring pre-authorization are services for which the treating provider must request authorization before initiating treatment and/or before continuing care for an extension of a previous authorization. In these instances, UM staff will perform prospective reviews of care that has yet to be provided and concurrent reviews of extensions of previous authorizations, when pertinent. Clinical scenarios that require pre-authorization include:
- Residential services (refer to page #61 for more details)
    - Residential pre-authorizations pertain to the provision of all residential services, including youth, adults, perinatal patients, and criminal justice involved patients.
    - Residential pre-authorizations are only required when initiating residential care or transitioning to a higher level of residential care (e.g., residential pre-authorizations are not necessary when transition from one level of residential care to another lower level of residential care.
    - Residential services require reauthorization after 60-calendar days for all adult populations and after 30-days for youth in order to assess for appropriate level of care utilization.

Authorized services are services that require authorization from SAPC, but do not require authorization prior to the provision of services. In these instances, UM staff will perform concurrent reviews of care and extensions of previous authorizations, when pertinent. Clinical scenarios that require authorization include:
- Medication-Assisted Treatments for those under age 18 (refer to page #33 for more details)

If after careful consideration of all case information UM staff determine that the proposed and provided services are necessary, appropriate, and in accordance with standards of clinical practice outlined in the Quality Improvement program, services and reimbursement will be authorized. Denials of authorization

will be reviewed by supervisorial staff within the UM program. Denials of authorization will result in denial of reimbursement for services rendered.

Denial notifications will consist of information including, but not limited to:

- Reason(s) including rationale and clinical judgment used.
- Any additional information needed to improve or complete the claim.
- Descriptions of the appeal process.

The purpose of this Executive Summary is to provide a brief overview of the QI/UM plan. If questions or concerns arise after reading this summary, please refer to the full QI/UM plan for additional details. If the full plan does not address the question/concern, please contact the SAPC.

OVERVIEW

The Substance Abuse Prevention and Control (SAPC) is a division of the Los Angeles County Department of Public Health, and is responsible for leading and facilitating the delivery of a full spectrum of prevention, treatment, and recovery support services for substance use disorders (SUD) and addiction across Los Angeles County.

Key organizational objectives are to develop a comprehensive, coordinated, and integrated continuum of care for the treatment of SUD that is accessible, evidence-based, effective, and sustainable. The Quality Improvement / Utilization Management (QI/UM) program helps to achieve these aims by providing a systematic method to oversee the quality and appropriate utilization of substance use services in Los Angeles County, and support providers in delivering timely, clinically necessary and evidence-based care.

This program plan document describes the goals, scope, structure and operations of the SAPC QI/UM program, and pertains to all providers who have contracts with SAPC to provide SUD services in Los Angeles County. The QI/UM program will be gradually phased in over a reasonable period of time.

Scope

The SAPC QI/UM plan establishes a framework for oversight that encompasses all clinical services, utilization management, and review of safety/risk management data. The QI and UM programs share complementary goals of ensuring that SUD treatment is accessible, quality-focused, evidence-based, timely, and appropriate. This objective is achieved through the routine and ongoing monitoring and evaluation of all providers who have contracts with SAPC. The continuum of SUD care provided includes: prevention, outpatient services, intensive outpatient services, residential services, withdrawal management services, and Opioid Treatment Programs (OTP). Provided services include psychosocial interventions, counseling, medication-assisted treatments, case management, care coordination, perinatal and postpartum services, physician consultation, and recovery support services.

The purpose of the QI program is to set standards in areas including medical necessity criteria, clinical practice, and level of care guidelines, founded on criteria established by the American Society of Addiction Medicine (ASAM). Additional elements of the QI program include performance and outcome measures, quality improvement projects, a grievance and appeals process, and guidelines for confidentiality and risk management, including ensuring service/billing integrity. Importantly, the QI program outlines a minimum standard and should not be construed as describing the totality of SUD care.

The QI program sets standards in areas including medical necessity criteria, clinical practice, and level of care guidelines, founded on criteria established by the American Society of Addiction Medicine (ASAM).

The UM program helps to ensure quality services by monitoring adherence to the guidelines established in the QI program, including processes involving eligibility and medical necessity criteria, as well as appropriate clinical care and level of care utilization.

Similarly, the UM program helps to ensure quality services by monitoring adherence to the guidelines established in the QI program, including processes involving eligibility and medical necessity criteria, as well as appropriate clinical care and level of care utilization.

The SAPC QI/UM program pertains to all SUD services provided within SAPC's network of providers, and strives to work collaboratively with community providers and stakeholders, while complying with state and federal regulations and guidelines.

Given the continual evolution of the field of addiction treatment, the QI and UM programs are dynamic and will evolve with the availability of new information and research, or changes in regulatory mandates or contractual agreements. As a result, this document is subject to ongoing review and revision.

Guiding Principles

The broad objective of the QI/UM program is for patients receiving SUD services to receive effective, coordinated care that is the right service provided at the right time, at the right intensity, and for the appropriate duration. Guiding principles include:

- Support providers to help patients achieve recovery, stability, and functional improvement.
- Ensure timely access to high quality, evidence-based, medically necessary SUD services in the most appropriate setting.
- Ensure effective and efficient utilization of SUD services and resources.
- Facilitate and coordinate care between physical health, mental health, and SUD services.
- Ensure the provision of services that are age-specific and developmentally, culturally, and linguistically appropriate.
- Involve patient support systems (e.g., family members, significant others), when clinically appropriate.
- Monitor and analyze clinical performance and outcome measures to identify and promote opportunities to improve service delivery, patient outcomes, and overall organizational and provider performance.

Program Staff Structure

The SAPC QI/UM program is comprised of multidisciplinary staff that carry out their responsibilities as defined by the scope of practice of their individual professional disciplines and assigned job descriptions. The program is overseen by the Medical Director and is comprised of a multidisciplinary team including a nursing supervisor, registered nurses, clinical psychologist, research analysts, and support staff. The QI/UM program will work collaboratively with the Research, Epidemiology, and Evaluation Unit and the Clinical Standards and Training Unit within the Office of the Medical Director and Science Officer. Various departments within SAPC provide essential support, including the Director's Office, Adult and Youth Services, Information Services, Contract Services, and the Finance department. The University of California, Los Angeles Integrated Substance Abuse Program (UCLA-ISAP) will provide additional research support and training expertise.

Committee Structure

The QI/UM program is comprised of a committee structure that provides a framework for the quality improvement and oversight responsibilities of SAPC. As such, the majority of committees are internal

and attended by SAPC department representatives and relevant vendors. However, there are two committees that include external stakeholders such as providers, consumers, and families, among others. The standing committees are listed below, followed by more detailed information:

- Quality Improvement / Risk Management Committee
- Utilization Management Committee
- Research and Data Management Committee
- Professional Development Committee
- Community Liaison Committee
- Cultural Competence Committee

A structure of standing committees will establish an organized framework to ensure quality both within SAPC and its network of providers. Relevant information from these committees will flow to the Quality Improvement / Risk Management Committee, which will be the lead committee responsible for ensuring quality-focused services and that SAPC is in a position to achieve its organizational mission.

Quality Improvement / Risk Management Committee

- The Quality Improvement / Risk Management Committee will serve as the lead committee that will be responsible for ensuring quality-focused services and that SAPC is positioned to achieve its organizational mission.
- Roles and Function:
    - Ensure patient safety and satisfaction, quality of care, and organizational efficiencies.
    - Review, update as necessary, and approve medical necessity criteria and Clinical Practice Guidelines annually.
    - Review and monitor clinical performance indicators across all provider sites, including accessibility of services.
    - Review and approve all new provider quality improvement projects (QIPs) on annual basis.
    - Quarterly review, at a minimum, of data required by external quality review organization (EQRO) process.
    - Oversee annual formal evaluation of QI program.
    - Review targeted clinical records, complaint/grievance and appeals filed by patients, their representatives, and/or providers.
    - Designated SAPC staff will ensure a tracking and documentation system for all reportable incidents (defined as a patient safety event that results in death, permanent harm, and/or severe temporary harm and intervention required to sustain life), conduct investigations, and implement and follow up on corrective actions, as appropriate.
    - Oversee and monitor compliance with the applicable legal and regulatory obligations that pertain to activities performed by the SAPC QI/UM programs.
    - Identify opportunities to improve compliance and risk management processes.
    - Review and evaluate QI activities, initiate needed QI actions, and ensure follow up of QI processes, including review of data related to safety and reportable incidents in order to identify trends and patterns associated with risks or to identify problem areas.
    - Provide guidance to educational processes for QI standards, in conjunction with the Clinical Standards and Training Unit of the Office of the Medical Director and Science Officer.
    - Identify opportunities to improve QI processes and support other organizational functions.
    - Collaborate with relevant internal and external committees and parties to design, implement, and ensure feasible measurement of interventions for improving quality, care and performance.

    - Provide support to other organizational functions.
- Lead SAPC department: Office of the Medical Director and Science Officer
- Involved SAPC departments and stakeholders: Director's Office, Office of the Medical Director and Science Officer, Systems of Care, Contract Services, Strategic Planning, Information Systems, Finance, UCLA-ISAP.
- Meeting Frequency: Minimum every other month.

Utilization Management Committee

- Roles and Function:
    - Evaluate consistent use of medical necessity and review process used to approve the provision of services.
    - Evaluate consistent provision of services in accordance with clinical standards described in QI/UM program plan, and review process of determining appropriate services.
    - Review initial and ongoing eligibility determinations, and initial and continued service authorization decisions.
    - Identify and monitor under-utilization and over-utilization of services.
    - Identify and monitor utilization patterns that:
        - Compromise enrollee health and safety.
        - Inappropriately use resources.
        - Result in clinical or organizational risk.
    - Oversee annual formal evaluation of UM program.
    - Identify opportunities to improve UM processes and support quality improvement activities.
    - Provide support to other organizational functions.
    - Perform special targeted monitoring activities, as required by regional need or regulatory mandate.
- Lead SAPC department: Office of the Medical Director and Science Officer
- Involved SAPC departments and stakeholders: Director's Office, Office of the Medical Director and Science Officer, Systems of Care, Contract Services, Information Systems, Finance.
- Meeting Frequency: Minimum quarterly.

Research and Data Management Committee

- Roles and Function:
    - Review process of data collection and management to ensure security, effectiveness, and efficiency.
    - Collect and analyze data to ensure that data collection aligns with and informs organizational goals and priority areas of improvement.
    - Identify opportunities to improve data management processes and support quality improvement activities, including the consideration of new technologies.
    - Provide guidance on quality-focused research priorities and projects.
    - Support Utilization Management Committee in performing special targeted monitoring activities related to data acquisition, as required by regional need or regulatory mandate.
    - Provide support to other departmental and organizational functions.
- Lead SAPC department: Office of the Medical Director and Science Officer
- Involved SAPC departments and stakeholders: Office of the Medical Director and Science Officer, Systems of Care, Information Systems, Strategic Planning, UCLA-ISAP.
- Meeting Frequency: Minimum quarterly.

Professional Development Committee

- Roles and Function:
    - Identify professional development needs of SAPC staff, based on issues and developments in the field of addiction care.
    - Review and implement educational processes to ensure continued professional development of SAPC staff.
    - Collaborate with Cultural Competence Committee regarding issues with cultural competency.
    - Collaborate with Community Liaison Committee regarding stakeholder input and concerns.
    - Provide support to other organizational functions.
- Lead SAPC department: Administrative Services
- Involved SAPC departments and stakeholders: Director's Office, Administrative Services, Office of the Medical Director and Science Officer, Systems of Care, Contract Services, Strategic Planning.
- Meeting Frequency: Minimum twice per year.

Community Liaison Committee

- The Community Liaison Committee will consist of an adult provider sub-committee, a youth provider sub-committee, as well as a consumer/family member sub-committee.
- **Adult Provider Sub-Committee**: Consists of the various provider meetings that are currently established (e.g., quarterly All Providers' Meeting, bimonthly [every other month] Los Angeles County Evaluation System [LACES] Advisory Workgroup meeting, quarterly Narcotic Treatment Provider meeting, quarterly CAADPE [California Association of Alcohol and Drug Program Executives] meeting, etc).
- **Youth Provider Sub-Committee**: Consists of quarterly Youth Provider meeting, etc.
- **Consumer/Family Member Sub-Committee**: Consists of consumer and family member stakeholders; will meet on a quarterly basis in rotating Service Planning Areas of the County.
- Roles and Function:
    - Promote stakeholder (consumers, families, providers, and Commission on Alcohol and Other Drugs, etc.) collaboration regarding the QI/UM process and SUD performance measures, including feedback, addressing transparency, concerns, and ideas for future projects.
    - Report stakeholder feedback, knowledge, and suggestions to departmental and organizational leadership, as well as pertinent Committees (e.g., Professional Development Committee, Cultural Competence Committee).
    - Provide support to other organizational functions.
- Lead SAPC department: Systems of Care
- Involved SAPC departments and stakeholders: Director's Office, Office of the Medical Director and Science Officer, Systems of Care, Strategic Planning, UCLA-ISAP, relevant stakeholders (see above).
- Meeting Frequency: Variable.

Cultural Competence Committee

- Roles and Function:
    - Review and evaluate cultural competency of services provided to patients and their families.
    - Collaborate with the QI and UM Committees to promote cultural awareness and sensitivity.

    - Identify opportunities to improve cultural competence within the QI/UM processes.
    - Collaborate with the Professional Development Committee and Community Liaison Committee around issues with cultural competency.
    - Provide support to other organizational functions.
- Lead SAPC department: Office of the Medical Director and Science Officer
- Involved SAPC departments and stakeholders: Director's Office, Office of the Medical Director and Science Officer, Adult and Youth Programs, Contract Services, Strategic Planning, relevant stakeholder groups identified in the Community Liaison Committee. As needed: Finance and subject matter experts.
- Meeting Frequency: Minimum quarterly.

Table 1. Committee Structure Summary

Committee	Function	SAPC Dept Lead	Meeting Frequency
Quality Improvement/Risk Management*	Identify opportunities to improve quality of services, compliance and risk management, review documents (records, complaints/grievances, appeals), ensure collaboration and information exchange, and support provider-level quality improvement.	OMDSO	Every other month
Utilization Management	Evaluate use of medical necessity, provision of services, review initial / ongoing eligibility, identify and monitor over/under utilization of services and risk patterns.	OMDSO	Quarterly
Research and Data Management	Provide guidance on research priorities, identify opportunities to improve data management, support quality improvement, and consider new technologies.	OMDSO	Quarterly
Professional Development	Identify professional development needs of SAPC staff, ensure continued professional development and collaboration with other committees.	Admin Services	Twice a year
Community Liaison (Adult, Youth, and Consumer/ Family Member)**	Promote stakeholder collaboration regarding SAPC programming and processes, including the QI/UM process and SUD performance measures. Report stakeholder feedback, knowledge, and suggestions to departmental and organizational leadership.	System of Care	Variable
Cultural Competence**	Evaluate cultural competency and identify opportunities to improve cultural competence of services provided to patients and their families; and promote cultural awareness and sensitivity.	OMDSO	Quarterly

** Quality Improvement / Risk Management Committee serves as lead committee*

*** The Community Liaison Committee and Cultural Competence Committee will include external stakeholders such as providers, consumers, and families, among others*

OMDSO – Office of the Medical Director and Science Officer

SAPC – Substance Abuse Prevention and Control

UCLA-ISAP – University of California Los Angeles, Integrated Substance Abuse Programs

QUALITY IMPROVEMENT PROGRAM

In light of SAPC's mission to lead and facilitate the delivery of a full spectrum of prevention, treatment and recovery support services proven to reduce the impact of substance abuse and addiction, quality improvement activities can help to ensure accessible, quality-focused, evidence-based, effective, and appropriate SUD treatment services for Los Angeles County residents.

The purpose of the QI program is to provide guidelines to ensure that the provision of services and care aligns with SAPC's organizational mission and goals, and follows generally accepted standards of clinical practice in terms of medical necessity, clinical practice, and level of care guidelines that are consistent with the ASAM Criteria. In doing so, the QI program strives to support the SAPC provider network in the provision of quality care, and to maintain programmatic, clinical, and fiscal integrity to adapt to a changing health care landscape.

The Quality Improvement / Utilization Management Program applies to all providers and patients, regardless of funding stream or modality of treatment.

The QI program will implement a multi-model approach in order to achieve its objectives by utilizing the following two models: 1) Continuous Quality Improvement Model (CQI), and 2) the Chronic Care Model (CCM).

Continuous Quality Improvement (CQI)

The CQI model is a respected quality improvement model that can be employed within a behavioral health setting (see Figure 1 below).

Figure 1. Continuous Quality Improvement (CQI) Framework

The CQI model is based on concepts of quality improvement and performance measurement, and employs a patient-centered philosophy and long-term approach to provide tools to help quantify what a system should do. Additionally, this model investigates common causes for variation within a system and is driven by data, process, and patient feedback. As a result, the SAPC will continue to work with providers to monitor performance and outcomes as part of the CQI process (see Performance and Outcome Measures below). The CQI model is very similar to other cyclical approaches utilized in Public Health (Planning, Implementation, Evaluation, and Review) and is based off earlier quality improvement models of "Plan-Do-Study-Act" activities. The six steps of CQI are defined in Table 2 below:

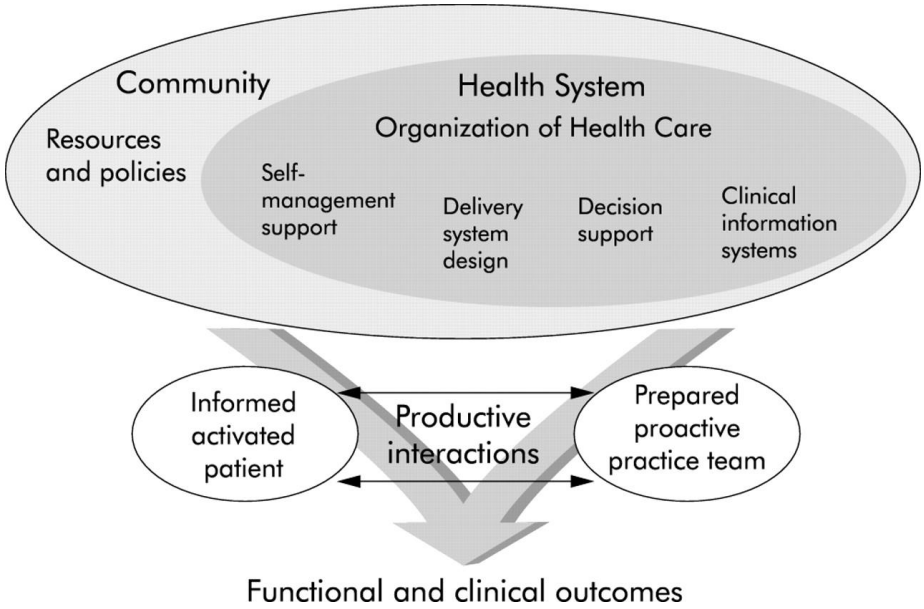
Table 2. Six Steps of Continuous Quality Improvement

1. **Identify** a need/issue/problem and develop a problem statement.
2. **Define the current situation -** Break down problem into component parts, identify major problem areas, develop a target improvement goal.
3. **Analyze the problem -** Identify the root causes of the problem and consider using visuals, as needed.
4. **Develop an action plan -** Outline ways to correct the root causes of the problem and specific actions to be taken.
5. **Look at the results -** Confirm that the problem and its root causes have decreased or resolved and identify if the target has been met
6. **Start over -** Repeat process for the additional identified problems.

Chronic Care Model (CCM)

Another model that lends itself well to quality improvement in behavioral health is Wagner's "Chronic Care Model" (see Figure 2 below).

Figure 2. Chronic Care Model



According to the authors (Wagner, Austin, Davis, Hindmarsh, Schaefer, Bonomi, 2001[1]), the CCM identifies the essential elements of a health care system that encourage high-quality chronic disease care. These elements are the community, the health system, self-management support, delivery system design, decision support and clinical information systems. Evidence-based change concepts under each element, in combination, foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise. These components are described in greater detail in Table 3.

Table 3. Components of the Chronic Care Model

1. ***Health Systems:*** Create a culture, organization and mechanisms that promote safe, high quality care.
   - Visibly support improvement at all levels of the organization, beginning with the senior leader
   - Promote effective improvement strategies aimed at comprehensive system change
   - Encourage open and systematic handling of errors and quality problems to improve care (2003 update)
   - Provide incentives based on quality of care
   - Develop agreements that facilitate care coordination within and across organizations (2003 update)
2. ***Delivery System Design:*** Assure the delivery of effective, efficient clinical care and self-management support
   - Define roles and distribute tasks among team members
   - Use planned interactions to support evidence-based care
   - Provide clinical case management services for complex patients
   - Ensure regular follow-up by the care team
   - Give care that patients understand and that fits with their cultural background
3. ***Decision Support:*** Promote clinical care that is consistent with scientific evidence and patient preferences
   - Embed evidence-based guidelines into daily clinical practice
   - Share evidence-based guidelines and information with patients to encourage their participation
   - Use proven provider education methods
   - Integrate specialist expertise and primary care
4. ***Clinical Information Systems:*** Organize patient and population data to facilitate efficient and effective care
   - Provide timely reminders for providers and patients
   - Identify relevant subpopulations for proactive care
   - Facilitate individual patient care planning
   - Share information with patients and providers to coordinate care
   - Monitor performance of practice team and care system
5. ***Self-Management Support:*** Empower and prepare patients to manage their health and health care
   - Emphasize the patient's central role in managing their health
   - Use effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up
   - Organize internal and community resources to provide ongoing self-management support to patients
6. ***The Community:*** Mobilize community resources to meet needs of patients
   - Encourage patients to participate in effective community programs
   - Form partnerships with community organizations to support and develop interventions that fill gaps in needed services
   - Advocate for policies to improve patient care

Source*: http://www.improvingchroniccare.org/index.php?p=Model_Elements&s=18*

Effective care of chronic conditions, such as SUD, is characterized by productive interactions between activated patients, as well as their family and caregivers, and a prepared practice team. This care takes place in a health care system that utilizes community resources. At the level of clinical practice, four

[1] Wagner, E.H., Austin, B.T., Davis, C., Hindmarsh, M., Schaefer, J., & Bonomi, A. (2001). Improving chronic illness care: translating evidence into action. *Health Affairs, 20 (6)*, 64-78.

areas influence the ability to deliver effective chronic illness care: 1) self-management support (empower and prepare patients to manage their health and health care), 2) delivery system design (assure the delivery of effective, efficient clinical care and self-management support), 3) decision support (promote clinical care that is consistent with scientific evidence and patient preferences), and 4) clinical information systems (organize patient and population data to facilitate efficient and effective care). The end goal is to deliver care that is safe, effective, timely, patient-centered, efficient and equitable.

Access to Care

Access to care refers to the psychosocial and physical access to the location where treatment services are rendered. Physical barriers may include the architecture of the site, such as treatment providers with steps but no ramp entrance, or environmental barriers such as program location in an area where patients do not feel safe. Lack of soundproofing in counseling offices and lack of privacy in assessment rooms are also potential barriers. Psychosocial barriers may include lack of communication capabilities for hearing- or visually-impaired individuals, attitudes expressed by counselors or other staff that denote biases or communicate stigma to the patients, lack of a diverse workforce, operational hours that restrict access to services, or a lack of opportunity for patient input into his or her treatment plan or program operations. One of the central goals of the SAPC is to ensure that access to SUD treatment in Los Angeles County is timely, broad, and evidence-based.

<u>Access to Timely Services</u>

The Beneficiary Access Line (BAL) is available 24 hours a day, seven days a week. Patients can call the BAL to initiate a self-referral for treatment. Patients can also be referred by an organization or others, including but not limited to, physical health providers, law enforcement, family members, mental health care providers, schools, and County departments. The BAL will be capable of providing referrals to programs that specialize in treating special populations or specific cultural groups. It will also have access to additional culture-based services such as translation services and services for the hearing and visually impaired.

Referrals for substance use disorder (SUD) care may include SUD providers or the nearest emergency room, in cases deemed to be medical or psychiatric emergencies.

Staff at the BAL will conduct a brief DMC-ODS eligibility determination and clinical assessment for youth and adults via phone in order to determine the most appropriate referral.

The BAL will set the appointment for the initial assessment/intake with the selected provider while the beneficiary is on the call except under limited circumstances (e.g., the caller is unable to schedule, the automated appointment system is not yet developed/not working), but no longer than 3-business days from the date of the brief triage assessment. Unless the beneficiary has specific provider or other preferences (e.g., cultural/linguistic specific services) that would require a longer waiting period, the assessment/intake appointment with a qualified SUD network provider that is geographically accessible will be conducted within 15-business days from the date of the brief triage assessment. In July 2017, the assessment/intake appointment target will be 5-business days for outpatient cases and 10-business days for residential cases. In July 2018, the assessment/intake appointment target will shift to 5-business days for all levels of care.

For individuals that present at the provider site first, the same timeliness expectations apply and alternate referrals should be offered and documented if this cannot be achieved before placing the individual on a waitlist. Expedited or other suitable/appropriate accommodations for scheduling appointments will be made for urgent situations whenever possible. DPH-SAPC will regularly evaluate timely receipt of services, including seeking service expansion to improve the ability to receive services upon demand.

Referrals may include SUD providers or the nearest emergency room, in cases deemed to be medical or psychiatric emergencies. If referred to an SUD provider, the referral would be based off patient preference after being given various options of available providers, as well as the preliminary appropriate level of care determination.

Screening and assessment processes may occur in person, over the phone, or via telehealth. The intensity of the screening and assessment process would correspond to the clinical need, and not be so intensive that the time required for the process becomes burdensome for the patient seeking services or the SUD program providing services. Furthermore, every effort should be made to minimize the elapsed time between the initial eligibility, clinical need determination, and referral, and the first face-to-face clinical appointment.

Patients who need SUD care must be scheduled for an appointment within 3-business days and receive an appointment with their treatment provider within 15-business days. These timeframe targets will shorten in future years.

Research indicates that travel distance is linked to patient outcomes. As such, unless otherwise requested by the patient, every effort must be made to refer the patient to a treatment program that is within one-hour of travel time by personal or public transportation from the patients' preferred location. If this is not feasible, every effort should be made to decrease the likelihood that the commute or transportation issues serve as a barrier to care. If patients prefer to have some aspect of treatment delivered in a different region than where they reside or work, this preference should be noted in their clinical record.

In cases where the preliminary level of care recommendation is residential treatment but residential beds are not available, the patient will be referred to the next most appropriate level of care and a warm hand off will be facilitated whenever necessary and feasible.

As a means to optimize access to SUD services, providers need to implement an ongoing evaluation process in order to identify barriers to treatment that may relate to the physical or psychosocial access issues mentioned above, counselor/staff attitudes around substance use, patient transportation, or any other accessibility issues. This includes considering patient and stakeholder feedback during this process to ensure adequate access to care. Once barriers are identified, providers would develop a plan detailing how they plan on addressing the identified barriers. The plan would also specify the barrier(s), the action(s) that will be taken to eliminate or reduce the impact of the barrier, and when these specific actions will be completed.

Access to Array of Services

Patients will have access to all levels of care provided by Los Angeles County including outpatient services, intensive outpatient services, residential services, withdrawal management services (only including youth on a case-by-case basis), and Opioid Treatment Program services. The SAPC will make every effort to ensure an adequate level of treatment providers for both adults and youth, based on

utilization and community needs. Access to the different levels of care will be based on ASAM Criteria. As patients move through the continuum of SUD care, appropriate placement will be reassessed at each transition in treatment modality in order to ensure that the patient is placed at the appropriate level of care. Additionally, providers are expected to perform clinical assessments to determine progress on a regular basis in order to transition patients to the next appropriate level of care as soon as clinically indicated.

Access to Evidence-Based Services

When implemented appropriately and performed by qualified counselors and clinicians, evidence-based practices (EBP) have been proven to improve clinical care and outcomes. A number of psychosocial interventions and medication-assisted treatments are considered EBPs (see Psychosocial Interventions and Medication-Assisted Treatment sections below) and should form the foundation of a modern system for care for substance abuse.

Providers are expected to provide a minimum of two psychosocial EBPs (i.e., motivational interview and cognitive-behavioral therapy) as a component of their treatment services, in addition to supporting the use of medication-assisted treatments, when clinically appropriate. The SAPC will continue to work with treatment providers to improve the quality of clinical services and provide access to trainings on evidence-based practices.

Access to Culturally Appropriate Services

Efforts must be made to provide culturally, linguistically, and developmentally appropriate services, including, but not limited to:

- Provide a provider list of services for special populations, such as young adults, veterans, older adults, LGBTQ, etc.
- Provide culturally, linguistically, and developmentally appropriate written information in threshold languages, including information on their rights to language assistance services.
- Work to expand capacity and ability to provide a broad range of culturally, linguistically, and developmentally appropriate services.

Workforce

Recent changes in the field of addiction have led to substance use systems moving toward a chronic disease and public health model that requires a diverse, skilled, and highly trained workforce.

The SAPC recognizes and values the contributions of contract providers of all sizes and capacities, and also realizes that the composition of a successful SUD system of care must reflect the diversity of needs of the population it serves. Subsequently, the provider workforce must be either composed of or have the capability to utilize the skills of multidisciplinary staff, all of whom are required to have appropriate experience and training at the time of hiring.

Professional clinical staff must be licensed, registered, certified, or recognized under California State scope of practice statutes. Licensed Practitioners of the Healing Arts (LPHA) include Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical

Psychologists (LCP), Licensed Clinical Social Workers (LCSW), Licensed Professional Clinical Counselors (LPCC) , and Licensed Marriage and Family Therapists (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians. Other professional staff, such as SUD counselors, and non-professional staff, must receive appropriate on-site orientation and training prior to performing assigned duties, and need to be supervised by appropriately qualified staff. Registered and certified SUD counselors must also provide services within their scope of practice and adhere to all requirements in the California Code of Regulations, Title 9, Chapter 8.

Licensed Practitioners of the Healing Arts (LPHA) include: Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologists (LCP), Licensed Clinical Social Workers (LCSW), Licensed Clinical Professional Counselors (LCPC), and Licensed Marriage and Family Therapists (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

Continuing education should be an integral component of professional development. The SAPC will provide training support to enhance providers' capability to deliver evidence-based, quality care. In order to maintain standards of excellence in care, patient-to-counselor ratios should allow for adequate individualized attention to ensure quality care and appropriate follow-up.

Additionally, SAPC will explore opportunities to work with provider agencies to establish a career ladder for SUD counselors based on the Substance Abuse and Mental Health Services Administration (SAMHSA) "Scopes of Practice & Career Ladder for Substance Use Disorder Counseling." Each step on the ladder requires increasing levels of education and work experience, and increasing professional responsibility (e.g., clinical supervisors). By laying out a clear career path, with increases in pay and responsibility commensurate with each step, a career ladder can help establish professional standards for the field of specialty SUD treatment and retain a qualified workforce.

Documentation

Clinical documentation refers to anything in the patients' health record (paper-based or electronic) that describes the care provided to that patient, and its rationale. It is observational and narrative in content, and is written by counselors and clinicians to analyze the process and contents of patient encounters. Clinical documentation is a critical component of quality healthcare delivery and serves multiple purposes, helping to:

- **Ensure comprehensive and quality care -** The process of writing initial assessments and proper progress notes requires thought and reflection. Preparing proper clinical documentation serves an important role of helping assure quality patient care by giving practitioners an opportunity to think about their patients, review and reflect on their therapeutic interventions, consider the efficacy of their clinical work, and weigh alternative approaches to the care. Good clinical documentation helps one organize clinical details into a case formulation that can then be used for treatment planning and is an essential element of professional practice and of the provision of quality clinical services. It also helps to assure appropriate utilization of team members from multiple disciplines in order to leverage interdisciplinary competencies and maximize the quality of services provided.
- **Ensure an efficient way to organize and communicate with other providers -** The documentation of clinical care helps to provide structure and efficiencies to clinical communications with other providers who may be involved in the care of shared patients. This assures coordinated rather than fragmented treatment/service delivery.

- **Protect against risk and minimize liability -** Accurate and comprehensive clinical documentation is not only important in terms of quality care, but is also essential in risk management. Detailing and justifying the 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 the provision of professional services.
- **Comply with legal, regulatory and institutional requirements –** Good clinical documentation practices help to assure compliance with recordkeeping requirements imposed by federal and state (including licensing boards) laws, regulations, and rules. It also helps to ensure that documentation meets the standards set by specific accreditation programs (e.g., CARF, Joint Commission), when applicable, and by health care institutions, facilities and agencies.
- **Facilitate quality improvement and application of utilization management –** Clinical documentation provides an opportunity to explain the process and substance of assessments, treatment and service planning, clinical decision-making, medical necessity, and the effectiveness of treatments and other services provided. As a result, it is essential for the utilization review process because clinical documentation helps to substantiate the need for further assessment, testing, treatment and/or other services, or to support changes in or termination of treatment and/or services. From a quality perspective, clinical documentation facilitates supervision, consultation, and staff/professional development, and helps to improve the quality of services by identifying problems with service delivery by providing data based upon which effective preventative or corrective actions can be taken. Appropriate recordkeeping also provides data for use in planning educational and professional development activities, policy development, program planning and research in agency settings.

Clinical documentation must be credible and complete, and is protected via the Health Insurance Portability and Accountability Act (HIPAA) and Title 42, Code of Federal Regulations (42 CFR). It encompasses every aspect of clinical care, including initial assessments, progress notes, and relevant encounters that occur outside of established appointments. Documentation of initial assessments follows the same format as the multidimensional ASAM assessment and reflects a comprehensive biopsychosocial approach. Progress notes are written during/after follow up appointments in order to gauge clinical progress and assess to determine if patient needs have changed and if modifications to the treatment approach/plan are required.

In general, clinical documentation includes the following characteristics:
- Notes that are dated, signed, and legible (if written by hand).
- Patient name and identifier are included on each page of the clinical record.
- Patient's race, ethnicity, and primary language spoken.
- Documented referral information.
- Sources of information are clearly documented.
- Patient strengths and limitations in achieving goals are noted and considered.
- The style of documentation is consistent and standardized throughout the agency/institution.
- The use of abbreviations is limited. However, when used, abbreviations are standardized and used in a consistent context.
- Documentation includes all relevant clinical information and reflects a biopsychosocial approach to the assessment process.
- Patient self-report of experiences and observed behavior is noted.
- Documentation reflects changes in patient status including response to and outcome(s) of the intervention(s) as well as progress towards goals and completion of objectives.

- Entries include the counselor's/clinician's professional assessment and continued plan of action.
- Changes in patient status are documented (e.g., change in level of care provided or discharge status).
- Describe how services provided reduced impairment, restored functioning, and/or prevented significant deterioration as outlined in the treatment plan.
- For patients with limited English proficiency, document if interpreter services were offered and provided, and an indication of the patient's response.

Patient-centered care is critical and requires that patients be provided the opportunity to actively shape their treatment plans. At a minimum, treatment plan updates for adults and adolescents are required at least every 30-days in all treatment settings, and it is recommended that the treatment plan in more intensive levels of care, such as residential settings, be updated more frequently if an individual is unstable or if there is a notable event that requires a change in the treatment plan. As patients advance through treatment, the corresponding treatment plan should be reviewed and adjusted accordingly based on stability and the likelihood of rapid changes in patient condition. If a patient's condition does not show improvement at a given LOC or with a particular intervention, then a review, abbreviated assessment, and treatment plan modification should be made in order to improve therapeutic outcomes. Changing the level of care or intervention should be based on a reassessment and modification of the treatment plan in order to achieve an improved therapeutic response.

Treatment Plans

Treatment plans must meet the requirements specified in Title 22, CCR, Section 51341.1 (h)(2)(A), or for Opioid Treatment Programs, Title 9, CCR, Section 10305, as specified in Title 22, CCR, Section 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 patient and provider for each identified problem.
- Action steps to be taken by the provider and/or patient in order 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.
- Required documentation regarding physical examinations, as specified in Titles 9 and 22.

Standardized documentation (e.g., SOAP, GIRP, SIRP, or BIRP) increases treatment consistency, quality of care and reduces reimbursement disallowances. SAPC requires that initial documentation be based on the format of the ASAM Criteria, and that progress notes for individual and group sessions follow either the SOAP, GIRP, SIRP, or BIRP formats.

Progress Notes

For level of care transitions, initial and relevant progress note documentation are based on the ASAM Criteria and include the following information:

- Date ASAM placement criteria were used.
- Documentation of the name, location and primary contact at referral site.
- Format of ASAM criteria used (software or paper-based).
- Justification of discrepancy if the level of care suggested by ASAM criteria is not recommended by counselor/clinician.
- Justification of discrepancy if the discussed level of care is not agreeable to patient.

- Justification of discrepancy if the level of care the patient was referred to does not match the level of care suggested by the ASAM Criteria.

Progress notes must, at a minimum, be documented each day there is a patient encounter in outpatient and intensive outpatient settings. In residential settings, progress notes must be documented at least weekly by staff who have provided services for the patient during that time period.

Standardized documentation by SUD counselors and clinicians assist with increasing treatment consistency and quality of care, as well as reducing reimbursement disallowances. As such, the SAPC requires that the multidimensional components of the ASAM Criteria be incorporated into initial documentation of the first full assessment, and that progress notes for both individual and group sessions follow one of four 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 patient services by providing a consistent and organized framework of clinical documentation to enhance communication among health care professionals and better recall the details of each patient's case. This format allows providers to identify, prioritize and track patient problems so they can attend to them in a timely and systematic manner. It also provides an ongoing assessment of both the patient's progress and the treatment interventions. While a full review of the SOAP note format is beyond the scope of this document, below (Table 4) is a summary of its components and providers should refer to additional resources for more information.

Table 4.

SOAP Note Format	
S	**Subjective –** Patient statements that capture the theme of the session. Brief statements as quoted by the patient may be used, as well as paraphrased summaries.
O	**Objective –** Observable data or information supporting the subjective statement. This may include the physical appearance of the patient (e.g., sweaty, shaky, comfortable, disheveled, well-groomed, well-nourished), vital signs, results of completed lab/diagnostics tests, and medications the patient is currently taking or being prescribed.
A	**Assessment –** The counselor's or clinician's assessment of the situation, the session, and the patient's condition, prognosis, response to intervention, and progress in achieving treatment plan goals/objectives. This may also include the diagnosis with a list of symptoms and information around a differential diagnosis.
P	**Plan –** The treatment plan, based on the assessment and clinical information acquired.

The GIRP, SIRP, and BIRP progress note formats are also used to record similar clinical information in a structured format. The information included in these progress note formats includes patient goals/situation/behavior, staff interventions used during the session, patient response to the session, and the plan for future sessions or progress made toward the treatment plan. Similar to 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. Tables 5, 6, and 7 (below) 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 more detailed information.

Table 5.

GIRP Note Format	
G	**Goal –** Patient's current focus and/or short-term goal, based on the assessment and treatment plan.
I	**Intervention –** Provider's methods used to address the patient's statements, the provider's observations, and the treatment goals and objectives.
R	**Response –** The patient's response to intervention and progress made toward individual plan goals and objectives.
P	**Plan** – The treatment plan moving forward, based on the clinical information acquired and the assessment.

Table 6.

SIRP Note Format	
S	**Situation –** Patient's presenting situation at the beginning of intervention. May include counselor/clinician observations, patient's subjective report and the intervention setting.
I	**Intervention –** Provider's methods used to address the patient's statements, the provider's observations, and the treatment goals and objectives.
R	**Response –** The patient's response to intervention and progress made toward individual plan goals and objectives.
P	**Progress** – The treatment plan progress made toward treatment goals and objectives, as well as the plan for future interventions as determined by the clinical picture.

Table 7.

BIRP Note Format	
B	**Behavior –** Patient statements that capture the theme of the session and provider observations of the patient. Brief statements as quoted by the patient may be used, as well as paraphrased summaries that closely adhere to patient statements. Provider observations may include the physical appearance of the patient (e.g., sweaty, shaky, comfortable, disheveled, well-groomed, well-nourished, etc.), vital signs, results of completed lab/diagnostics tests, and medications the patient is currently taking or being prescribed.
I	**Intervention –** Provider's methods used to address the patient's statements, the provider's observations, and the treatment goals and objectives.
R	**Response –** The patient's response to intervention and progress made toward individual plan goals and objectives.
P	**Plan** – The treatment plan moving forward, based on the clinical information acquired and the assessment.

For patients 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.

Medical Necessity Criteria

The Los Angeles County system of care and its SUD providers need to have a shared definition and understanding of medical necessity that involves diagnosis, impairment, and intervention. Medical necessity will be consistently applied to ensure equitable access to services and can be performed via a face-to-face review or telehealth by a Licensed Practitioner of the Health Arts (LPHA).

Medical Necessity Criteria:

- Patient must have 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.
- Patient must meet the ASAM Criteria definition of medical necessity for services. Medical necessity encompasses all six dimensions so that a more holistic concept would be clinical necessity, necessity of care, or clinical appropriateness. Medical necessity pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient. It must not be restricted to acute care and narrow medical concerns (such as severity of withdrawal risk as in Dimension 1); acuity of physical health needs (as in Dimension 2); or Dimension 3 psychiatric issues (such as imminent suicidality).

In order to meet the medical necessity criteria:
- Patient must have 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.
- Patient must meet the ASAM Criteria definition of medical necessity for services.

Clinical Practice Guidelines

The SAPC recognizes that clinical care needs to be an individualized process that balances patient needs, established clinical standards, and available resources. Each clinical case is unique and there are many variables that impact care. However, care guidelines can be helpful to outline generally accepted clinical standards.

The guidelines outlined below are not intended to be a comprehensive overview of all aspects of clinically appropriate substance use care. It is strongly recommended that one refer to more detailed clinical guidelines provided through SAMHSA and other respected resources for additional information.

Assessment

There are various types of assessments, including initial eligibility determinations, and assessments focusing on medical necessity and clinical care, including level of care determinations. Assessments and its corresponding documentation serve as the foundation of high quality care. In the treatment of persons with SUDs, assessments are an ongoing process and are essential in order to identify patient needs and help the provider focus their services to best meet those needs. They are also an important aspect of patient engagement and treatment planning, and are generally performed in the initial phases of treatment, though not necessarily during the initial visit.

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

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

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

1) Acute intoxication and/or withdrawal potential
2) Biomedical conditions and complications
3) Emotional, behavioral, or cognitive conditions and complications
4) Readiness to change
5) Relapse, continued use, or continued problem potential
6) Recovery/living environment

Clinical assessments are based on the ASAM Criteria, which includes multidimensional assessments comprised of six dimensions:
1) Acute intoxication and/or withdrawal potential.
2) Biomedical conditions and complications.
3) Emotional, behavioral, or cognitive conditions and complications.
4) Readiness to change.
5) Relapse, continued use, or continued problem potential.
6) Recovery/living environment.

The multidimensional ASAM assessment provides a common language to describe holistic, biopsychosocial assessment and treatment across addiction, physical health, and mental health services. At a minimum, comprehensive assessments include the following elements:

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

Assessments based on the ASAM Criteria ensure that necessary clinical information is obtained in order to make appropriate level of care determinations. Assessments need to be appropriately documented (see Documentation section above), reviewed, and updated on a regular basis, including at every care transition, in order to promote engagement and meet the patient's needs and preferences. If during the course of assessments the patient and provider(s) determine that adequate progress toward treatment goals has been made, plans to build upon these achievements need to be made, which may include transitions to other services and recovery-focused strategies. 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 time.

Patients who no longer meet medical necessity criteria for SUD treatment services, or prematurely exit the SUD system of care, should receive recovery monitoring services for a minimum of 6 months by the last treatment provider of care, who will reengage the individual in treatment if needed.

Psychosocial Interventions

Psychosocial interventions in the treatment of addictions are vital to engaging patients and promoting behavior change, and need to play an integral role in every treatment encounter. Research has shown that the longer a patient is engaged in addiction treatment, the better his or her long-term prognosis. Thus, the quality of the therapeutic alliance between patient and provider and the degree to which hope for recovery is conveyed are essential contributors to positive treatment outcomes.

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

In Los Angeles County, although other psychosocial approaches may be used, SUD providers are at a minimum expected to implement the two evidence-based psychosocial interventions of Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT). Below are descriptions of a selection of these evidence-based psychosocial interventions:

- **Motivational Interviewing (MI) -** A patient-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment by paying particular attention to the language of change. This approach frequently includes other problem solving or solution-focused strategies that build on patients' past successes. According to the Motivational Interviewing Network of Trainers, MI "is designed to strengthen an individual's motivation for and movement toward a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion."
- **Cognitive-Behavioral Therapy (CBT) -** According to the National Institute of Drug Abuse's *Principles of Drug Addiction Treatment: A Research-Based Guide*, "Cognitive-behavioral strategies are based on the theory that in the development of maladaptive behavioral patterns like substance abuse, learning processes play a critical role. Individuals in CBT learn to identify and correct problematic behaviors by applying a range of different skills that can be used to stop drug abuse and to address a range of other problems that often co-occur with it. A central element of CBT is anticipating likely problems and enhancing patients' self-control by helping them develop effective coping strategies. Specific techniques include exploring the positive and negative consequences of continued drug use, self-monitoring to recognize cravings early and identify situations that might put one at risk for use, and developing strategies for coping with cravings and avoiding those high-risk situations." The Matrix Model is an example of an integrated therapeutic approach that incorporates CBT techniques and has been empirically shown to be effective for the treatment of stimulant use.
- **Relapse Prevention -** According to SAMHSA's *National Registry of Evidence-Based Programs and Practices*, relapse prevention is "a behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment. Coping skills training strategies include both cognitive and behavioral techniques. Cognitive techniques provide patients with ways to reframe the habit change process as a learning experience with errors and setbacks expected as

SUD providers are at a minimum expected to implement the two evidence-based psychosocial interventions of Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT).

mastery develops. Behavioral techniques include the use of lifestyle modifications such as meditation, exercise, and spiritual practices to strengthen a patient's overall coping capacity."

- **Trauma-Informed Treatment -** According to SAMHSA's concept of a trauma-informed approach, "a program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in patients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization." Seeking Safety is an example of an evidence-based trauma-informed practice.
- **Psychoeducation -** Psychoeducational interventions educate patients about substance abuse and related behaviors and consequences. The information provided may be broad, but are intended to lead to specific objectives. Psychoeducation about substance abuse is designed to have a direct application to patients' lives, to instill self-awareness, suggest options for growth and change, identify community resources that can assist patients in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

Elements of these psychosocial interventions may be used in any type of service setting and need to be performed by trained providers within their scope of practice. Fidelity to these evidence-based models is critical. Of note, the descriptions of the evidence-based psychosocial interventions above are simply summaries and providers are encouraged to refer to other available resources and manuals for more detailed guidance as to the effective clinical application of these approaches. Implementation of these EBPs will be a contract requirement and monitored through the contract compliance monitoring process. Corrective action ranging from technical assistance to disallowance will occur depending on the nature of the deficiency, frequency and/or severity of the findings.

Medication-Assisted Treatments (MAT)

According to research, a combination of medications and behavioral therapies is more successful than either intervention alone. Subsequently, medication-assisted treatments (MAT) need to be part of a comprehensive, whole-person approach to the treatment of substance use disorders.

Research has shown that for the treatment of addiction, a combination of medications and behavioral therapies is more successful than either intervention alone. Subsequently, medication-assisted treatments (MAT) need to be part of a comprehensive, whole-person approach to the treatment of SUDs that includes psychosocial interventions such as counseling, behavioral therapies, case management, and care coordination. The passive or active discouragement of the use of addiction medications that have been approved by the U.S. Food and Drug Administration (FDA) is contrary to the science of effective SUD treatment.

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

Patients receiving MAT must receive a minimum of 50 minutes of counseling sessions with a therapist or counselor, not to exceed 200 minutes per calendar month, although additional services may be provided based on medical necessity. All prescribed MAT should be consistent with generally accepted standards of medical practice and best practice guidelines for the condition being treated.

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 efficacy and progress to inform treatment decisions. The frequency of drug testing should be based on the patient'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.

There are currently several FDA-approved medications for the treatment of various types of addiction in adults:

- Opioid Use Disorder
    - Methadone
    - Buprenorphine
    - Naltrexone (oral and long-acting injectable formulation)
        - In addition to the above medications for opioid use disorder treatment, Naloxone is an FDA-approved medication used to prevent opioid overdose deaths.
- Alcohol Use Disorder
    - Naltrexone (oral and long-acting injectable formulation)
    - Disulfiram
    - Acamprosate
- Tobacco Use Disorder
    - Varenicline
    - Bupropion
    - Nicotine replacement therapy

With the exception of methadone and buprenorphine, which can be prescribed in youth age 16 and above if specific criteria are met and if they are under the treatment of a licensed prescriber, MAT is currently only FDA-approved for those over the age of 18. Current and emerging knowledge is that the routine use of MAT for adolescents is premature and requires further study. Other pharmacotherapies are used off-label for the treatment of addiction in adults and adolescents, but should be used cautiously and only on a case-by-case basis when deemed clinically appropriate by a licensed prescriber. The use and dosages of MAT should also be carefully considered in the treatment of elderly and adolescent populations, who oftentimes require unique treatment approaches given variable body composition and metabolism.

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

Physician Consultation

Consultations with addiction-trained physicians ensure that SUD providers have access to clinical and medical information that can be used to improve care and services for addiction. These consultations will occur either telephonically or electronically, via the DPH-SAPC website or Electronic Health Record (EHR), and will not occur in real-time. Physician consultations may involve questions about medication-assisted treatments, dosage recommendations, the management of unusual or difficult cases, and level of care recommendations. Based on the best judgment of the treating providers, urgent and emergent clinical issues and questions need to be directed to appropriate emergency personnel.

Physician consultation requirements include:
- Non-urgent in nature
- Physicians practicing within the network of SAPC providers

The physician consultation service is available to Drug Medi-Cal (DMC) physicians, and is not available to non-physicians or non-DMC physicians at this time. SAPC will continue to explore opportunities to expand this service, according to community need.

Culturally Appropriate Services

Culturally competent care is critical in providing high quality SUD services. Research indicates that lack of cultural competency in the design and delivery of services can result in poor outcomes in areas such as access, engagement, receptivity to treatment, help-seeking behaviors, treatment goals, and family response.

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

Providing developmentally, culturally, and linguistically appropriate services is critical to quality care. Lack of cultural competency in the design and delivery of services can result in poor outcomes.

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

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

Co-Occurring Disorder Population

For the purposes of this document, co-occurring disorders (COD) are defined as when an individual has a combination of any SUD or any mental health condition. The COD must meet the diagnostic criteria independently from the other condition and cannot simply be a cluster of symptoms resulting from a single disorder. The significant co-morbidity of 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 the process of ensuring that treatment interventions for COD are combined within a primary treatment relationship or service setting. Research has generally supported that the ideal approach toward treatment for CODs is to address all conditions simultaneously, as opposed to addressing the SUD and mental health condition separately and in a silo of separate treatment approaches. When providers have staff who possess the skills and training to adequately address the needs of the COD population within their scope of practice, integrated care is best provided in-house. However, if providers are unable to provide necessary services to this population, patients with CODs should receive appropriate referrals to providers who are able to deliver these necessary services.

As opposed to addressing health conditions separately and in silos, the ideal approach to treating co-occurring disorders is to address all conditions simultaneously.

According to SAMHSA's Treatment Improvement Protocol (TIP) series titled "Substance Abuse Treatment for Persons with Co-Occurring Disorders," consensus panel members recommend the following guiding principles in the treatment of patients 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 patients 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 patient engagement in continuing treatment.
- **Plan for the patient's cognitive and functional impairments –** Patients with 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 need and functional level of COD patients.
- **Use support systems to maintain and extend treatment effectiveness –** Given that many COD patients have strained support systems, and the central importance of supportive people and environments in the recovery process, a vital element of effective treatment of the COD population is ensuring that patients are aware of available support systems and motivated to use them effectively.

Comprehensive screening and assessments that are multidimensional in nature, combined with accurate diagnostic impressions, form the foundation of high quality integrated services. These elements are discussed in greater detail elsewhere in this document and require a strong therapeutic alliance between counselor/clinician and patient to allow for open and accurate communication. An important component of being able to develop a therapeutic alliance with the COD patient is the counselor or clinician's own comfort level in working with the patient. Some SUD counselors/clinicians may find some patients with significant mental health conditions threatening or unsettling, and likewise, some mental health clinicians may feel uncomfortable or intimidated by patients with SUDs. As a result, it is critical for the counselor/clinician to recognize these feelings so that they can develop strategies to avoid allowing them to interfere with the treatment of the COD patient. Oftentimes, these reactions can eventually be overcome with further experience, training, supervision and consultation with a supervisor or peer, and mentoring.

While SUD counselors and staff are not expected to diagnose mental health disorders, it is important that they familiarize themselves with the terminology, criteria, and how to identify if there may be mental health concerns that may benefit from referral to other health providers. In order to meet the needs of this population, SUD counselors and clinicians need to receive training designed to help them better understand the signs and symptoms of mental disorders and how and when to access medical or mental health support.

Appropriate staffing is a key element of effectively addressing the needs of the COD population. An organizational commitment to professional development, skills acquisition, values clarification, and competency attainment is necessary to implement integrated care programs successfully and to maintain a motivated and effective staff. Ideally, enhanced staffing for COD patients at SUD treatment sites would include mental health professionals, and vice versa at mental health treatment sites.

Psychosocial interventions that have been demonstrated to be effective for the COD population include motivational enhancement, contingency management, relapse prevention, and cognitive–behavioral techniques. These strategies need to be tailored to the patient's unique stage of recovery and can be helpful even for patients whose mental disorder is severe. For patients with functional and cognitive deficits in areas such as understanding instructions, repetition and skill-building strategies can aid progress. Finally, 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. In general, the ability to balance the need for empathy and support, and the need to be firm, is essential in maintaining the therapeutic alliance with a patient who has a COD. A straightforward and factual presentation of conflicting material or of problematic behavior in an inquisitive and caring manner can be both "confrontational" and caring at the same time.

The use of appropriate psychotropic medications and medication-assisted treatments for addiction are an essential component of the treatment of individuals with a COD. Oftentimes the appropriate use of medications can help COD patients stabilize and control their symptoms so that they can better focus on their recovery for either their substance use or mental health conditions. Research had clearly demonstrated that medications used in conjunction with psychosocial interventions for both SUDs and mental illness is preferable and leads to better outcomes than either intervention alone. An important component of the treatment of COD patients is thus ensuring a recovery environment that is supportive of the various and individualized paths to recovery that many patients with CODs take. This includes ensuring that staff is receptive to the use of medications for both substance use and mental health

conditions when determined to be necessary and appropriate by counselors and clinicians practicing within their scope of practice.

In summary, the treatment of COD patients requires a comprehensive and flexible treatment approach, in addition to coordination with other systems of care.

Perinatal (Pregnant and Postpartum) Patients

Substance use during pregnancy can result in significant maternal, fetal, and neonatal morbidity. However, research indicates that targeted interventions to pregnant women with SUDs increases the incidence of prenatal visits, improves birth outcomes, and lowers overall health care costs for both mother and baby. The unique needs of pregnant and postpartum women must be considered in the provision of services for this special population.

There is widespread agreement that treatment for pregnant and postpartum women is more effective when the services provided are wide-ranging. Care for this population needs to be interdisciplinary, comprehensive, evidence-based, and coordinated in order to best address issues related to prenatal, perinatal, and postpartum mental and physical health concerns. Psychosocial and practical issues need to be considered as well, as transportation and childcare are common barriers to treatment in this population.

Motivational therapies are critical to the engagement and recovery process. While there is overlap between treatment approaches for the general population and pregnant/postpartum patients, ideal therapies for this special population incorporate treatment elements that are unique to this group, such as promoting bonding with the expected child, reproductive counseling, and targeted case management and care coordination to address the material and physical/mental health needs that accompany pregnancy. The initial assessment, treatment plan, and reassessments of progress need to take into account the varied needs related to the health and well-being of both woman and fetus/infant.

Ideal therapies for pregnant/postpartum patients incorporate treatment elements that are unique to this group, such as promoting bonding with the expected child or infant, reproductive counseling, and targeted case management and care coordination to address the material and physical/mental health needs that accompany pregnancy.

Federal priority guidelines for SUD treatment admission give preference to pregnant and/or female substance and injection drug users. However, a specific level of care is not prescribed and thus the appropriate setting and level of care for this population needs 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 safety and support during this period. Level of care determinations need to be based on individualized and multidimensional ASAM assessments, and may lead to placement recommendations in the residential or outpatient setting, depending on clinical need.

Staff working in settings that provide services for pregnant and postpartum patients need to be trained in proper procedures for accessing medical services related to prenatal care, labor and delivery, and therapeutic responses to the varied positive and negative outcomes of pregnancy. Services need to be provided in a non-judgmental, supportive, and open environment.

The use of medication-assisted treatments during pregnancy needs to include careful and individualized consideration of the potential impact of both treatment and lack of treatment on mother and baby. Though there is some risk in using medications during pregnancy, there is also known risk in the inadequate treatment of addiction during pregnancy, and this needs to be considered and discussed with patients. For pregnant women with opioid use disorders, medication-assisted treatments such as methadone and buprenorphine are the standard of care. In these instances, informed consent needs to be obtained, including discussions regarding Neonatal Abstinence Syndrome and what to expect at delivery. Opioid detoxification should also be reserved for selected women because of the high risk and potential consequences of relapse on both mother and baby. The risks and benefits of breastfeeding while patients are receiving medication-assisted treatments need to be weighed on an individual basis. Methadone and buprenorphine maintenance therapy are not contraindications to breastfeeding.

Given that women may be at increased risk of resuming substance use following delivery, treatment should not end with delivery. Post-delivery treatment services include, but are not limited to: support for parenting a newborn, education about breast feeding, integration with other children and family members, case management 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.

Adolescent Patients

Adolescence represents an opportunity to influence risk factors that are still dynamic and not yet entrenched in their influence on development and addiction. Adolescent SUD treatment needs to be approached differently than adults because of differences in their stages of psychological, emotional, cognitive, physical, social, and moral development. Examples of these developmental issues include their relative immature independent living skills, the powerful influence of interactions between adolescent and family/peers, and the fact that a certain degree of limit-testing is a normal feature of adolescence.

Generally, optimal treatment of the adolescent population requires greater amounts of external assistance and support compared to adults, and more intensive treatment and/or higher levels of care for a given degree of severity or functional impairment, when compared with adults.

For youth, casual substance use can quickly escalate to highly problematic abuse, which highlights the importance of early invention in this population.

Although most adolescents 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, adolescents may be more susceptible to the functional impact of SUDs. For youth, casual substance use can quickly escalate to highly problematic abuse. Subsequently, adolescents often exhibit higher rates of co-occurring disorders, such as anxiety and depression, because of the negative impact that substance use has on normal adolescent social and psychological development.

These unique characteristics of the adolescent population are reflected in both clinical practices as well as in the ASAM Criteria, as adolescents tend to require more intensive levels of care than their adult counterparts. As a result, the patient-to-counselor ratio for adolescent cases is ideally less than the ratio for adult cases to accommodate for this increased treatment intensity.

Due to the rapid progression of adolescent substance use, particular attention must be paid to streamlining the treatment admission process so that adolescent SUD needs are identified and addressed as soon as possible. Strategies to engage adolescents, hold their attention, channel their energy, and retain them in treatment are especially critical. Adolescent treatment needs to also address their increased rates of co-occurring disorders, highlighting the need to coordinate care with the mental health system, as clinically indicated.

Treatment planning needs to begin with a comprehensive assessment based on the ASAM Criteria. The assessment includes all the dimensions and biopsychosocial components of the complete adult assessment, the nuances of the adolescent experience, and their unique needs and developmental issues. Strengths and weaknesses need to be identified and adolescents need to be involved in setting their treatment objectives. Comprehensive adolescent assessments include information obtained from family, and when the appropriate releases are obtained, members of the community who are important to the adolescent patient, such as school counselors, peers, and mentors. The support of family members is important for an adolescent'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 of the adolescent population, every effort needs to be made to support the adolescent's larger life needs in order to maximize the likelihood of treatment success, for example by having flexible weekend and evening hours to accommodate continued engagement with school and appropriate social activities. These larger life issues may be related to 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. Failing to address such needs simultaneously could sabotage the adolescent's treatment success.

Behavioral therapies, delivered by trained counselors and clinicians practicing within their scope of practice, need to be employed to help adolescent patients 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 craving, replace drug use with constructive and rewarding activities, improve problem-solving skills, and facilitate better interpersonal relationships.

The use of medication-assisted treatments for adolescents is promising, but the current and emerging knowledge is that the routine use of MAT for adolescents is premature and requires further study. With the exception of methadone and buprenorphine, which can be prescribed in youth age 16 and above if specific criteria are met and if they are under the treatment of a licensed prescriber, there are currently no FDA-approved medications for the treatment of addictions in adolescents. As a result, the use of MAT for adolescents should be considered and used cautiously and only on a case-by-case basis when deemed clinically appropriate by a licensed prescriber. While most adolescents do not develop classic physical dependence or well-defined withdrawal symptoms as a result of shorter durations of substance use compared with adults, youth opioid addiction is an exception that at times may require MAT when clinically indicated, particularly for severe withdrawal symptoms.

The ASAM level of care criteria for adolescents are distinct from that of adults, and are tailored to the particular needs of this population. In general, the ASAM Criteria tends to place adolescents in more intensive levels of care than their adult counterparts.

Treatment services for adolescents occur in a setting that is clinically appropriate and comfortable for this population. The adolescent treatment environment should be physically separate from that of adult patients. Staff also need to be familiar and appropriately trained to address the developmental nuances of caring for this unique population.

Similar to other groups, treatment of the adolescent 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.

Adolescent patients should be referred to a qualified adolescent/youth outpatient treatment agency where they will receive a full assessment and referral to an appropriate LOC as necessary. If the individual initially presents at a 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 beneficiaries will be referred to, and/or served by, a DMC certified agency for DMC reimbursable services

Young Adult

In this document, the term "young adult" refers to individuals between the ages of 18 – 25 and represents young people transitioning into adulthood, some of whom may have received services from the adolescent service system and may need continued services and supports from the adult system. Clinically, age range definitions should be viewed flexibly given the variable nature of chronological age and developmental maturity. This population presents unique service challenges because they are often too old for youth services, but may not be ready for adult services. Young adults are simultaneously emerging into independence while still relying on the support of parents and caregivers. The mixture of adolescent and adult characteristics in the young adult population often requires a specialized approach due to issues of confidentiality, financial support, and shared living environments, among others.

In general, the treatment needs of young adults will be more intensive than the typical adult, but less than the typical adolescent. This will require a blending of programs that currently exist for adolescents and adults, and ideally would occur within programs with specific expertise in treating this population. The approach toward caring for young adults needs to include a flexible mixture of treatment techniques depending on prior contacts with the treatment system and the unique needs of each clinical case. For young adults who have previously been served in the youth system of care for their substance use and other health needs, every effort need to be made to coordinate care with their prior providers to determine the best treatment approach. Prior response to interventions should inform and guide future interventions, with the understanding that the approach toward treatment would be dynamic as young adults transition into adulthood.

The treatment needs of young adults will generally be more intensive than the typical adult, but less intensive than the typical adolescent.

Multidimensional assessments include determinations of the developmental stage of young adult populations to help inform treatment approaches and whether care modeled after adolescent approaches or adult approaches may be more appropriate. Strengths and weaknesses need to be identified and young adults need to be involved in treatment planning. When the appropriate

authorizations are obtained, family should be involved in the information gathering and treatment process, when family involvement is clinically appropriate and determined to be beneficial.

Similar to youth, young adults typically have various life needs beyond their substance use treatment, and every effort need to be made to support these needs to increase the likelihood of positive outcomes. These larger life issues may be related to 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.

Behavioral therapies and medication-assisted treatment, delivered by trained counselors and clinicians practicing within their scope of practice, should be employed depending on clinical need. As discussed in the Medication-Assisted Treatment section of this document, there are various medications used for addictions that have been FDA-approved for individuals over the age of 18 (and some over the age of 16), and need to be a treatment option available to young adults in conjunction with psychosocial interventions and as a component of a multifaceted treatment approach. Effective psychosocial interventions may provide incentives for abstinence, enhance motivation for change and recovery, build skills to resist and refuse substances and deal with triggers or craving, replace drug use with constructive and rewarding activities, improve problem-solving skills, and facilitate better interpersonal relationships.

Ideally, staff working with the young adult population would be familiar with and interested in working with the unique needs of this population. They should have experience in treating both the adolescent and adult populations in order to best blend necessary treatment approaches.

While the ASAM Criteria does not specifically explore the specialized considerations of young adults, the ASAM Criteria does note that an intermediate stage between adolescence and adulthood may become standard in the future, with accompanying treatment approaches that are individualized to address the unique assets, vulnerabilities, and needs of this group.

Older Adults

Given the chronic nature of substance use disorders and the expanding population of older adults, it is increasingly important to modify treatment approaches to the unique needs of this population. In general, older adults include individuals over the age of 65, but this definition should be individualized based on clinical need. For example, some individuals younger than age 65 may have cognitive deficits, medical conditions, or social situations that necessitate the utilization of treatment approaches that are more typical for individuals of more advanced age.

Health care providers sometimes overlook substance use in the older adult population over the age of 65, mistaking symptoms and indications of substance use for dementia, depression, or other problems common to this population.

Key differences between older and younger populations necessitate different approaches toward treatment. Due to altered metabolism and brain function, and the medical conditions that often accompany advanced age, the quantity and frequency of substance use in older adults may underestimate the functional impact in this population and create diagnostic challenges. In addition to the fact that many older adults are retired, limiting the sensitivity of using work or social impairment as a diagnostic indicator, a smaller amount of alcohol or substances may impact older adults more severely than younger counterparts. Health care providers also sometimes overlook substance use in this population, mistaking symptoms and indications of substance

use for dementia, depression, or other problems common to older adults. Social isolation, lack of transportation, and heightened levels of shame and guilt in this group may make accessing services for the older adult population more difficult than other age groups. As a result older adults may be more likely to attempt to hide their substance use and less likely to seek professional help. Older adults are also more likely to be primary caregivers for a spouse who has greater needs than their own, which may limit their willingness to enter into treatment due to their caregiving responsibilities.

Research has demonstrated that age-specific assessment and treatment is associated with improved outcomes when compared with mixed-aged treatment. Assessments need to be age-specific and multidimensional, given the various physical and mental health needs, as well as social needs, of the older adult population. The treatment of older adults needs to be paced to the individual's physical and cognitive capabilities and limitations. The schedule of programs and expectations, and the overall timeframe for clinical progression and change is typically slower for older adults than other age groups. As such, treatment programs should be realistically designed to accommodate these anticipated differences.

Studies have generally indicated that cognitive-behavioral techniques are effective for older populations, particularly those that address negative emotional states that pose significant risk for relapse (e.g., self-management approaches for overcoming depression, grief, or loneliness). In general, confrontational therapy in this population has been shown to be less effective than in other age groups and should be avoided. Educational treatment approaches should be geared toward the specific needs of older adults (e.g., coping strategies for dealing with loneliness, general problem-solving). Older adults may absorb presented information better if they are given a clear statement of the goal and purpose of the session and an outline of the content to be covered. Repetition of educational information may also be helpful (e.g., simultaneous visual and audio).

Given that social isolation is a common problem in this population, group therapies and skill building around establishing social support networks are often beneficial, in addition to family therapy. According to SAMHSA's Treatment Improvement Protocol (TIP) series titled "Substance Abuse Among Older Adults," consensus panel members recommend limiting involvement of family members or close associates to one or two members to avoid overwhelming or confusing older adults. Panel members also suggest that the involvement of grandchildren may lead to obstacles for open communication, as older adults may at times resent their problems being aired in the presence of younger relatives.

Medications used in older populations should be used with caution due to the physiological changes that occur with advanced age. Dosages of medications may need to be lowered, particularly if co-morbid medical conditions are involved. In cases where medications are used for withdrawal management, dosages for older populations should often be one-third to one-half the usual adult dosage. Concerns or questions regarding the safe use of medications in the older adult populations need to be directed toward appropriately trained medical professionals.

Staff working with older adults should ideally have training in aging and geriatric issues. Staff should also have an interest in working with this population and the skills required to provide age-specific services for individuals of more advanced age. The best results are typically achieved when staff is experienced in dealing with the physical, psychological, social, and spiritual issues unique to older adults. Staff who interacts with older patients need to receive regular trainings on empirically demonstrated principles and techniques effective for older populations.

In general, panelists from SAMHSA recommend the following treatment approaches for the older adult population:

- Treat older people in age-specific settings, where feasible, ensuring appropriate pace and content of treatment.
- Create a culture of respect for older patients. Follow treatment approaches that are supportive, non-confrontational, and aim to build self-esteem.
- Take a broad, flexible, holistic approach to treatment that emphasizes age- and gender-specific psychological, social, and health problems. These approaches need to include building social support networks and coping skills dealing with depression, loneliness, and loss.
- Staff working with older adults need to be interested and experienced in working with this population.

Patients Involved with the Criminal Justice System

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

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

Staff working with criminal justice populations need to be specifically trained in working with criminogenic risk, need, and responsivity (RNR), as well as SUDs and CODs. Staff also need to be capable of integrating identified treatment goals with the goals of the involved agencies. As a result, it is critical for treatment providers to have a strong working relationship with probation and parole officers, judges, the court, and other legal entities involved in the patient's care.

The first step in providing SUD treatment to people under criminal justice supervision is to identify offenders in need of treatment. Comprehensive assessments incorporate issues relevant to criminal justice involved individuals, such as assessment of criminogenic RNR, anger management, impulse control, values and behaviors, family structure and functioning, criminal lifestyle, and antisocial peer relationships. Assessments also pay particular attention to CODs, developmental and cognitive disorders, and traumatic brain injury.

Criminal justice patients from cultural minority groups may have unique cultural needs. For example, women offenders are more likely to have been traumatized by physical and sexual abuse and to have concerns about their children, and many offenders have co-occurring substance use and mental health conditions that can complicate treatment.

In general, clinical approaches and the use of medication-assisted treatments need to parallel those used with individuals who are not involved with the criminal justice system, and a qualified

counselor/clinician should determine the appropriate level of placement and interventions rather than court/probation requirements. Treatment interventions need to be based on a multidimensional assessment and individualized needs. However, working with the criminal justice population does have unique requirements that necessitate modified treatment approaches in order to meet their specific needs. Additionally, it is essential to collaborate with correctional staff to ensure that the treatment goals align with correctional and supervision case planning and/or release conditions (particularly involving the prescription of certain MAT).

For example, offenders from cultural minority groups may have unique cultural needs, women offenders are more likely to have been traumatized by physical and sexual abuse and to have concerns about their children, and many offenders have co-occurring substance use and mental health conditions that can complicate treatment. Strategies to engage offender populations are especially critical. Criminal justice patients often have problems dealing with anger and hostility, and experience the stigma of being criminals, along with accompanying guilt and shame. Other groups with specific needs include older adults, violent offenders, people with disabilities, and sex offenders.

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

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

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

Homeless Population

Homelessness is an issue that impacts many individuals with SUDs as a result of the socioeconomic decline that oftentimes accompanies addictions. Conservative estimates of the prevalence of substance use among homeless individuals are approximately 20 – 35%. Although homeless patients typically require more intense treatment and have greater and more varied needs than housed individuals, homeless patients pose significant challenges to the SUD treatment community because of the various structural, interpersonal, and biopsychosocial barriers they face in accessing care. Some of these obstacles include social isolation, distrust of authorities, lack of mobility and/or transportation, and multiplicity of needs.

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

On the whole, research demonstrates that effective programs for homeless patients address their substance use as well as their tangible needs (e.g., housing, employment, food, clothing, finances); are flexible and non-demanding; target the specific needs of subpopulations, such as gender, age, or diagnoses (e.g., COD/TAY/older adult populations); and provide longer-term, continuous interventions. As a result of these diverse needs, effective treatment for homeless patients must involve various disciplines and collaboration across agencies and organizations.

Services that link patients to secure housing early in treatment tend to produce better outcomes, emphasizing the importance of case management in order to meet the varied needs of homeless patients.

Stable housing is often critical to attaining treatment goals, and is an important component of necessary services. Services that link patients to secure housing early in treatment tend to produce better outcomes, emphasizing the importance of case management in order to meet the varied needs of homeless patients.

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

Successful counselors and clinicians who work with homeless patients tend to have a particular interest and comfort level in working with this challenging and rewarding population. Staff need to be experienced with the various aspects of care involved in working with homeless patients, and need to be familiar with the resources available in the community so that appropriate referrals and linkages can be made in order to best address the varied needs of patients. Ideally, care teams work collaboratively and include interdisciplinary staff comprised of medical, mental health, substance use, and social service providers.

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

Lesbian, Gay, Bisexual, Transgender, Questioning Population

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

Substance use disorder providers need to carefully explore the individual situation and experiences of their patients, particularly in the LGBTQ (lesbian, gay, bisexual, transgender, questioning) population. Failing to do so may result in poor outcomes due to their unique circumstances and needs.

Although there are various protections in place that are intended to shield recovering substance abusers from many forms of discrimination, LGBTQ individuals are oftentimes not afforded the same protections. As a result of homophobia and/or heterosexism, some may find it difficult or uncomfortable to access treatment services and be afraid to speak openly about their sexual orientation or identity. Many LGBTQ patients may also internalize the effects of society's negative attitudes, which can result in feelings of sadness, doubt, confusion, and fear. Problems in traditional health care systems may lead to distrust of health care professionals, requiring extra sensitivity from SUD providers.

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

As with any patient, 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 patients in accessing appropriate care for their physical and mental health concerns.

The methods of best practice outlined in the counseling competency model apply to all populations, particularly in working with LGBTQ patients. In this model, a counselor respects the patient's frame of reference; recognize the importance of cooperation and collaboration with the patient; maintain professional objectivity; recognize the need for flexibility and be willing to adjust strategies in accordance with patient characteristics; appreciate the role and power of a counselor as a group facilitator; appreciate the appropriate use of content and process therapeutic interventions; and be non-judgmental and respectfully accepting of the patient's cultural, behavioral, and value differences.

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

Family dynamics are also important in working with LGBTQ individuals and SUD providers need to be aware that family therapy may be difficult because of alienation owing to the patient's sexual identity. However, inclusion of family in the treatment process may also result in more positive outcomes. Given common concerns regarding living environments (in terms of recovery and safety), social isolation, employment and finances, and ongoing issues related to sexual orientation or identity, particular attention needs to be paid to discharge planning in the LGBTQ population.

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

Because each patient brings his or her unique history and background into treatment, furthering our understanding of individuals different from ourselves helps to ensure that patients are treated with respect and improve the likelihood of positive outcomes. At times, SUD treatment staff may be uninformed or insensitive to LGBTQ issues, may have preconceived biases toward LGBTQ patients, or may falsely believe that sexual identity causes substance abuse or can be changed by therapy. In these cases, providers need to be aware of these beliefs in order to prevent them from becoming barriers to effective treatment of the LGBTQ patient. A substance abuse treatment program's commitment to promote sensitive care for LGBTQ patients can be included in its mission statement and administrative policies and procedures. Providing staff training and education are oftentimes valuable and include sexual orientation sensitivity training to promote better understanding of LGBTQ issues, LGBTQ -specific training, and educational programs 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 patients feel comfortable and safe while they start their recovery journey.

Veterans

According to U.S. Census estimates, there are over 330,000 veterans who live in Los Angeles County. Although veterans share commonalities, their experiences are as varied and unique as their needs. Some veterans may have experienced combat in one or more wars, while others may have served in non-combat roles. Likewise, some veterans may have experienced injury, including traumatic brain injuries (TBI), loss of limb, or other physical injury, while others may have emotional scars. In particular,

gender may also influence veteran experiences, as reports of women veterans who have experienced sexual harassment and/or physical and sexual trauma are becoming more common. As a result of the cumulative effects of these events and experiences, veterans and family members may develop SUDs and present to treatment with a unique set of needs and circumstances that must be addressed. Under certain circumstances, veterans may be ineligible for Veteran's Administration (VA) benefits due to a dishonorable discharge or discharge "under other than honorable conditions," among other circumstances. Additionally, some veterans and family members may attempt to secure services from SUD treatment programs due to the long wait times at the VA. Regardless of the situation, SUD treatment providers should work to ensure that the services provided address the varied and unique needs of individuals.

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

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

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

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

Levels of Care Guidelines

Addiction treatment is delivered across a continuum of services that reflect illness severity and the intensity of services required. One of the key goals of the SAPC is to facilitate SUD service delivery in Los Angeles County that is the right service, at the right time, for the right duration, in the right setting. While the levels of care are presented as discrete hierarchies, they need to be viewed as points along a continuum of treatment services, each of which may be provided in a variety of settings.

Referral to a specific level of care must be based on a comprehensive and individualized assessment of the patient, with the primary goal of placing the patient at the most appropriate level of care. Initial

referrals may be accomplished through a brief screening tool with a more comprehensive assessment completed at the treatment program to confirm placement. In Los Angeles County, level of care determinations are based off of the ASAM Criteria, which helps to organize the assessment and clinical formulation in a manner that provides more structure and consistency in level of care determinations. In general, the preferable and most appropriate level of care is one that is the least intensive while still safely meeting the unique treatment objectives of the patient and treatment team.

Level of care determinations begin with the ASAM multidimensional assessment in order to explore patient risks, needs, strengths, skills, and resources. Dimension-specific risk ratings are generated from the assessment process and are used to help inform providers as to dimensional priorities, which are subsequently used for service planning and placement. When physical or mental health conditions are apparent, the need for immediate stabilization should be prioritized and the highest severity problem should determine the patient's entry point into the treatment continuum, whether it is within the SUD system of care (including Opioid Treatment Programs), or in the physical or mental health systems. Placement within the levels of care is best conceptualized as a flexible continuum, marked by the ASAM's five broad levels of service, each with gradations of service intensities (see Table 8 below).

Opioid Treatment Programs (OTPs; aka: Narcotic Treatment Programs) are an essential component of the continuum of care for substance use disorders. As is the expectation with other levels of SUD care, ensuring a flow of appropriate referrals between OTPs and other SUD providers, the provision of necessary services such as case management, and appropriate referrals into other health systems (if needed) are all critical to high quality OTP services. As such, the quality and resource management standards and requirements set within the QI/UM program pertain to OTPs as well, in addition to the various State and Federal requirements that also govern the delivery of care in this setting.

Table 8.

ASAM Continuum of Care	
Level of Care	**Level**
Early Intervention	0.5
Outpatient Services	1
Intensive Outpatient / Partial Hospitalization Services	2
- Intensive Outpatient Services	2.1
- Partial Hospitalization Services	2.5
Residential / Inpatient Services	3
- Clinically Managed Low-Intensity Residential Services	3.1
- Clinically Managed Population-Specific High-Intensity Residential Services *Does not pertain to adolescent populations	3.3
- Clinically Managed High-Intensity Residential Services	3.5
- Medically Monitored Intensive Inpatient Services	3.7
Medically Managed Intensive Inpatient Services	4
Opioid Treatment Program (aka: Narcotic Treatment Program)	OTP

The ASAM Criteria also outlines a continuum of five levels of withdrawal management (also known as detoxification) for adults (see Table 9 below). Given that severe withdrawal is less common in adolescents than in adults, the approach to withdrawal management for adolescents is unique. When adolescent physiologic withdrawal is evident and when the clinical scenario does not require emergent care, a more integrated approach is ideal and every effort should be made to provide withdrawal

management services in the setting in which adolescent patients are receiving their SUD care. Withdrawal management for adolescent populations will be handled on a case-by-case basis.

Table 9.

ASAM Continuum of Care- Withdrawal Management (ADULT)	
Withdrawal Management- Level of Care	**Level**
Ambulatory Withdrawal Management without Extended On-Site Monitoring	1-WM
Ambulatory Withdrawal Management with Extended On-Site Monitoring	2-WM
Clinically Managed Residential Withdrawal Management	3.2-WM
Medically Monitored Inpatient Withdrawal Management	3.7-WM
Medically Managed Intensive Inpatient Withdrawal Management	4-WM

A detailed description of ASAM level of care guidelines is beyond the scope of this document. Providers are encouraged to refer to The ASAM Criteria textbook or other helpful resources for additional information. Similarly, providers should refer to the contractual requirements of each level of care to ensure compliance with all federal, state, and local mandates. Level of care transitions should follow the relevant pre-authorization and authorization protocols established in the UM program.

Services provided at the various levels of care should reflect the patient's clinical condition, including consideration for severity level and functional impairment. Interventions may include, but are not limited to: individual counseling, group counseling, family therapy, patient education, psychosocial interventions, medication-assisted treatments, collateral services, care coordination, case management, crisis intervention, treatment planning, recovery support services (recovery monitoring/coaching, educational and vocational support, housing assistance, transportation services, peer and family support, spiritual support, etc.), and discharge services.

As patients transition between levels of service, progress in all six dimensions should be formally assessed at regular intervals, in accordance with the patient's severity level and functional impairment, as clinically indicated. These assessments help to ensure that patients are placed in the appropriate level of care and must be based on medical necessity, which need to be performed by the Medical Director, licensed physician, or LPHAs. Level of care transitions need to be based on clinical need, as opposed to funding source or programmatic need.

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

In cases in which the recommended level of care is not available, which can occur due to a variety of reasons (lack of availability, funding limitations, resource constraints, etc.), the treatment plan needs to be revised in order to provide needed services in a different placement. Effectiveness and safety should be first priority in these circumstances, which may require that patients be placed in higher levels of care than the ASAM Criteria indicates. In these instances, it is the providers' responsibility to advocate

for the patient and justify and explain the rationale for the alternative level of care or intervention, based on the available clinical documentation.

Recovery Support Services

Recovery is a personal process that is built on an individual's strengths, coping abilities, resources, and inherent values. Recovery should be holistic, addressing the whole person within their community. It is characterized by continual growth and improvement in one's health and wellness that may involve setbacks which are a natural part of life. Resilience and the ability to cope with adversity and adapt to challenges or change are also key components of recovery. Resilience develops over time and gives an individual the capacity not only to cope with life's challenges, but also to be better prepared for the next stressful situation.

SAMHSA has outlined four major dimensions that support a life in recovery:

- **Health** - overcoming or managing one's disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and, for everyone in recovery, making informed, healthy choices that support physical and emotional well-being.
- **Home** - having a stable and safe place to live.
- **Purpose** - conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society.
- **Community** - having relationships and social networks that provide support, friendship, love, and hope.

Recovery support services (RSS) refer to services that foster health and resilience in individuals and families by helping them to navigate systems of care, and reduce barriers to employment, housing, education, and other life goals. They are developmentally, culturally, and linguistically appropriate, and facilitate securing necessary social supports, remaining engaged in the recovery process, and living full and healthy lives in communities of their choice. They incorporate a broad range of support and social services that facilitate recovery, wellness, and linkage to and coordination among service providers, with the greater goal of improving the quality of life for people in and seeking recovery.

Recovery support services (RSS) refer to non-clinical services that foster health and resilience in individuals and families by helping them to navigate systems of care, and reduce barriers to employment, housing, education, and other life goals.

These RSS may be provided by a number of individuals, including: substance use providers, physical and mental health providers, peer providers, family members, friends and social networks, and the faith community.

The ASAM Criteria's multidimensional assessment includes Dimension 6, which assesses the recovery environment of the individual and helps to identify specific recovery needs that should be supported by RSS. Substance use providers, physical and mental health providers, peer providers, family members, friends and social networks, and the faith community may provide recovery support services. They may be provided wherever patients obtain services and can occur during treatment or as aftercare. In accordance with the chronic disease model and the fact that recovery is often a lifelong journey rather than a final destination, SUD treatment should not end when the treatment episode ends. Similar to the manner in which patients frequently see their primary care provider for periodic health checkups even when healthy, RSS can be viewed as

continuity of care in SUD treatment. The frequency of RSS should be dependent on patient need, preference, and where an individual is in their stage of recovery.

Because of its individualized nature, RSS may include a number of different services and approaches:

- **Recovery Monitoring -** Recovery monitoring by recovery coaches and/or care navigators help individuals become and stay engaged in the recovery process and reduce the likelihood of relapse. These services can effectively extend the continuum of care beyond the clinical setting into the everyday environment of those seeking to achieve or sustain recovery. Utilizing a recovery management model, the recovery coach or care navigator functions as the primary and ongoing point of contact for patients in order to follow up with patients on a regular basis and monitor their recovery status. As needed, recovery coaches and care navigators may provide patients with linkages to educational and job skills, housing and transportation, self-help and support, and spiritual and faith-based supports, depending on the patient's preference. Recovery coaching and/or care navigation encounters may occur via in-person meetings telephone, text messages, and/or Internet.
- **Substance Abuse Assistance -** Peer-to-peer services and relapse prevention.
- **Education and Job Skills -** Linkages to life skills, employment services, job training, and education services.
- **Family Support -** Linkages to childcare, parent education, child development support services, and family/marriage education.
- **Support Groups -** Linkages to self-help and support, spiritual and faith-based support.
- **Ancillary Services -** Linkages to housing assistance, transportation, case management, individual services coordination.

Recovery residences are a broad term describing a safe, sober, and healthy living environment that promotes recovery from alcohol and other drug use. The purpose of a recovery residence is to provide a living environment conducive to initiating and sustaining recovery. There are many different types and variations of these settings with different levels of support, providing a spectrum of housing to best meet the unique and dynamic needs of individuals across the stages of recovery. The services provided at recovery residences vary, and include peer support, group and house meetings, self-help, life skills development, treatment services (excluding treatment services that require a DHCS residential license), among other recovery-oriented services. Recovery residences must meet all zoning, fire clearance and other local requirements.

Patients who no longer meet medical necessity criteria for SUD treatment services, or prematurely exit the SUD system of care, should receive recovery monitoring services for a minimum of 6 months by the last treatment provider of care, who will reengage the individual in treatment if needed. The frequency of recovery monitoring contacts should depend on the individualized recovery situations of patients. For example, patients who have just exited SUD treatment and those at higher risk for relapse should generally receive more recovery monitoring contacts than those who have been in sustained recovery.

Case Management/Care Coordination

Case management is a coordinated approach to the delivery of health and social services, linking patients with appropriate services to address specific needs and achieve stated goals. At its core, case

management should be comprised of several key functions: assessment, planning, linkage, monitoring, and advocacy.

Various members of the treatment team can function as the case manager, including registered/certified SUD counselors, social workers and Marriage and Family Therapists (MFTs), nurses, physicians, etc. Case management services may be provided face-to-face, by telephone, or by telehealth with the patient and may be provided anywhere in the community.

Research suggests two main reasons why case management is effective as an adjunct to substance abuse treatment: 1) retention in treatment is associated with better outcomes, and a principal goal of case management is to keep patients engaged in treatment and moving toward recovery; and 2) treatment may be more likely to succeed when a patient's other problems are addressed concurrently with substance abuse.

In order to link patients with services and resources (e.g., financial, medical, or community services), case managers must have a working knowledge of the appropriate services needed for the patient to optimize care through effective, relevant networks of support. Case managers provide assistance with accessing transportation, securing safe housing, and looking for potential employment and vocational training opportunities, particularly in geographic locations convenient for the patient. Skill development services help the patient learn how to budget, plan meals, practice hygiene and personal care, and perform housekeeping. Services provided through case management are thus tailored to facilitate continuity of care across all systems of care, and provide extensive assessment and documentation of the patient's progress toward self-management and autonomy.

Case managers must have a working knowledge of the appropriate services needed for the patient to optimize care through effective, relevant networks of support.

Although an important component of case management in the SUD population is linking patients to outside systems of care, such as physical and mental health systems, these services are equally important in navigating patients through the SUD system of care. Comprehensive substance abuse treatment often requires that patients move to different levels of care within the SUD continuum, and case managers helps to facilitate those transitions. When implemented to its fullest, case management enhances the scope of addiction treatment and the recovery continuum.

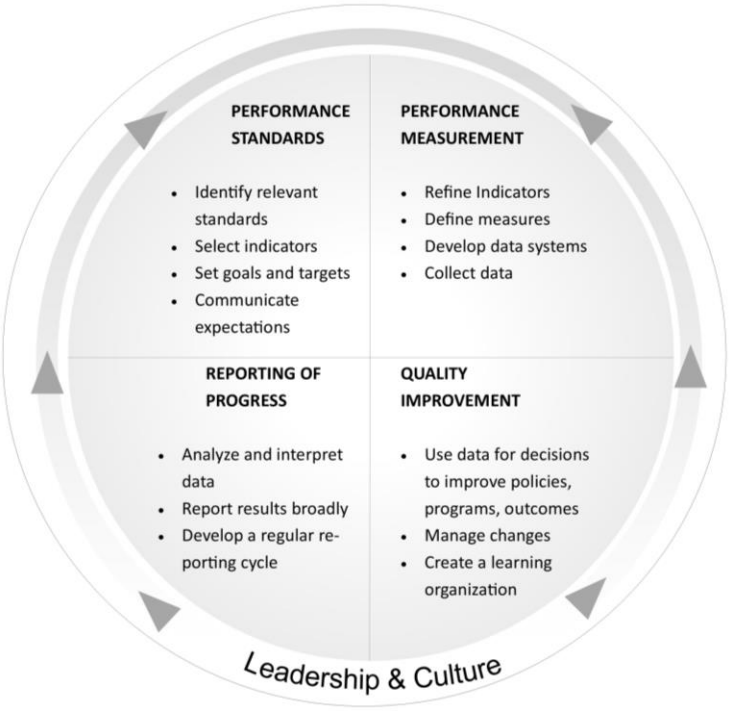
Guiding principles of comprehensive case management include:

- Comprehensive assessments and periodic reassessments of patients to determine service needs.
- Aiding in transitions in care, both within the SUD system of care and between physical and mental health systems.
- Using a patient-centered, collaborative approach to address the medical, psychosocial, behavioral, and spiritual needs of the patient, and improve treatment retention.
- Promoting advocacy, shared decision-making, and education by moving the individual to self-management and autonomy through community resources and linkages.
- Participating in communication, coordination, referral and related activities.
- Using culturally competent and evidence-based practices in the daily practice of case management.
- Promoting quality outcomes that measure and improve patient safety, satisfaction and other dimensions of optimal health and well-being.
- Maintaining and reinforcing compliance with federal, state, local rules and regulations.

Performance and Outcome Measures

Healthcare providers, including SUD providers, share the common goal of providing high quality care. Measuring performance and outcomes help organizations and providers understand how well they are accomplishing this goal and allows for an analysis of where and what changes need to be made in the process of striving for continual improvement. Providers are required by contract to have ongoing mechanisms for quality assessment and performance improvement. Metrics also allow providers to understand what is working well so that others can learn from their success. Assessing and evaluating performance and outcome measures is consistent with the Department of Public Health's Performance Management System (see Figure 3 below).

Figure 3. **Public Health Performance Management System**



Importantly, performance and outcome measurement differ as follows:

- Outcome measures are used at the patient level to examine changes in substance use behaviors and psychosocial functioning. 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, and 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 quality improvement strategies aimed at changing *clinical practices* and *organizational cost management*.

The process of striving for quality and continual improvement is dependent on the ability to measure performance and outcomes.

Although the SAPC recognizes that performance and outcome measurement in the field of addiction is challenging due to the nuances of clinical care that are not always reflected in the measures, and that consensus standards need to continue to improve, there is also a recognition of the important role that this will play in moving the field ahead. As a result, the SAPC has worked with UCLA and stakeholders to develop an inventory of measures that will be used as part of the Continuous Quality Improvement (CQI) process. The SUD Measure Inventory below (Table 10) includes a compilation of performance and outcome measures that are derived from national experts on quality improvement and performance measurement, such as the National Quality Forum, National Committee on Quality Assurance, The Washington Circle, and UCLA, among others.

The SUD Measure Inventory includes performance and outcome measures that highlight key areas of interest, such as prevention, detection, access, treatment, care continuity, integrated care, patient-centered care, medication-assisted treatment, functional improvement, and agency level metrics. To address patient perception of care (patient satisfaction), SAPC will use the Modular Survey developed by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment. The survey measures consumer perceptions of their experience during treatment in the area of access, quality, social connectedness, and commitment to change.

In addition to these more clinical measures, the SAPC has also worked with UCLA and stakeholders to develop a set of research measures that allow for the review of treatment data in order to identify areas that require additional study, training, or technical assistance. These research measures, in conjunction with the SUD Measure Inventory, help to ensure that Los Angeles County has an evaluation system that allows for continuous improvement and high quality clinical care at the provider and systems level.

The SAPC will work to automate the data collection process to the extent that is possible, but data entered by providers will continue to be critical to ensure high quality data. Given that this data will inform policy and ultimately impact clinical practice, ensuring data integrity is to the benefit of both the SAPC and contracted providers, and providers are expected to develop internal processes to support data integrity efforts.

The SAPC recognizes the importance of sharing performance and outcomes data with its provider network, and will make every effort to provide metrics to assist providers in their quality improvement efforts. The sharing of performance and outcomes data with providers will include patient satisfaction information and other meaningful issues that pertain to clinical care.

Given the continual evolution of the field of addiction treatment, the SUD Measure Inventory will evolve with the availability of new information and research, and is subject to ongoing review.

Table 10. Substance Use Disorder (SUD) Measure Inventory

ALCOHOL AND OTHER DRUGS (AOD)

Domain	Measure Title	Measure Description
TBD	TBD	TBD

TOBACCO

Domain	Measure Title	Measure Description
TBD	TBD	TBD

Peer Review

Provider agencies must incorporate peer reviews into their continuous quality improvement activities, and establish a formal process for regularly identifying processes or variations in care/services that may lead to undesirable or unanticipated events affecting patients or clinical care. The goal of the peer review process is to establish an educational and evaluative mechanism for providers to contribute to the identification of opportunities to improve care and services.

As a component of the peer review process, SUD counselors/clinicians of various disciplines review their colleagues' patient charts and provide feedback on the care that is recommended and provided, in a professional and non-adversarial manner. Reviews should be performed by practitioners within their appropriate scope of practice, and when possible, supervisors should review and follow up with counselors/clinicians in order 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 goal of the peer review process is to establish an educational and evaluative mechanism for providers to contribute to the identification of opportunities to improve care and services.

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 must include:

- Review of diagnosis/diagnoses and assessment(s).
- Review of documentation clarity and organization.
- Ensure treatment plans 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 agency for each site, but no less than three (3) patient charts for each counselor/clinician must be reviewed twice annually.

All records and information obtained during peer review functions should remain confidential and be used only for the purpose of reviewing the quality and appropriateness of care for improved practices.

Quality Improvement Projects

A quality improvement project (QIP) is a concentrated effort on an identified problem in one area of a provider agency. It involves gathering information systematically to clarify issues or problems, and intervening for improvements. The purpose of QIPs is 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 quality improvement projects that organizations may already be using, which may be used or adapted to qualify as their QIP.

All QIPs should follow the Continuous Quality Improvement 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 patient population served and have a potentially significant impact on health, functional status or satisfaction. Over time, areas selected for improvement focus should address a broad spectrum of care and services.

Each provider agency must be involved in at least one QIP at all times, and these projects and their evolution will be reviewed on an annual basis by SAPC staff.

Confidentiality

All programs must operate in accordance with legal and ethical standards. Federal and state laws and regulations protect the confidentiality of patient records maintained by all SAPC contracted providers. Maintaining appropriate confidentiality is of paramount importance. All SAPC contracted providers are required by contract to establish policies and procedures regarding confidentiality and must ensure compliance with Title 42, Chapter I, Subchapter A, Part 2 of the Code of Federal Regulations, Part 2 (42 CFR Part 2), the Health Insurance Portability and Accountability Act (HIPAA) standards, and California State law regarding confidentiality for information disclosure of alcohol and drug use, and other medical records.

HIPAA and 42 CFR Part 2 both cover what information can be disclosed with and without patient permission, as well as exceptions to confidentiality (e.g., emergency care, evaluation, research and audit activities).

- For a summary of 42 CFR Part 2, please see: http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;node=42%3A1.0.1.1.2 - se42.1.2_131
- Subpart A includes an introduction to the statute (e.g., purpose, criminal penalty, reports of violations, etc).
- Subpart B covers general provisions (e.g., definitions, confidentiality restrictions, and minor patients, etc).
- Subpart C covers disclosures allowed with the patients' consent (e.g., prohibition on re-disclosure, disclosures permitted with written consent, disclosures to prevent multiple enrollments in detoxification and maintenance treatment programs, etc).
- Subpart D covers disclosures that do not require patient consent (e.g., medical emergencies, research, evaluation and audit activities).
- And Subpart E includes information on court orders around disclosure (e.g., legal effects of order confidential communications, etc).
- A summary of the HIPAA privacy rule can be found here: http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html. For more general information on HIPAA, please see: http://www.hhs.gov/ocr/privacy/index.html. For more specific information concerning covered entities, consumer information and health information technology, please see http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html.

These laws and regulations must not be used as barriers to provide coordinated and integrated care. Provided that the appropriate patient 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 also across systems of care (physical and mental health, etc). Within the requirements of the laws and regulations governing confidentiality in the provision of health services, all SAPC contracted providers must cooperate with system-wide efforts to facilitate the sharing of pertinent clinical information for the purposes of improving the effectiveness, integration, and quality of health services.

Risk Management

Risk management refers to strategies that minimize the possibility of an adverse outcome or a loss, and maximize the realization of opportunities. Good risk management techniques improve the quality of patient care and reduce the probability of an adverse outcome and resulting liability to the health care provider. Standards of care, quality improvement, and the systematic gathering, analysis, and utilization of data are the foundations of risk management.

The SAPC recognizes the growing need and importance of risk management strategies in an evolving health care landscape. As a result, each provider agency contracted to provide services by SAPC is responsible for investigating and reporting on specific functions and aspects of care dealing with risk management issues, including reviewing reportable incidents and adverse events, verifying service/billing integrity, and establishing peer review processes among service providers.

Good risk management techniques improve the quality of patient care and reduce the probability of an adverse outcome and resulting liability to the health care provider.

Adverse events are defined as incidents that have a direct or indirect impact on the community, patients, staff, and/or the provider agency as a whole need 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. The functions and responsibilities of the providers' Risk Management Committee should be systematic and ongoing to include appropriate and timely responses for addressing areas of concern or deficiency.

Reportable incidents are patient safety events that result in death, permanent harm, and/or severe temporary harm, and intervention required to sustain life. Reportable incidents must be investigated by the provider's Risk Management Committee, and must be reported to the SAPC Quality Improvement/ Risk Management Committee immediately. These incidents may result in corrective actions and are viewed as learning opportunities to improve care and risk management processes.

While reportable incidents must be reported to the SAPC Quality Improvement/Risk Management Committee, adverse events and other risk management and quality-related issues may be reported to the SAPC at the discretion of the leadership of contracted providers.

Overall, the functions and responsibilities of the providers' Risk Management Committee should be systematic and ongoing to include appropriate and timely responses for addressing areas of concern or deficiency. The goals of the provider Risk Management Committees may include:

- To assure implementation of an agency-wide safety program that includes development of policies and procedures, and subsequent staff trainings, relating to quality improvement, fire safety, disaster preparedness, hazard reporting, etc.
- To assure a tracking and documentation system for all reportable incidents, including follow up and implementation of any corrective action until follow up is no longer indicated.
- To review safety and incident related data and to identify trends and patterns associated with risks or to identify problem areas.
- To investigate adverse events, as necessary and appropriate.
- To provide thorough investigation on all reportable incidents, which must be reported to the SAPC.
- To establish processes to maintain service/billing integrity and quality care, including peer review processes for service providers.
- To promote quality improvement activity through identifying opportunities towards maximizing safety of physical and therapeutic environment and reducing agency, staff, and patient risks.

Complaints/Grievances and Appeals Process

A complaint/grievance process is available for patients, their authorized representative, or providers ("involved parties") who are dissatisfied with elements of care including, but not limited to, quality of care, services, and/or treatment. An appeals process is also available for patients or involved parties to challenge authorization denials regarding eligibility, services, or level of care decisions.

Involved parties may contact QI/UM staff in these instances to discuss their concerns. In many cases, a responsible and reasonable resolution can be achieved through an informal and professional discussion. However, additional action in the form of a complaint/grievance or appeal may be required in some instances. The QI/UM program is responsible for processing these complaints/grievances and appeals.

At the agency level, providers must have policies and procedures in place for collecting, reviewing, and acting on complaints/grievances that are filed by their patients. This process should be clear and transparent to all patients and providers, and should be integrated into the quality improvement processes of the provider agency.

A complaint or grievance process is available for patients, their authorized representative, or providers ("involved parties") who are dissatisfied with elements of care including, but not limited to, quality of care, services, and/or treatment.

An appeals process is also available for patients or involved parties to challenge authorization denials regarding eligibility, services, or level of care decisions.

Similarly, patients, their authorized representative, or providers have the opportunity to file a complaint/grievance and/or appeal. Involved parties may review and respond to the evidence and rationale provided by QI/UM staff in instances of denials of authorization, and may challenge denials of eligibility or authorizations for levels of care.

Complaint/Grievance Process

- Complaints/grievances are a process of expressing dissatisfaction with elements of care including, but not limited to, quality of care, services, treatment, and/or authorization decisions.

- Complaints/grievances may be initiated by phone or in writing by submitting a completed Complaint/Grievance/Appeal Form to QI/UM staff, either via web application, fax, or mail within 180-calendar days of the reason for filing the complaint/grievance. See below for contact information.
    - Complaints/grievances initiated by phone must be followed by a completed and signed Complaint/Grievance/Appeal form.
- Upon receipt, complaints/grievances will be logged by QI/UM staff and an acknowledgement letter will be sent to the requesting party within 5-calendar days of receipt of the complaint/grievance.
- Patients and/or providers are entitled to a full and fair review conducted by QI/UM staff that possess the appropriate clinical expertise.
- All complaints/grievances will be reviewed by supervisorial staff within the QI/UM program, who will work with QI/UM staff and the involved party/parties filing the complaint/grievance to research all facts associated with these inquiries and conduct additional research, such as contacting the treating provider, if necessary. Every attempt will be made to achieve a satisfactory resolution, if applicable.
- A decision regarding the grievance will be rendered within the timeframes listed in Table 11, though many complaints/grievances will be addressed sooner. If the complaint/grievance cannot be resolved within the respective timeframe, an extension of fourteen (14) days may be granted by the QI/UM supervisor.
    - Decision notifications will include, but not be limited to:
        - The date and result of the grievance.
        - Reasons and rationale for decision.
        - Contact information for the reviewer.
        - Information regarding the state fair hearing process and the patient's right to continue to receive benefits while the fair hearing is pending.
- Complaints/grievances will be addressed as a component of the quality improvement activities within the QI program, and depending on the nature of the complaint/grievance, may trigger more targeted follow up at the provider level.
- Concerns that arise during the complaint/grievance process will be discussed with providers and are viewed as a learning opportunity for both QI/UM staff and SAPC contracted providers, with the shared goal of improving our system of SUD care.
- Complaints/grievances may be presented to the Quality Improvement / Risk Management Committee during its meetings every other month in order to identify trends, areas needing process or performance improvement, and determine necessary action steps.

Complaint/Grievance is a process of expressing dissatisfaction with elements of care including, but not limited to, quality of care, services, treatment, and/or authorization decisions.

Appeal Process

- Utilization management decision makers are not incentivized or rewarded to issue denials, and encouraging under-utilization of services is contrary to the organizational mission and goals of the SAPC.

- Appeals offer an opportunity for additional review and reconsideration of denial decisions in instances in which patients, their authorized representative, or providers may disagree with the decisions rendered by UM staff. In these circumstances, parties may file a formal appeal to challenge denials of eligibility, level of care decisions, or payment for services.
- Patients and/or providers are entitled to a full and fair review. Appeals reviewers will consist of supervisorial and/or higher management staff.
- Appeals must be submitted in writing by forwarding a completed Complaint/Grievance/Appeal Form to QI/UM staff, either via web application, fax, or mail, and cannot be submitted more than 90-calendar days from the date of the written decision notification for the authorization request. See below for contact information.
- Upon receipt, appeals will be logged by QI/UM staff and an acknowledgement letter will be sent to the requesting party within the timeframes outlined in Table 11.
- Staff reviewing the appeal request will research the facts associated with the initial denial and conduct additional research, such as contacting the treating provider, if necessary. Reviewers will also consult the ASAM Criteria and/or other appropriate clinical resources.
- After careful consideration of all case information, a decision will be rendered and the rationale and outcome will be conveyed to the appealing patient and/or provider, in accordance with the timeframes outlined in Table 11. If the complaint/grievance cannot be resolved within the respective timeframe, an extension of fourteen (14) days may be granted by the QI/UM supervisor.
    - Decision notifications include, but are not limited to:
        - The date and result of the appeal.
        - Reasons and rationale for decision.
        - Contact information for the reviewer.
        - Information regarding the state fair hearing process and the patient's right to continue to receive benefits while the fair hearing is pending.
- Appeals for initial residential authorizations and medication-assisted treatment for youth under age 18 will be expedited, according to the timeframes outlined in Table 11, whereas residential reauthorizations will follow the standard appeal timeframe.
- Concerns that arise during the appeals process will be discussed with providers, may result in corrective actions, and are viewed as a learning opportunity for both QI/UM staff and SAPC contracted providers, with the shared goal of improving our system of SUD care.
- Appeals will be presented to the Quality Improvement / Risk Management Committee during its meetings every other month in order to identify trends, areas needing process or performance improvement, and determine necessary action steps.

If patients, their authorized representative, or providers disagree with the decisions rendered by UM staff, a formal appeal can be filed in order to challenge a denial of eligibility, level of care decision, or payment for services. Appeals offer an opportunity for additional review and reconsideration of denial decisions.

<u>Contact Information</u>:

County of Los Angeles, Department of Public Health
Substance Abuse Prevention and Control
Office of the Medical Director and Science Officer
1000 South Fremont Avenue; Building A-9 East, 3rd Floor
Alhambra, California 91803
(626) 299-4160

In all cases, patients who have exhausted the Complaint/Grievance and/or Appeals process, may request a state fair hearing process with the California Department of Health Care Services.

Table 11. Complaint, Grievance, and Appeal Notification Timeframes

Description	Receipt Notification	Decision Notification	Written Decision Notification
Complaint/Grievance A process of expressing dissatisfaction with elements of care including, but not limited to, quality of care, services, and/or treatment. * Must be filed within 180-calendar days of the reason for filing the complaint/grievance.	Within 3-calendar days of receipt of complaint / grievance	Within 7-calendar days of receipt of complaint / grievance	Within 30-calendar days of receipt of complaint/grievance
Expedited Appeal for Initial Residential Authorizations and Medication-Assisted Treatment for Youth Under Age 18	Within 2-business days of appeal	Within 3-business days of receipt of appeal	Within 7-business days of receipt of appeal request
Standard Appeal for Residential Reauthorizations, Grievance Decisions, etc. * Formal process of challenging authorization denials regarding eligibility, services, or level of care decisions. ** Must be filed within 180-calendar days from the date on the written decision notification.	Within 3-calendar days of appeal	Within 21-calendar days of receipt of appeal	Within 45-calendar days of receipt of appeal request

***** These <u>timeframes may be extended by up to 14-calendar days</u> if the patient requests an extension, or if QI/UM staff determine that there is a need for additional information and that the delay is in the patient's best interest. In this event, a written notice of the extension and the rationale for the extension will be sent to the requesting party.

UTILIZATION MANAGEMENT PROGRAM

The Utilization Management (UM) program analyzes how the SAPC provider network is delivering services and how it is utilizing resources for eligible patients. The various responsibilities of the UM program include: ensuring adherence to established eligibility and medical necessity criteria; ensuring that clinical care and ASAM level of care guidelines are followed; 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; and 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 patients and providers:

SAPC follows federal and state decision and notification timeframes for all UM determinations.

- 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 assure fair and consistent UM decision-making.
- To focus resources on a timely resolution of identified problems.
- To assist in the promotion and maintenance of optimally achievable quality of care.
- To educate health care professionals on appropriate and cost-effective use of health care resources.

The SAPC follows federal and state decision and notification timeframes for all UM determinations. The SAPC will make every effort to complete UM determinations expeditiously in order to facilitate timely treatment for the patients served in the system of SUD care in Los Angeles County, and to assure compliance with all requirements.

Eligibility and Medical Necessity Review Process

Initial eligibility determinations should occur at the point of first contact between a patient and the SUD system of care, whether it be the Beneficiary Access Line or at the treatment provider site. Medical necessity determinations will occur at the provider site. The initial eligibility determination may be performed by trained support staff and/or registered or certified SUD counselors, however medical necessity determinations must be performed by a Medical Director, licensed physician, or Licensed Practitioner of the Health Arts (LPHA) (see Workforce section above).

Initial eligibility requirements for patients:
- Resides within Los Angeles County.
- Must be enrolled in Medi-Cal.
- Must meet medical necessity criteria.

Initial eligibility determinations may be performed by trained support staff and/or registered or certified SUD counselors, however medical necessity determinations must be performed by a Medical Director, licensed physician, or Licensed Practitioner of the Health Arts (LPHA).

Medical necessity eligibility requirements for patients:
- Must have one diagnosis from the DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders.
- Must meet the ASAM Criteria definition of medical necessity for services. Medical necessity pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient. It must not be restricted to acute care and narrow medical concerns (such as severity of withdrawal risk as in Dimension 1); acuity of physical health needs (as in Dimension 2); or Dimension 3 psychiatric issues (such as imminent suicidality).

Benefits for SUD services shall be available to all patients who meet the requirements of the eligibility and medical necessity criteria listed above. Legal status (e.g., parole, probation) is not a barrier to access substance use services, provided that the prospective patient meets the specified eligibility and medical necessity requirement.

Eligibility will be determined at least every six months through the reauthorization process for all SUD services other than Narcotic Treatment Program services, which will involve an annual reauthorization process. During the reauthorization process, the Medical Director, licensed physician, or LPHA at the provider agency will be required to justify ongoing eligibility for services by submitting a completed Authorization Request Form, current treatment plan, assessment information, progress notes, and laboratory test results (if available). All documentation should be submitted at least 21-calendar days in advance of end date of current eligibility authorization in order to prevent the disruption of

reimbursable services. The provider agency will be notified of the eligibility reauthorization decision within the timeframe listed in Table 12.

After the initial eligibility and medical necessity determination, UM staff will perform a patient case review in situations that require authorization or pre-authorization in order to verify that these criteria have been met prior to payment for services. For other cases that do not require authorization or pre-authorization, as a component of the UM program, a random retrospective review of a portion of all provider caseloads will also ensure fidelity to eligibility and medical necessity criteria.

Utilization management staff have the authority to approve services and reimburse
ment. If the decision is outside the scope of the UM staff member's authority, the case will be referred to UM management and/or the Medical Director for a determination.

Information for case reviews is obtained from a variety of sources. Although each case is unique, these sources of information may include, but are not limited to, information from the patient or responsible family member, patient record, substance use providers, physical/mental health providers, etc. Utilization Management staff will use this information, along with clinical judgment, departmental policies and procedures, needs of the patient, recommendations from providers, and characteristics of the system of care, to render a decision about the provision of SUD services, as needed.

If UM staff determines that eligibility and medical necessity criteria have been met, and the proposed or provided services are deemed clinically appropriate, services and reimbursement will be authorized and the applying agency will be notified in accordance with the notification timeframes listed in Table 12. Reimbursements for services will be retroactive to the date of the referral submission, pending case review and approval.

If UM staff render a denial determination for eligibility and medical necessity, the case will be reviewed by supervisorial staff within the UM program. If the decision is consistent with the original denial, the applying agency will be notified of the decision within the timeframes listed in Table 12. Adverse eligibility and medical necessity determinations will result in denial of reimbursement for services rendered. Denial notifications will include information including, but not limited to:

- Reason(s) including specific plan provisions, clinical judgment used.
- Any additional information needed to improve or complete the claim.
- Descriptions of the appeal process.

Patients, or providers acting on behalf of the patient, have the opportunity to review and respond to the evidence and rationale outlined in the initial denial, and may challenge a denial of eligibility, coverage of services, or denial of payment for services (see Grievances and Appeal Process).

Table 12. Utilization Management Notification Timeframes

Review Type	Email/Verbal Decision Notification	Written Decision Notification
INITIAL AUTHORIZATIONS		
Initial Authorization for Eligibility and Medical Necessity – Non-Residential Services	Within 1-business day of receipt of request	Within 5-calendar days of receipt of request
Initial Authorization for Eligibility and Medical Necessity – Residential Services	Within 24 hours of receipt of request	Within 5-calendar days of receipt of request

Initiation of Pre-Authorized Service * e.g., residential services	Within 24 hours of receipt of pre-authorization request	Within 5-calendar days of receipt of pre-authorization request
Initiation of Authorized Service * e.g., medication-assisted treatment for those under age 18	Within 5-calendar days of receipt of authorization request	Within 7-calendar days of receipt of authorization request
RE-AUTHORIZATIONS		
Re-authorization for Eligibility and Medical Necessity * Must submit re-authorization request at least 21-calendar days in advance of end date of current authorization	Within 14-calendar days of receipt of re-authorization request for Eligibility and Medical Necessity	Within 21-calendar days of receipt of re-authorization request for Eligibility and Medical necessity
Re-authorization of Pre-Authorized Service * e.g., residential services ** Must submit re-authorization request at least 7-calendar days in advance of end date of current authorization	Within 5-calendar days of receipt of re-authorization request	Within 7-calendar days of receipt of re-authorization request
Re-authorization of Authorized Service * e.g., medication-assisted treatment for those under age 18 ** Must submit re-authorization request at least 7-calendar days in advance of end date of current authorization	Within 5-calendar days of receipt of re-authorization request	Within 7-calendar days of receipt of re-authorization request

Clinical Case Review Process

Utilization Management staff will review clinical cases from SAPC providers, including both adolescent and adult patients. The purpose of these case reviews is to establish an ongoing monitoring program to ensure appropriate and quality care, as well as appropriate utilization of services across the SUD service continuum. In some instances, these reviews are related to reimbursement of services and in others, the reviews are important and necessary to ensure the quality and appropriateness of services provided. Providers contracted to provide services with SAPC are required to cooperate with all case reviews conducted by the UM program.

Utilization Management staff will review clinical cases from SAPC's network of providers in order to establish an ongoing monitoring program to ensure appropriate and quality care, as well as appropriate utilization of services across the service continuum.

Multidisciplinary UM reviewers will possess appropriate clinical expertise to evaluate the case and will conduct thorough case analyses, assess for appropriate care that is consistent with generally accepted standards of clinical practice, and determine appropriate utilization of services and resources to ensure that patient needs are met. Reviewers will conduct additional research, discuss the case with the requesting provider when appropriate, and consult the ASAM Criteria and/or other appropriate resources.

Information for case reviews is obtained from a variety of sources. Although each case is unique, these sources of information may include, but are not limited to, information from the patient or responsible family member, patient record, substance use providers, physical/mental health providers, etc. Utilization Management staff will use this information, along with clinical judgment, departmental policies and procedures, needs of the patient, recommendations from providers, and characteristics of the local delivery system, to render a decision about the provision of SUD services.

Case review considerations include, but are not limited to:

- Patient/family/guardian identified goals and preferences.
- Care/service is necessary and clinically appropriate in terms of level of care, intervention, frequency, timing, and duration, and considered effective to promote recovery.
- Care/service is consistent with generally accepted standards of clinical practice based on:
    - Credible scientific evidence published in peer-reviewed medical literature that is generally recognized by independent clinical experts at the time the services are provided.
    - Recommendations of a physician-specialty society.
    - The DSM and ASAM Criteria.
    - Case discussions with treating providers, when appropriate.
    - Any other relevant factors.
- Case management to ensure that care/service is coordinated both across the continuum of SUD care and across relevant physical and mental health systems, as clinically indicated.
- Regular patient assessments ensure that care/service is provided in the least restrictive, most cost-effective environment that is consistent with clinical standards of care.
- Care/service is not provided solely for the convenience of the provider, recipient, recipient's family, or custodian (e.g., placing patients in a residential level of care primarily for housing purposes).
- Care/service is not experimental, investigational, and/or unproven.
- Care/service is deemed necessary and furnished by or under the supervision of an appropriate and authorized licensed practitioner, and in accordance with all applicable rules, regulations, and other applicable federal, state, and local directives.

Provider caseloads for adults and adolescents at each ASAM level of care will be randomly and retrospectively reviewed on at least an annual basis, in addition to the cases that require authorization and pre-authorization (described below). These case reviews are independent from SAPC contract monitoring activities, and the quantity of these reviews will occur at County discretion. Utilization Management staff may also conduct focused, retrospective chart reviews whenever concerns arise about a particular provider or patient. Such reviews may be conducted on site and without prior notice to the provider. As needed, Utilization Management and Contracts staff will confer on cases to determine the most appropriate responding SAPC entity. These cases will then be addressed, as appropriate.

Reportable incidents (defined as a patient safety event that results in death, permanent harm, and/or severe temporary harm and intervention required to sustain life) must be reported to the SAPC for further investigation, in accordance with State requirements. The SAPC recognizes the importance of flexibility in clinical decision-making and the individualized nature of each unique patient case. Concerns that arise will be discussed with providers and are viewed as learning opportunities for both the SAPC and its providers, with the shared goal of improving our system of SUD care.

The following methods of review are utilized by 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. The prospective review is performed by UM reviewers, who apply pre-established medical necessity/appropriateness criteria and render a decision on 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.
        - Pre-authorization of MAT for patients under age 18.
- **Concurrent Review -** A concurrent review examines ongoing care to evaluate medical necessity, and the quality and appropriateness of care. This review is conducted by UM reviewers, in accordance with pre-established criteria, as previously mentioned.
    - 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 patient progress, and to anticipate treatment needs and transitions that promote recovery.
    - Example of concurrent review:
        - Reauthorization of ongoing residential services.
        - Reauthorization of ongoing MAT for patients under age 18.
- **Retrospective Review -** Retrospective reviews examine various aspects of previously provided services. These reviews yield information about the quality of eligibility determinations and service authorization decisions, and other aspects associated with the services provided to patients. 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 under- and over-utilization of services, to identify utilization patterns and trends, to continually evaluate the consistency of the UM review and decision-making process, and to continually identify areas of improvement.
    - Example of retrospective review:
        - Random, focused chart review of services that have already been rendered to ensure fidelity to eligibility and medical necessity criteria, as well as quality of care.

The UM program utilizes a variety of methods of review when performing case reviews to monitor care quality and appropriateness, and to inform decisions regarding eligibility, coverage of services, and authorizing reimbursements. Given the complications that can result from the denial of retrospective reviews after the provision of services by providers, whenever possible, prospective and concurrent reviews are preferable to retrospective reviews. The timely submission of authorization requests by providers is helpful in minimizing the potential complications and financial impact of retrospective review denials, and is therefore beneficial to the submitting provider.

<u>Pre-Authorization</u>

Services requiring pre-authorization are services for which the treating provider must request approval before initiating treatment. In these instances, UM staff will perform prospective reviews of care that has yet to be provided and concurrent reviews of extensions of previous authorizations, when pertinent.

The provider will be required to notify UM staff of the recommended services via web application or fax in order to begin the pre-authorization review process. Notifications from providers must, at a minimum, include a completed Authorization Request Form and initial intake documentation, including assessment information. Requests for continuation of services that require pre-authorization must be submitted at least 7-calendar days in advance of the end date of current authorization, and required documentation includes, at a minimum, a completed Authorization Request Form, current treatment plan, assessment information, and progress notes, and laboratory test results (if available).

Utilization Management staff will perform clinical reviews of the case being referred for pre-authorization, based on the case review considerations listed above. Approval for initial pre-authorization requests is based on medical necessity and ASAM Level of Care 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.

If a decision determination cannot be made due to insufficient documentation, UM staff will return the authorization request and notify the provider that additional information is needed to process the request.

Services that require pre-authorization, such as residential services, are services for which the treating provider must request approval before initiating treatment and/or before continuing care for an extension of a previous authorization.

For services that require pre-authorization, notifications will occur within the prospective and concurrent review timeframes specified in Table 12.

Clinical scenarios that require pre-authorization, and relevant service-specific details, include:

- **Residential services (adults and youth):**
    - The provider will submit a pre-authorization request to the UM unit, which will conduct a prospective review, and then approve or deny the request within 24 hours of receiving the request. If relapse risk is deemed to be significant without immediate placement in residential care, a residential treatment provider may admit an individual prior to receiving residential authorization, with the understanding that authorization denials will result in financial loss, whereas authorization approvals will be retroactively reimbursed to the date of admission.
    - Requests for continuation of residential services must be submitted at least 7-calendar days in advance of the end date of current authorization.
    - Residential pre-authorizations pertain to the provision of all residential services, including youth, adults, perinatal patients, and criminal justice involved patients.
    - Residential pre-authorization is only required when initiating residential care or transitioning to a higher level of residential care. Pre-authorization for residential services is not necessary if transitioning to a lower level of residential care.
    - Residential lengths of stay:
        - There will be a maximum residential treatment limit of 90-days for adults and 30-days for adolescents, unless medical necessity warrants a one-time extension of up to 30-days on an annual basis. For adult populations, only two non-continuous 90-day regimens will be authorized in a one-year period.
        - In general, adolescents require shorter lengths of stay and should be stabilized and then moved down to a less intensive level of care.
        - Residential lengths of stay for criminal justice involved patients can be authorized for up to 6 months based on medical necessity.

        - Residential lengths of stay for perinatal patients may be extended on a case-by-case basis, based on medical necessity.
    - Residential services for all adult populations require reauthorization after 60-calendar days to assess for appropriate level of care utilization.
    - Youth residential services require reauthorization after 30-calendar days to assess for appropriate level of care utilization.
    - Residential patients must receive regular assessments of their progress within these 60- and 30-calendar day residential authorizations for adult and youth populations, respectively. Given the fluid nature of clinical progression, the expectation will be that clinical progress note assessments are performed on a regular basis during residential treatment as clinically warranted and that certain patients will not require the full period of authorized residential services. In these instances, patients must be transitioned to a lower level of care as soon as clinically indicated. Required treatment plan updates every 30-days will help to facilitate these regular case reviews to ensure that patients receive care in the least restrictive setting that is clinically appropriate.
    - If upon clinical review, either during a focused or random retrospective review, an ongoing residential treatment case is determined to be unnecessary based on the aforementioned considerations, UM staff will have the authority to terminate/modify the current authorization and to deny ongoing reimbursement for residential services, and require transition to an appropriate lower level of care. In these instances, reimbursement for residential services that have already been provided will be maintained, but future reimbursement for the identified episode will be denied. Providers will be responsible for ensuring successful care coordination during all level of care transitions.
    - Providers will be required to notify UM staff of residential discharges and to submit a completed discharge summary within 24 hours.

<u>Authorization</u>
Authorized services are services that require approval from SAPC, but do not require authorization prior to the provision of services. 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 3-calendar days via web application or fax in order to begin the authorization review process. Notifications from providers must, at a minimum, include a completed Authorization Request Form and initial intake documentation, including assessment information. Required documentation for requests for continuation of authorized services must, at a minimum, include a completed Authorization Request Form, current treatment plan, assessment information, progress notes, and laboratory test results (if available).

Utilization Management staff will perform clinical reviews of the case being referred for authorization, based on the case review considerations listed above. Approval for initial authorization requests is based on medical necessity and ASAM Level of Care 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 12.

Clinical scenarios that require authorization, and relevant service-specific details, include:

- **Medication-Assisted Treatment for individuals under age 18:**
    - Individuals under the age of 18 who initiate medication-assisted treatment (MAT). Re-authorization required every 30-calendar days, until age 18, if the clinical determination is that patients under age 18 require ongoing MAT.
    - Requests for continuation of MAT for individuals under age 18 must be submitted at least 7-calendar days in advance of the end date of current authorization.

Table 13. Pre-Authorized and Authorized Services

Service Type	Initial Service Request Timeframe	Ongoing Service Request Timeframe	Notification Timeframe	Reauthorization Timeframe
PRE-AUTHORIZED SERVICES				
Residential Services	Pre-authorization must be submitted prior to service delivery	Re-authorization request must be submitted at least 7-calendar days in advance of end date of current authorization	See Table 12	Re-authorization required after 60-calendar days for adults, and 30-calendar days for youth, as clinically indicated
AUTHORIZED SERVICES				
Medication-assisted treatment for individuals under age 18	Authorization must be submitted within 3-calendar days of initiation of service	Re-authorization request must be submitted at least 7-calendar days in advance of end date of current authorization	See Table 12	Re-authorization required every 30-calendar days until age 18, or as clinically indicated

A summary of services that require pre-authorization and authorization is included in Table 13.

If after careful consideration of all case information UM staff determine that the proposed and provided services are necessary, appropriate, and in accordance with standards of clinical practice outlined in the QI program, services and reimbursement will be authorized and the applying provider will be notified in accordance with the notification timeframes listed in Table 12. Reimbursements for services will be retroactive to the date of the referral submission, pending case review and approval.

Denials of authorization will be reviewed by supervisorial staff within the UM program and if the decision is consistent with the original denial, the applying agency will be notified of the decision within the timeframes listed in Table 12. Denials of authorization will result in denial of reimbursement for services rendered. Denial notifications will include information including, but not limited to:
- Reason(s) including specific plan provisions, clinical judgment used.
- Any additional information needed to improve or complete the claim.
- Descriptions of the appeal process.

Patients, or providers acting on behalf of the patient, have the opportunity to review and respond to the evidence and rationale outlined in the initial denial, and may challenge a denial of eligibility, coverage of services, or denial of payment for services (see Grievances and Appeal Process).

APPENDIX

Provider Staff Roles and Responsibilities

Responsibilities	Provider's Medical Director	Licensed Physician	LPHA	Registered / Certified SUD Counselors	Trained Support Staff
Initial Eligibility Determination	✓	✓	✓	✓	✓
Clinical Assessments	✓	✓	✓	✓	
Medical Necessity	✓	✓	✓		
Reauthorization	✓	✓	✓		
Filing Appeals	✓	✓	✓	✓	
Case Management	✓	✓	✓	✓	

Licensed Practitioner of the Health Arts (LPHA): Licensed Practitioner of the Health Arts (LPHA), which includes the following:

- Physician
- Registered Nurse
- Nurse Practitioner

- Physician Assistant
- Psychologist (Licensed/Waivered)
- Social Worker (Licensed/Waivered/Registered)
- Marriage And Family Therapist (Licensed/Waivered/Registered)
- Licensed Professional Clinical Counselor (Licensed/Waivered/Registered)
- Registered Pharmacist

These LPHAs must provide services within their individual scope of practice and receive supervision required under their respective scope of practice laws.

GLOSSARY

American Society of Addiction Medicine - **(ASAM)** - The ASAM is a professional society representing physicians and associated professionals dedicated to increasing access and improving the quality of addiction treatment. The ASAM Criteria is a set of guidelines for assessing and making placement decisions for patients with addiction and co-occurring conditions.

Beneficiary Access Line (BAL) - Centralized screening and referral service that is available 24 hours a day, seven days a week. Patients can call the BAL to initiate a self-referral for treatment or can also be referred by an organization or others, including but not limited to, physical health providers, law enforcement, family members, mental health care providers, schools, and County departments.

Care Coordination - The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services.

Commission on Accreditation of Rehabilitation Facilities (CARF) - An independent, nonprofit accreditor of health and human services whose mission it is to "*promote the quality, value, and optimal outcomes of services through a consultative accreditation process and continuous improvement services that center on enhancing the lives of persons served*."

Case Management - A collaborative process of assessment, planning, facilitation, care coordination,

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.

Chronic Care Model (CCM) - A well-established organizational framework for chronic care management and practice improvement that identifies the six essential elements of a health care system that encourage high-quality chronic disease care: organizational support, clinical information systems, delivery system design, decision support, self-management support, and community resources.

Cognitive Behavioral Therapy (CBT) - A type of psychotherapy that is evidence-based and uses strategies based on the theory that learning processes play a critical role in the development of maladaptive behavioral patterns. Cognitive behavioral therapy focuses on examining the relationships between thoughts, feelings and behaviors.

Clinical Practice Guidelines - Recommendations for counselors/clinicians about the care of patients with specific conditions, which should be based on the best available research evidence and practice experience.

Co-occurring Disorders (COD) - Describes the presence of two or more health conditions at the same time. For example, a person may have a substance use disorder as well as a mental health condition, or a substance use disorder as well as a physical health condition.

Continuum of Care - A concept involving an integrated system of care that guides and tracks patients over time through a comprehensive array of health services spanning all levels and intensities of care.

Continuous Quality Improvement (CQI) - An approach to quality management that is based on concepts of quality improvement and performance measurement, and encourages health care team members to continuously identify opportunities for improvement. It employs a patient-centered philosophy and long-term approach to provide tools to help quantify and inform program planning.

Diagnostic and Statistical Manual of Mental Disorders (DSM) - The standard classification of mental disorders used by a wide range of health and mental health professionals.

Evidence-Based Practice (EBP) - A clinical approach that applies the best available research results to inform health care decisions. Health care professionals who perform evidence-based practice use research evidence along with clinical expertise and patient preferences.

Licensed Clinical Social Worker (LCSW) - Professionals that have either a masters or doctoral level degree in social work, and licensure or professional supervision that allows them to provide counseling and psychotherapy from a social work orientation. They are qualified to assess, diagnose and treat mental and emotional conditions and addictions.

Licensed Mental Health Counselor (LMHC) - Professionals that hold a master's degree in counseling or another closely related field in behavioral health care. Although their scope of practice varies, LMHCs are generally qualified to assess, diagnose and treat mental and emotional conditions and addictions.

Licensed Marriage and Family Therapists (LMFT) - Master's level professionals trained in psychotherapy and family systems, and licensed to diagnose and treat mental and emotional disorders within the context of marriage, couples and family systems.

Licensed Practitioners of the Healing Arts (LPHA) - Term that includes physicians, nurse practitioners, physician assistants, registered nurses, registered pharmacists, licensed clinical psychologists, licensed clinical social workers, licensed clinical professional counselors, and licensed marriage and family therapists.

Medication-Assisted Treatments (MAT) - The use of medications, in combination with counseling and behavioral therapies, to comprehensively treat substance use disorders and provide a whole-patient approach to treatment that includes addressing the biomedical aspects of addiction.

Medical Necessity Criteria - A definition of accepted health care services that involves diagnosis, impairment, and intervention. Medical necessity in Los Angeles County requires that individuals have at least one diagnosis from the current Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders. The service must also meet a recommended level of intervention consistent with the current edition of the American Society of Addiction Medicine (ASAM) placement guidelines, which include a consideration of biopsychosocial severity.

Motivational Interviewing (MI) - A type of evidence based practice and clinical interviewing approach that is a directive, patient-centered couseling style designed to elicit behavior change by helping patients to explore and resolve ambivalence towards change.

Opioid Treatment Programs (OTP) - Treatment programs that provide opioid treatment, including the use of medication-assisted treatments such as methadone and buprenorphine, and comprehensive medical, psychosocial, and addiction treatment for opioid-dependent individuals in a therapeutic environment.

Progress note formats: SOAP, GIRP, SIRP, or BIRP - SOAP (Subjective, Objective, Assessment and Plan), GIRP (Goals, Intervention, Response and Plan), and SIRP (Situation, Intervention, Response and Progress), and the BIRP (Behavior, Intervention, Response and Plan) are specific methods of documentation that describe the format and content of progress notes to ensure communication and monitoring of patient interactions.

Quality Improvement (QI) - The planned and systematic activities that are implemented in order to ensure that the quality requirements for a service is fulfilled, with the greater goal of measurable improvements in health care services. The QI program is responsible for ensuring that the provision of substance use disorder services aligns with the SAPC's organizational mission and goals, and that services follow a standard of clinical practice consistent with medical necessity, best practice, and level of care guidelines described by the American Society of Addiction Medicine (ASAM).

Quality Improvement Project (QIP) - A provider-level project that follows the Continuous Quality Improvement model in order to identify and quantify issues or problems, and subsequent interventions, with the goal of improving care or services.

Performance Management - The strategic use of performance standards, measures, progress reports,

and ongoing quality improvement efforts to ensure an agency achieves desired results. Ideally, these practices should be integrated into core operations, and can occur at multiple levels, including the program, organization or system level.

Recovery Support Services (RSS) - Non-clinical services that foster health and resilience in individuals and families by helping them to navigate systems of care, and reduce barriers to employment, housing, education, and other life goals.

Risk, Need, Responsivity (RNR) - An evidence-based practice framework that emphasizes that criminal justice agencies should match offenders to services and programs based on their risk and need factors.

Screening, Brief intervention, and referral to treatment (SBIRT) - An evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence of alcohol and other drugs.

Substance Abuse Prevention and Control (SAPC) - The Los Angeles County agency responsible for leading and administering a full spectrum of prevention, treatment, and recovery support services for County residents.

Standardized Documentation - A structured method of clinical documentation that ensures an efficient way to organize and communicate with other providers. Examples include the SOAP, GIRP, SIRP, and BIRP progress note formats mentioned in this document.

Treatment Improvement Protocol (TIP) - A series of best-practice manuals for the treatment of substance use and other related disorders. The TIP series is published by the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the U.S. Department of Health and Human Services.

Transition Age Youth (TAY) - Commonly defined as young individuals between the ages of 16 and 25 who have unique service challenges due to their developmental stage and transition from adolescence to adulthood.

Utilization Management (UM) - The evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.


COUNTY OF LOS ANGELES
Public Health
Substance Abuse Prevention and Control