Drug Medi-Cal Organized Delivery System

For San Mateo County Behavioral Health and Recovery Services

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Forward

The County of San Mateo is located on the San Francisco Bay Area Peninsula flanked by the bay and the Pacific Ocean. The Board of Supervisors consisting of five elected members has a rich history of supporting the health and well-being of the county's 719,000 residents. This is evidenced by the dedication of discretionary funding, such as Measure A, a local property tax that generates revenue to support a service delivery model unlike any other California county, a comprehensive health system managed by a single public insurance plan and an administration that integrates governmental and private institutions, multiple funding streams, and public health programs, known as the San Mateo Health System. The Health System consists of eight divisions, including the Behavioral Health & Recovery Services Division (BHRS), Family Health Services, San Mateo Medical Center, Public Health Policy & Planning, Aging and Adult Services, Emergency Medical Services, Environmental Health, and Correctional Health Services.

BHRS consists of the Mental Health Plan, Substance Use Disorder Services, and under contract with the managed care plan, serves the mild and moderate population. The Health System also provides extensive outpatient services, residential treatment, a long term MRHC, a youth detention center, psychiatric emergency services and acute psychiatric inpatient services. Under Medicaid expansion, BHRS manages the entire continuum of care (Mild, Moderate, and Severely Mentally Ill) and maintains a network of 200 private therapists supported by BHRS psychiatrists for the mild and moderate, and severely mentally ill are served by a system of care with private providers, agency providers and five regional County clinics. The clinics are organized as community service areas (CSA) overseen by committees of community members so that each CSA reflects the goals of the local community.

Patients access the system through the Access Call Center where clinicians determine the appropriate level of care within the continuum, initiate the case, and authorize services, all during the original call by the patient. Each regional clinic and some community-based providers offer "Same Day Assistance," where a patient can walk in and be screened to initiate the assessment and treatment process so no one leaves BHRS without a referral or service the same day of their first engagement. A lean and dynamic local government agency, BHRS is constantly improving itself and client outcomes.

The following is a general organizational chart of the San Mateo Health System and BHRS:

[This is a placeholder for the San Mateo Health System and BHRS general organization chart.]

Part I
Plan Questions

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

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

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

How was community input collected?

☒Community meetings
☒County advisory groups
☐Focus groups
☐Other method(s) (explain briefly)

_____

2. 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_____

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

   ☒SUD, MH, and physical health representatives in our community 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 not 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.

4. What services will be available to DMC- ODS clients under this county plan?

   REQUIRED

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

   How will these required services be provided?
   ☐All county operated
   ☒Some county and some contracted
   ☐All contracted

OPTIONAL

☒Additional Medication Assisted Treatment

☐Partial Hospitalization

☒Recovery Residences

☒Other (specify) Telepsychiatry/addiction medicine

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

   ☒Yes (required)

   ☐No, Plan to establish by:_____

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

6. 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

7. The county will comply with all quarterly reporting requirements as contained in the STC's.

   ☒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 other participated in the development of this plan and how ongoing involvement and effective communication will occur.

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

The collaborative process utilized to develop this DMC-ODS Implementation by San Mateo County Behavioral Health and Recovery Services (BHRS) included interviews with key informants, multiple groups and public input meetings.

Input derived from the collaborative process was reviewed and analyzed by a steering committee. The steering committee met, on average, weekly and sometimes more frequent. The steering committee members included the Director, Assistant Director, Medical Director, SU Program Manager, SU Program Supervisor, Deputy Director for Adult Services, Deputy Director for Youth Services; Deputy Director for Administration and Fiscal; Director of the Office of Diversity and Equity, and the Manager for Quality Assurance.

The steering committee identified a list of groups and individuals that the committee believed had a role or contribution to make in drafting the plan (see below list). The participants were assigned to members of the steering committee to meet and engage in the process. Each meeting included a presentation overview of the DMC-ODS. Each group was asked a series of standard questions.

1. What are the benefits of the proposed service delivery model to those in need of treatment in San Mateo County?

2. Which of the levels of care need the most attention?

3. What might be some challenges in developing this system of care?

4. Are services in San Mateo County accessible for the individuals who need the service? Geographically? Linguistically? Timely?

5. Given the requirements for timely access what are the barriers to meet them and what are some suggested steps to mitigate the barriers?

6. Recommendations for future information and input?

Discussions with SUD treatment providers also included the following questions:

7. What screening and assessment tools are currently used by providers to ensure placement of clients into the appropriate level of care?

8. Describe how clients are referred to other levels of care.

9. Describe how care is coordinated with MH, Primary Care.

10. What indicators and processes does your program use to determine how often to reassess clients?

The list of individuals and groups that provided input includes the following:

[This is a placeholder for TABLE 1: Individuals and Community Groups Engaged For Implementation Plan.]

The major themes from these groups that impacted the development of the plan are summarized below. The themes guided the development of the plan sections and all have been incorporated into the document with the exception of "Coordination with Employment Training" (we already cooperate through CalWORKs) and "Stigma Issues" (the plan includes language and ADA).

[This is a placeholder for TABLE 2: Major Themes from Community Engagement.]

Opportunities for involvement by the various stakeholder groups during implementation will occur in a variety of settings including but not limited to: ongoing and regularly scheduled monthly meetings between BHRS and contracted SUD providers; monthly BHRS Mental Health and Substance Abuse Recovery Commission meetings; ongoing collaborative meetings held monthly and quarterly between BHRS management staff and various stakeholders including education, law enforcement, physical health, other criminal justice agencies, and others. These encounters will include updates on the progress of the implementation plan and where and how improvements can be made. Any further input from these ongoing meetings will be forwarded to the steering committee for consideration and incorporation into the implementation effort. The steering committee will continue to meet bi-weekly through the first 90 days of implementation and monthly thereafter.

2. **Client Flow.** Describe how clients move through the different levels identified in the continuum of care (referral, assessment, authorization, placement, transactions 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 timeliness established for the movement between one level of care to another.

Review Note: A flow chart may be included.

A principal goal of BHRS DMC-ODS is to provide timely access to medically necessary quality care in the most clinically appropriate and cost-effective therapeutic settings. Beneficiaries can access the BHRS system of care through multiple pathways. Whether individuals reach out to a known treatment provider in their community, or call the 24-hour toll free Access Call Center, or are connected via warm handoff through their primary care physician, the emergency department, or even their probation officer, BHRS welcomes individuals in need of treatment in the places where they already show up. Beneficiaries have access to a full continuum of SUD services with an emphasis on receiving the right care, at the right time, with the right provider.

Care Coordination and Case Management Strategy

BHRS defines Care Coordination as services and supports for individuals not presently connected to any part of the BHRS DMC-ODS. Care Coordination's principle goal and responsibility is to connect individuals to the appropriate SUD service provider. Once connected and the transition has been completed the County Care Coordination Team (CCCT) no longer provides services. All CCCT services and supports are provided by County staff. CCCT staff work closely with and are embedded in the San Mateo Medical Center and Primary Care clinics, Emergency Department, and Psychiatric Emergency Services. The CCCT also works closely with the Health Plan of San Mateo, Probation and Social Services. In addition to general referrals from these community partners, the CCCT has specific responsibility for work with high utilizer clients from the Emergency Department, Psychiatric Emergency Services and Correctional Health. The CCCT can work with difficult to engage clients for extended periods of time to eventually facilitate entrance into SUD care.

San Mateo CCCT BHRS defines Case Management as services and supports for individuals in a SUD program and delivered by a contract provider. Case management facilitates connections to ancillary services and supports that are identified in the client's treatment and recovery plan.

As described, the CCCT will turn over case management responsibilities to the provider once the client is enrolled in the new program. Below are responsibilities that are provided by either or both CCCT and CM.

1. Assesses client needs, motivation, and barriers to care (CCCT, CM)
2. Provides patient education and engagement (CCCT, CM)
3. Coordinates quality referrals to improve transitions into SUD and other needed services (CCCT, CM)
4. Provide SBIRT services, including comprehensive substance use, physical and mental health screening (CCCT)
5. Engage clients and support their participation in integrated health programs. (CCCT,CM)
6. Evaluate clients with SUD to determine residential treatment need (authorization and reauthorizations) and to identify the most appropriate service provider(s) for the client (CCCT)
7. Provide logistical support for clients to ensure seamless and timely entry or transitions between levels of care (CCCT, CM)
8. Provide services to high risk and high utilizers of emergency services with an emphasis on outreach, engagement, systems navigation, and collaborative care planning across SUD services, mental and physical health services, and other social and community based service providers (CCCT).
9. Initiate complex case conferences and physician consultation (CCCT, CM)

10. Receive referrals for individuals who are at-risk of or have histories of unsuccessful treatment engagements. Deliver engagement strategies including motivational interventions (CCCT)

CCCT and CM may be provided to a client face-to face, by telephone, or by telehealth and may be provided anywhere in the community and are provided in compliance with confidentiality of alcohol or drug patients as established by 42 CFR Part 2 and California law.

[This is a placeholder for: FIGURE 1 Client Flow Process: Request for help initial call or referral.]

Requesting Services

San Mateo County has a “no wrong door” philosophy to treatment. Any individual or family member may contact BHRS or a community SUD provider to learn about available services. There are typically three pathways of system entry: 1) calls or walk-ins to a SUD network provider, 2) calls to the BHRS Access Call Center (ACC), 3) walk-ins or direct referrals to the BHRS County Care Coordination Team (CCCT). Direct referrals to CCCT come from a variety entities including but not limited to: probation, correctional health, primary care clinics, the emergency department and psychiatric emergency services, specialty mental health clinics, child welfare and CalWORKs. Regardless of the entry point, each individual is registered and screened following the same process and tools described below in the Initial Service Screening section.

Initial Service Screening

All individuals are triaged for risk (suicidality, homelessness, emergent physical health needs), insurance coverage/eligibility verification, and are advised of the benefits to which they are entitled under the DMC-ODS. A uniform SUD screening tool and decision tree based on the American Society of Addiction Medicine (ASAM) dimensions will be developed and implemented by the Access Call Center staff, BHRS Care Coordinators, and network SUD providers by July 1, 2016. The screening will include client eligibility and demographics and preliminary SUD level of care (LOC) determination. Screening will be completed by clinicians or certified SUD counselors.

Once screened, the beneficiary will be referred /linked to the appropriate ASAM LOC. Placement considerations include findings from the screening, geographic accessibility threshold language needs, and beneficiary preference. Uniform referral procedures for all entry pathways will be established. Beneficiaries may be referred directly to any SUD network provider for an intake appointment for the following services:

- Outpatient and Intensive Outpatient Services
- Narcotic Treatment Program Services
- Outpatient Withdrawal Management Services
- Medication Assisted Treatment Services

- Recovery Services
- Case Management Services

Individuals with an initial screening suggestive of a residential placement shall be provided a residential evaluation prior to scheduling the intake appointment.

Residential Evaluation and Authorization

The County Care Coordination Team (CCCT) completes the residential services evaluation and authorization as described in Section 20: Residential Authorization. An evaluation appointment will be offered within 24 hours of the initial screening call and may be provided face-to-face, by telephone, or by telehealth, and may be provided anywhere in the community. After hour requests on nights, weekends or holidays will be delegated to the BHRS Access/Call Center after hours contract provider.

The residential evaluation may include the following: SUD identification, screening, assessment, stage of change evaluation, motivational enhancement, preliminary recovery/treatment planning, treatment authorization, referral, placement, and case management to facilitate prompt client placement. The CCCT may also assist clients in connecting to other types of needed services, such as food and shelter.

Intake Appointment: Assessment and Medical Necessity Determination

Once a beneficiary has completed the initial screening process and the residential evaluation when appropriate, he or she will be offered an intake appointment at a provider location of the client's choosing within the parameters of the ASAM screening results. The CCCT will assist individuals in scheduling an intake appointment with a SUD network provider. The appointment will meet the BHRS standards for timeliness based on clinical need (see 8e).

All SUD network providers will verify Medi-Cal eligibility and complete a comprehensive client assessment at intake. BHRS requires the use of the Addiction Severity Index lite (ASI-lite), a validated assessment tool developed by Tom McLellan Ph.D. and the Treatment Research Institute (http://www.tresearch.org/wp). An ASAM placement tool (still to be identified) will also be required to determine client severity in each of the six ASAM domains areas to guide placement decisions. See Section 14: Assessment for more details about the BHRS assessment process and requirements.

Medical necessity for services must be determined as part of the intake assessment process and will be performed through a face-to-face review or via telehealth. The Medical Director, a licensed physician, or a Licensed Practitioner of the Healing Arts (LPHA) must diagnose the beneficiary as having at least one DSM Substance-Related and Addictive Disorder, excluding Tobacco-Related Disorder and non-Substance-Related Disorders. A qualifying diagnosis for beneficiaries under the age 21 includes an assessed risk for developing a SUD. All providers must document the diagnosis in the client chart and indicate how the client meets the ASAM Criteria definition for services.

The final determination for level of care placement is based on the results from the full comprehensive ASAM assessment and therefore may override the findings from the preliminary screening. In such cases the provider must work with the client to transition him/her to the appropriate level or care, up to and including transitioning to another provider facility. If it is determined residential detoxification or residential treatment is required, the provider shall request prior authorization from the BHRS CCCT and provide evidence for that level of care from the comprehensive assessment following the process outlined in Section 20: Residential Authorization. In the event that a beneficiary does not meet medical necessity for residential treatment, even if the beneficiary has obtained a prior authorization from the BHRS CCCT, the provider shall notify and work with the CCCT and the client to identify appropriate services (and provider when necessary) and transition the beneficiary within 5 days of the residential admission.

Re-Assessment

Re-assessments allow the treatment team to review client progress, comparing the most recent client functioning and severity to the initial assessment and to evaluate the client's response to care or treatment services. Each ASAM dimension is reviewed to determine the current level of functioning and severity. Providers are required to demonstrate beneficiaries continue to meet current level of care criteria or determine that an alternative is most appropriate.

All beneficiaries will be reassessed any time there is a significant change in his/her status, diagnosis, a revision to the client's individualized treatment plan, and as requested by the client.

Providers will reassess for medical necessity and appropriate level of care within the maximum timeframes noted below.

[This is a placeholder for TABLE 3: Level of Care and Reassessment Timeframe Maximum.]

Recovery Services

All SUD providers are expected to individualize treatment and use the full continuum of services available to beneficiaries to ensure clients receive the most appropriate care. Case management services will help assure clients move through the system and access other needed health and ancillary services to support their recovery. As beneficiaries complete their course of treatment, they are connected to recovery services to build connections with the recovery community and to continue to develop self- management strategies such as WRAP (Wellness Recovery Action Plan) to prevent relapse. If an individual does relapse, peer coaches can quickly reconnect the beneficiary to treatment for further care. Access Call Center staff, the BHRS CCCT, or a SUD network provider can all redirect individuals to more intensive care in the event of a crisis or relapse.

Role of County Care Coordination Team and Quality Management

Timely and seamless client transitions to SUD providers and other health, social service, and community based providers are supported through the CCCT emphasis on partnering, training, and technical assistance. The CCCT has developed referral protocols and tracking tools, completes daily shift reports, obtains a daily census report from SUD providers to track bed availability and to monitor placements and utilization. The CCCT coordinates, and at times intervenes on behalf of patients and providers to ensure smooth transitions between levels of care. Referral, engagement and treatment data is tracked to monitor the success of care coordination activities. Through the DMC ODS, BHRS will expand the CCCT capacity to serve beneficiaries who risk not connecting to needed services without care coordination.

The CCCT case manager staff functions as the "lead" when multiple providers are working with a single individual. Once a client is placed in a distinct treatment modality, such as residential or outpatient, the day to day case management will be provided by the treating provider agency. The CCCT will consult with the treatment provider on intersystem care coordination needs, can convene complex case conference and consult on discharge planning and future placement decisions.

The CCCT conducts the initial residential evaluation and authorization, and reviews all residential reauthorization requests for medical necessity, ASAM criteria, and appropriate placement. Recovery Residence placements also require BHRS CCCT authorization. Since the CCCT will monitor bed availability, they are able to facilitate

rapid entry to residential services and effectively coordinate care within the SUD provider network ensuring beneficiary access and utilization of the full continuum of services. This process will be expanded under the DMC ODS implementation. BHRS monitors capacity through its electronic health record, which reconciles authorizations, utilization, and contract funding levels to assure financial integrity.

To support the SUD provider network in serving clients in the most appropriate ASAM level, BHRS will make available physician consultation services to physicians needing added support in treating a beneficiary. Consultation services may address medication selections, dosing, side effects, level of care considerations, or other complexities which arise in treating a client. Consultation services may be provided by addiction medicine physicians, addiction psychiatrists, or clinician pharmacists.

BHRS Quality Management (QM) will audit the CCCT authorizations, review individual client records and system-wide data to ensure that the BHRS system of care is working in accordance with ASAM criteria. Specifically, QM will ensure medical necessity for level of care placement has been determined by the intake assessment. SUD provider charts will be audited to ensure client care is individualized. System-wide data will be reviewed, such as length of stay in a particular level of care, to determine that care is provided based on the client's assessment and progress. Transition from one level of care to another will also be analyzed for evidence of appropriate care coordination. (See Section 11 for additional details.)

3. **Beneficiary Access Line.** For the beneficiary toll free access number, what data will be collected (i.e. measure the number of calls, waiting time, and call abandonment)?

BHRS operates a 24-hour toll free number beneficiaries can call to access services. Each call answered is logged and the following data is collected:

- Call time
- Call duration
- Caller's name
- Call type
- Disposition
- Person who answered the call
- Caller's preferred language
- Utilization of interpreter services

Other data collected includes:

- Insurance type
- Disposition type (Specialty, Network, AOD, PCP, Community Resources)
- Total calls received
- Total calls answered
- Abandonment rate
- Average answered hold time (in seconds)

- Average abandoned hold time (in seconds)
- Number of complaint or grievance calls

4. **Treatment Services.** Describe the required types of DMC- ODS services (withdrawal management, residential, intensive outpatient, outpatient, opioid/narcotic treatment programs, recovery services, case management, physician consultation) and optional (additional medication assisted treatment, recovery residences) 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 American Society of Addiction Medicine (ASAM) level, including opioid treatment programs. Names and descriptions of individual providers are not required in this section; however, a list of all contracted providers will be required within 30 days of the waiver implementation date.

BHRS maintains and monitors a network of providers under Board of Supervisors approved contracts, ensuring adequate access to services for beneficiaries. Services are individualized for beneficiaries when determined medically necessary and based on the level of care indicated utilizing the ASAM multidimensional assessment criteria. It is an expectation that all providers connect beneficiaries to services to meet other physical health, mental health, and ancillary service's needs based on the ASAM multidimensional assessment. All DMC network providers are required to meet established timely access standards.

Contracted DMC provider facilities are required to maintain DHCS SUD licensure, in addition to DMC certification. Perinatal Services Network Guidelines are followed by the appropriate providers. Facility staff are licensed or certified and are in compliance with certification requirements. All contracted providers are required to comply with Federal, State, and local requirements, including BHRS standards and evidence-based practices that meet the DMC- ODS quality requirements.

[This is a placeholder for TABLE 4: Services BHRS will provide as part of the DMC-ODS System (including service type, ASAM level, required or optional service type).

Service Descriptions

A. Early Intervention (ASAM Level 0.5)

BHRS staff provides Screening, Brief Intervention, and Referral to Treatment (SBIRT) for all substance use conditions in collaboration with the San Mateo Medical Center (SMMC) within primary care clinics, specialty care clinics, Emergency Department and Psychiatric Emergency Services Department. Beneficiaries at risk of developing a SUD or those with an existing SUD are

identified and offered: screening for adults and youth, brief treatment as medically necessary, and, when indicated, a referral to treatment with a formal linkage.

B. Outpatient Services (ASAM Level 1.0)

Outpatient services consist of up to 9 hours per week of medically necessary services for adults and less than 6 hours per week of services for adolescents. Providers will offer ASAM Level 1 services including: assessment, treatment planning; individual and group counseling; family therapy; patient education; medication services; collateral services; crisis intervention services; and discharge planning and coordination. Services may be provided in-person, by telephone, or by telehealth in any appropriate setting in the community.

C. Intensive Outpatient Services (ASAM Level 2.1)

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

D. Withdrawal Management Services (ASAM Levels 1-WM, 3.2-WM)

Withdrawal Management services are provided as medically necessary to beneficiaries and include: assessment, observation, medication services, and discharge planning and coordination. Beneficiaries receiving a residential withdrawal management shall reside at the facility for monitoring during the detoxification process. BHRS will offer ASAM Levels 1-WM: Ambulatory Withdrawal Management without Extended On-Site Monitoring by the end of Implementation Year 1 (**IY1**). BHRS will release a request for proposals (RFP) to identify qualified DMC-ODS providers for ASAM Level 3.2-WM: Clinically-Management Residential Withdrawal Management. At this time, BHRS will not offer ASAM Level 2-WM, however we will review utilization and ASAM data and make a determination by the end of IY2 whether there is a demonstrated need for this level of care within our continuum. Should a need be substantiated an RFP would be released for ASAM L 2-WM.

BHRS will work with Sutter Health's Mills Peninsula Hospital and other area service providers to assist beneficiaries to access ASAM Levels 3.7-WM (Medically-Monitored Inpatient Withdrawal Management) and 4.0-WM (Medically-Managed Inpatient Withdrawal Management) when medically necessary. BHRS will coordinate with these providers to smoothly transition and support beneficiaries to less intensive

levels of care available within the DMC- ODS.

E. Residential Treatment Services (ASAM Levels 3.1, 3.3, 3.5)

Residential treatment is a 24-hour, non-institutional, non-medical, short-term service that provides residential rehabilitation services to youth, adult, and perinatal beneficiaries. Residential services are provided in facilities designated by DHCS as capable of delivering care consistent with ASAM Level 3.1: Clinically-Managed Low-Intensity Residential, ASAM Level 3.3: Clinically Managed Population-Specific High-Intensity Residential Services (Adult only), and ASAM Level3.5: Clinically-Managed High-Intensity Residential.

Beneficiaries are approved for residential treatment through a prior authorization process based on the results identified by the residential evaluation and ASAM assessment. The length of stay for residential services may range from 1-90 days, unless a reassessment of medical necessity justifies a one-time services reauthorization/extension of up to 30 days. Only two non-continuous 90-day regimens will be authorized in a one-year period. Perinatal and criminal justice involved clients may receive a longer length of stay based on medical necessity.

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

BHRS is awaiting DHCS to issue provisional ASAM designations for currently contracted licensed residential providers. We believe current providers offer ASAM residential levels 3.1 and 3.5, and that these services will be available in **IY1** DMC-ODS providing timely DMC Certification can be secured from the DHCS Provider Enrollment Division. BHRS will ensure ASAM level 3.3 is available within 3 years of final approval of the County's implementation plan and will follow the County policy and process for selecting new providers.

For clients in any residential treatment program, case management services will be provided to facilitate "step down" to lower levels of care and support.

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

BHRS contracts with a licensed Narcotic Treatment Program to offer services to beneficiaries who meet medical necessity criteria requirements. Services are provided in accordance with an individualized client plan determined by a licensed prescriber. Prescribed medications offered include methadone, buprenorphine, naloxone and disulfiram and other medications covered under the DMC- ODS formulary.

Services provided as part of an OTP include: assessment, treatment planning,

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

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

BHRS offers medically necessary MAT services through BHRS staff and contracted providers, an NTP program and a provider licensed as a primary care clinic. Services include: assessment, treatment planning, treatment, case management, ordering, prescribing, administering, and monitoring of medication for substance use disorders.

MAT will expand the use of medications for beneficiaries with chronic alcohol related disorders and opiate use. Medications will include: naltrexone, both oral (ReVia) and extended release injectable (Vivitrol), topiramate (Topamax), gabapentin (Neurontin), acamprosate (Campral), and disulfiram (Antabuse)

- Opiate overdose prevention: naloxone (Narcan)
- Opiate use treatment: buprenorphine-naloxone (Suboxone) and naltrexone (oral and extended release) (Note: Methadone will continue to be available through the licensed narcotic treatment program)
- For tobacco cessation/nicotine replacement therapy

Additionally, BHRS is currently coordinating care and expanding the availability of MAT outside the DMC- ODS by building the capacity of the entire health system to use these treatments for beneficiaries with a substance use disorder. BHRS is training physicians, nurse practitioners, and psychiatrists in primary care and specialty mental health clinics on the efficacy of using MAT, practice guidelines, and medication administration. Physician consultation is supporting implementation in areas such as: medication selection, dosing, side effect management, adherence, and drug-drug interactions.

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

Recovery services are available once a beneficiary has completed the primary course of treatment and during the transition process. Beneficiaries accessing recovery services are supported to manage their own health and health care, use effective self-management support strategies, and use community resources to provide ongoing support.

Recovery services may be provided face-to face, by telephone, via the internet, or elsewhere in the community. Services may include: outpatient individual or group counseling to support the stabilization of the client or reassess the need for further care; recovery monitoring/recovering coaching; peer-to-peer services and relapse prevention, WRAP development, education and job skills; family support; support

groups and linkages to various ancillary services. Any eligible DMC provider within the network may provide medically necessary recovery services to beneficiaries.

I. Case Management Services

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

Case management services may include: comprehensive assessment, level of care identification; client plan development; coordination of care with mental health and physical health; monitoring access; client advocacy and linkages to other supports including but not limited to mental health, housing, transportation, food, and benefits enrollment. Case managers will be trained and utilize Motivational Interviewing (MI) and Motivational Enhancement Therapy (MET), harm reduction, and strength based approaches. Case management services will be provided by contract providers and BHRS staff. High utilizers and complex clients will have an assigned lead case manager from the BHRS CCCT to oversee SUD care and coordinate with other treatment services and systems. The CCCT communicates with the treatment provider to reduce risk of duplicated case management efforts and will lead complex care coordination when the client needs services from multiple county systems. All other clients receive case management services exclusively from the contract the provider agency where the client is admitted and receiving treatment services. All case management services are consistent with confidentiality requirements identified in 42 CFR, Part 2, and California law, and the Health Insurance Portability and Accountability Act (HIPAA).

J. Physician Consultation

Physician consultation services assist physicians and nurse practitioners seeking expert advice on complex client cases and designing the treatment plan in such areas as: medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.

BHRS trains psychiatrists and psychiatric nurse practitioners in integrated settings on medication guidelines and offer the opportunity for them to consult one-on-one with a psychiatrist who has an addiction medicine background. Physician consultation to primary care and behavioral health providers for the use of Vivitrol, buprenorphine, other medications, and pain management is made available in an effort to build the capacity of the entire health system to treat beneficiaries with

substance use disorders.

San Mateo County may use existing staff, or contract with addiction medicine physicians, addiction psychiatrists, or clinical pharmacists to provide consultation services.

K. Recovery Residences

Recovery residences (RR) are available for beneficiaries who require housing assistance in order to support their health, wellness and recovery. There is no formal treatment provided at these facilities however residents are required to actively participate in outpatient treatment and/or recovery supports during their stay. There is no predetermined maximum length of stay. On a case by case basis BHRS CCCT will determine the length of stay. The County is developing standards for contracted RR providers and will monitor to these standards. RRs are not reimbursable through Medi-Cal.

L. Optional Service Levels Pending ASAM Utilization Review

BHRS will consider whether to offer additional optional services available under the waiver once baseline data on beneficiary ASAM service need and utilization has been collected and analyzed. If an unmet need for a service is determined, BHRS will amend this plan to incorporate the additional service(s) and will initiate a RFP process to identify qualified providers. Service levels which BHRS anticipates for possible expansion include: Withdrawal Management (ASAM 2-WM) and Partial Hospitalization Services (ASAM 2.5)

M. Service Level Barriers

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

N. Coordination with Surrounding Counties

BHRS has established strong relationships with surrounding counties' substance use service divisions through state level associations and Bay Area collaborations. We periodically meet to discuss service models and best practices forming a foundation of coordination to ensure beneficiaries who reside in an opt-out county will not experience a disruption of services. BHRS will provide original DMC modalities to any beneficiary in an opt-out county seeking services within San Mateo County and we will coordinate with neighboring counties, whether opt-in or opt out, to ensure beneficiaries can access services easily and quickly. We will also work together, as needed, when a regional approach is required to deliver a component of

the continuum of care e.g. youth residential treatment.

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

BHRS consists of substance use and mental health (MH) services consolidated into a single division within the Health System of San Mateo County. Each program is supervised under a single executive management structure consisting of a director, assistant director, and medical director; a deputy director for youth programs and services and a deputy director for adult services; and a single team of program managers. SUD staff and programming are integrated into the organization, sharing the same policies and procedures, administrative support, and often facilities with mental health. The DMC-ODS provides further opportunity to fully align BHRS programs and services not only for cases of co-occurring disorders, but to assure that there is no wrong door when an individual makes the decision to seek treatment and begin their recovery.

Approximately eight years ago, SUD and MH services were organized in separate departments with little interaction between staff and contract providers. With the implementation of the Mental Health Services Act, the two departments began collaborating on service delivery to individuals with co-occurring substance use and mental health disorders with a common understanding, that people with co-occurring SUD and MH conditions are the “expectations” and not the “exception”. This collaboration eventually led to a reorganization that established BHRS and brought under a single administrative structure SUD and MH services.

Over this period of time continuous training and technical assistance to staff and providers in both systems has been provided through our “co-occurring initiative” and Change Agent efforts. SUD Counselors and MH Clinicians partner to co-facilitate groups at various county and contractor locations. A co-occurring screening tool (ACOK, Andrew Cherry Oklahoma) has been identified and implemented by MH and SUD providers. Care coordination and referral procedures have evolved and improved during the past eight years. The BHRS Access/Call Center is now responsible for service requests for both SUD and MH treatment requests.

Under the direction of the BHRS Medical Director, complex case conferences are convened for individuals who are not progressing in their treatment and recovery. The large percentage of these clients has co-occurring issues.

BHRS facilitates “Field Crisis Committee” meetings throughout the County in collaboration with law enforcement, education, providers, NAMI, city representatives, etc. to identify individuals who are experiencing significant challenges, most frequently including co-occurring issues, and not well connected to services. The committee develops

engagement and care coordination strategies.

BHRS deliberately set out in the DMC-ODS planning process to avoid the development of another silo. Instead, we looked for opportunities to build upon the existing structures within BHRS to enhance services to individuals with co-occurring disorders. It will be a contractual requirement for all service providers to have at a minimum a medical director and a professional staff who meets the standards for a Licensed Practitioner of the Healing Arts. With these professionals on staff, providers will have greater capacity to serve this population and provide integrated care. To support the integration of services and ensure quality, BHRS will expand quality assurance and improvement functions by extending the oversight of the quality management unit to include DMC-ODS programs and services. The experience and skill of quality review staff in cooperation with fiscal, technical, and administrative staff will prove invaluable during performance reviews, audits, reporting, and evaluations, assuring compliance within DMC-ODS requirements. This approach provides the support to conduct regular internal reviews and ongoing monitoring to test for compliance and help to achieve performance standards and benchmarks. This creates opportunities for more holistic quality improvement measures that incorporate both SUD and MH practices, which will have greater impact on client outcomes when conducted within an integrated service delivery system.

Currently, BHRS coordinates services between programs for individuals with co-occurring disorders through a single electronic health record, coordinated treatment and recovery plans, and integrated or coordinated service teams that remain in regular communication with one another since BHRS employees belong to the same organization, are often co-located, share the same email, calendaring, and telephone systems. Several contract providers have user accounts for computer and communications systems and have staff that are co-located. All HIPPA and 42 CFR part 2 requirements are met.

SUD/MH integration occurs in a few ways. A number of SUD contract agencies also contract with BHRS to provide mental health services to beneficiaries. The Access Call Center can refer beneficiaries to these integrated agencies. Some SUD contract providers can perform screening and assessment functions for new mental health clients as well as for SUD clients; mental health providers screen and refer clients to needed SUD service providers within the network. Same Day Assistance is designed to screen individuals with substance use and mental health conditions on the day of a request for service. SDA is organized in geographic regions in the County. For each region there are primary points of entry for SDA. For individuals likely to have a primary SUD, beneficiaries will be directed to a SUD provider in that region. For individuals likely to have a serious mental health condition the beneficiary will be directed to the County operated mental health clinic. For individuals that may have co-occurring SUD and MH conditions the initial SDA contact may occur at either the SUD provider or MH clinic. From the SDA screening a determination is made where best to refer and serve the beneficiary. If services are not provided by the SDA provider they will facilitate a “warm hand-off” whereby the SDA provider will secure an intake appointment for the client, provide a bus token/taxi voucher if transportation is a potential barrier, and with the client’s consent share information derived from the SDA screening process with the

treatment provider. The SDA provider will contact the treatment provider subsequent to the intake appointment to find out if the client made the appointment as scheduled.

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

BHRS and the San Mateo County Medical Center (SMMC) which operates a public hospital, psychiatric emergency and inpatient unit, and primary care centers throughout the county are part of the Health System of San Mateo County. Integrating behavioral health and physical health care in San Mateo County began almost twenty years ago by embedding mental health (and later substance use counselors) in the primary care centers, while out stationing nurse practitioners in BHRS regional clinics to serve adults living with a serious mental illness (many of whom have a co-occurring SUD).

Five years ago BHRS and SMMC built on this foundation by implementing a "Total Wellness" program that created a team consisting of a primary care physician, nurses, counselors and peer workers. Total Wellness provides, in addition to primary care services, a full array of services and supports to individuals with co-occurring disorders that includes smoking cessation, weight management, diabetes education and support, and physical conditioning.

Within the past year, a significant level of integration and coordination between primary care and BHRS has been achieved with the Medication Assisted Treatment (MAT) program by embedding a substance use screening and brief intervention service directly into the Medical Center's Emergency Department and Psychiatric Emergency Services so that individuals living with a SUD, who have a tendency to be frequent visitors to emergency rooms, can be engaged directly at the time they may be most likely to be open to treatment. BHRS also has five full-time substance use case managers embedded with the primary care BHRS team noted above. These case managers will directly assist and coordinate substance use treatment services to patients in a primary care setting. BHRS also has substance use case managers dedicated to working with identified patients in the Innovative Care Clinic at the County medical center, the pain management clinic, and our HIV clinic. There is also a dedicated SUD youth case manager who works to engage youth admitted to psychiatric emergency services with substance use treatment needs.

More recently, the Health System initiated a project called "Enterprise-Wide Master Patient Index (EMPI)," which will assign an index number to all cases from information systems within the Health System and allow for the basic sharing of patient information to improve care coordination. It will also allow for data analysis across divisions including matching to determine if referrals from one division to

another were completed, to determine if a patient is commonly known to several programs, and for sharing of electronic health record data so services are integrated, coordinated, and effective. The EMPI will also be deployed to conduct population level studies using predictive modeling tools. All information sharing will be compliant with HIPPA and 42 CFR Part 2.

BHRS is in a “one plan” managed care county and the one plan is the Health Plan of San Mateo (HPSM). HPSM understands county operations and service delivery systems since several of their key executive staff once worked for the county. BHRS maintains several agreements with HPSM that create performance standards, compliance monitoring, and reporting requirements that reinforce quality, responsiveness, timeliness, and effective of services to beneficiaries.

Through a Qualified Service Organization agreement, HPSM has access to BHRS' electronic health record, allowing HPSM care coordination staff access to treatment plans and progress notes. HPSM care coordination staff work closely with BHRS case managers, therapists, and psychiatrists to coordinate care and include them in the care team. HPSM and BHRS leadership meet regularly through multiple forums that include the Adult Services Oversight Committee (monthly), weekly HPSM/BHRS operations meetings, and quarterly joint operations meetings.

HPSM delegates behavioral health and recovery services for beneficiaries with mild and moderate mental health conditions to BHRS, so that all beneficiaries with SUD and MH conditions that make up the continuum of care are coordinated through one single entity. It is more common for the mild and moderate populations to be treated in primary care or individual practitioner settings, but BHRS assumes care responsibility for all populations, and also directly supports individuals with substance use disorders in a primary care setting by providing doctor to doctor consults and embedding BHRS staff in primary care clinics. BHRS also maintains a provider network of LPHAs to provide network adequacy to meet new service demands of the beneficiary expansion.

In response to the implementation of the DMC-ODS, BHRS continues to develop the resources by expanding the number of contract providers and recruiting organizations with significant experience in serving individuals with growing case complexity. This complexity can include co-morbidity and the lack of health homes for patients to achieve optimum health and positive outcomes.

Recently, a contractor opened a treatment facility providing medication assisted treatments in the county; the provider now seeks to expand to a primary care services clinic so that individuals seeking substance use disorder treatment can also have their physical health needs met concurrently. This provider will be adding capacity over time in hope that they can meet the primary care needs of BHRS clients.

Existing relationships, contractual obligations to collect and analyze performance data, ongoing and regular meetings, treatment programs embedded in primary care, open access data sharing, and the development of contract providers will help with coordination between the DMC-ODS and physical health.

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

   - Comprehensive substance use, physical, and mental health screening;
     There are challenges with the implementation of SBIRT within the Medicaid Managed Care Plan's (Health Plan of San Mateo – HPSM) provider network. BHRS will work with HPSM to assess whether technical assistance in engaging and incentivizing primary care providers is necessary.

     To help facilitate access to care for beneficiaries, BHRS will be implementing a decentralized screening process that will require significant training, coordination and oversight of network providers for consistent application of requirements and standards. Implementation of the STCs will place new expectations on SUD providers that may require individualized technical assistance.

   - Collaborative treatment planning with managed care;

     BHRS works closely with HPSM on coordination of care issues for mental health, substance use and physical health. Planning and problem solving occurs at the population health and individual client levels of care. Part of the initial implementation will be to educate HPSM care coordinators on the specific level of care, and referral and assessment protocols for the DMC- ODS. BHRS would be interested in information and/or technical assistance on models of care coordination with managed care plans.

   - Care coordination and effective communication among providers;
     With the implementation of the full continuum of care of the DMC- ODS and the emphasis on levels of care based on ASAM criteria, there will be an increased expectation and need for care coordination among providers. We anticipate some challenges during the initial implementation and BHRS will be working closely with providers to identify obstacles and develop improvements. BHRS will also evaluate grievances to determine if beneficiaries are experiencing any negative repercussions due to problems with care coordination. BHRS may seek technical assistance to improve care coordination if challenges arise.

   - Navigation support for patients and caregivers;
     The implementation of case management and recovery supports will be significant system improvements in assisting clients and others in navigating

services. BHRS has implemented a “same day assistance” protocol that upon referral (including self-referrals) directs clients to services that best meets their presenting needs. At this time we are not anticipating significant challenges in this area.

8. **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:

   a. The anticipated number of Medi-Cal clients.
   b. The expected utilization of services
   c. The number and types of providers required to furnish the contracted Medi-Cal Services
   d. Language capability for the count y threshold languages
   e. Timeliness of first face to face visit, timeliness of services for urgent conditions and access to afterhours care
   f. The geographic location of providers, hours of operation and Medi-Cal beneficiaries, considering distance, travel time, transportation, and access for beneficiaries with disabilities
   g. Is there a current waiting list for services?
   h. How will counties address service gaps?

8a. The Anticipated Number of Medi-Cal Clients

As of October 2015, San Mateo County had approximately 118,000 Medi-Cal beneficiaries according to local health officials. Prevalence estimates vary. Up to 14.2% of the Medicaid population meets the diagnostic criteria for a substance use disorder according to NSDUH (2008-2010 National Survey of Drug Use and Health, 2013 American Community Survey), while the California Department of Health Care Services (DHCS Behavioral Health Needs Assessment, Vol. 2 2013, page 30) estimates 10.3% of the population meets criteria for a SUD. Using these prevalence estimates BHRS projects between 16,756 to 12,154 Medi-Cal beneficiaries have a SUD and could benefit from treatment.

SAMHSA data indicate 10.8 percent of those who needed treatment received treatment in a specialty program. Given this, BHRS anticipates serving between 1,313 and 1,810 new beneficiaries in the first year of implementation that have not been able to access treatment services until this expansion. Table 5 below presents the actual beneficiary counts with prevalence and penetration high and low estimates for adults and youth for BHRS.

The Department of Health Care Services in the 2013 Behavioral Health Needs Assessment estimated the penetration rate at 7.29 percent for San Mateo County. This results in a caseload range of 1,222 to 929 beneficiaries. For planning purposes BHRS will be using the SAMHSA methodology because with the implementation of the DMC-

ODS there will be a more structured outreach and engagement processes as well as a full continuum of services that will be more responsive to the treatment needs of this population than has previously existed. Therefore, BHRS will use an estimate high of 1,810 and an estimate low of 1,313.

[This is a placeholder for TABLE 5: Beneficiary Estimates Based on 2015 Actuals with Prevalence and Penetration Estimates by Adult and Youth.]

[This is a placeholder for TABLE 6: Prevalence and Penetration Calculations Projected over 5 Years.]

8b. the Expected Utilization of Services

San Mateo County used a number of historical and forecasted approaches in determining service utilization and projections. Table 7 below details service utilization reported from existing data collection systems. This information is based on actual treatment admissions for Fiscal Year 2013-2014 and Fiscal Year 2014- 2015. This data reflects the pre-expansion effort of BHRS to develop residential in-patient capacity needed in the short term and the increase of residents in need of these modalities whose previous options were mostly outpatient modalities or accessing residential treatment through other funding sources. Prior to January 1, 2014 residential treatment was not a Drug Medi-Cal treatment option. Specifically, Table 7 shows an increase between FY13/14 and FY 14/15 in residential inpatient treatment due to the implementation of the ACA January 1, 2014 so Fiscal Year 13-14 only represents 6 months of beneficiary expansion, the County's efforts to increase detox and residential treatment providers and expanding or maintaining the capacity of existing providers. Although the percentage of admissions of beneficiaries into outpatient treatment appears to be less, there were 62 more beneficiaries in FY 14/15 and there were 532 more beneficiaries in residential treatment modalities because of County and provider efforts mentioned above and the implementation date of the ACA.

Just over half, or 53% of treatment admissions for the two time periods were for outpatient and non-Residential Services. Just under half of the admissions, 47%, were for services in residential and inpatient modalities. These admissions are generally split evenly between residential detox and residential treatment that is greater than 30 days.

[This is a placeholder for TABLE 7: Medi-Cal Beneficiary SUD Treatment Admissions by Modality Actuals for FY 13-14 and FY 14-15.]

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

Table 8 below details the beneficiary penetration estimates shown in the previous section to establish the needed network capacity to meet beneficiary service demand. Taking into consideration the estimates in Table 8 combined with the average length of stay, capacity and utilization estimates by modality that BHRS will

need to dedicate resources to develop to meet the needs of the beneficiary expansion are 14 beds for residential detox, 90 beds for residential treatment greater than 30 days, capacity for 258 NTP maintenance slots, and 245 outpatient slots. The San Mateo Drug and Alcohol Treatment Access Report (DATAR), which tracks total treatment capacity by modality, indicates that existing provider capacity exceeds the capacity and utilization estimates listed above. As of December 2015, existing capacity for residential detox is 22 beds (6 dedicated to public treatment), for residential treatment greater than 30 days there are 191 beds available (115 dedicated to public treatment), there are 550 slots available for NTP maintenance (114 dedicated to public treatment), and 789 outpatient slots (547 dedicated to public treatment).

[This is a placeholder for TABLE 8: Medi-Cal Beneficiary SUD Treatment Admissions by Modality with Caseload Estimates for Current and Future Years through FY 2018-19.]

8d. Language capability for the county threshold languages

Drug Medi-Cal (DMC) providers will be required to abide by the San Mateo County Health System' language access policies specifically in providing interpretation and translation services to all clients. Interpretation will be made available to all clients and potential enrollees. DMC providers will include in their fiscal planning appropriate resources for providing language services to threshold populations in San Mateo County including but not limited to Spanish, Tagalog, Chinese, (and Mandarin). In addition, DMC providers will be required to attend mandatory "How to Work with Interpreters" training to ensure proper use of interpreters in service provision. BHRS through its Quality Management unit will ensure that DMC providers comply with the language access requirements for its beneficiaries. Currently, 20% of BHRS employees receive bilingual pay-which means 50% of their caseload are provided in languages other than English. Another 10-20% of staff are bilingual and/or bicultural and provide services in other languages but do not meet the 50% caseload threshold. BHRS does not currently track the percent of bilingual employees working at contractor facilities, but will begin tracking this as part of the BHRS annual cultural competency plan. All forms and appropriate materials will be translated to the threshold languages and be made available to DMC providers. Every effort will be made to have materials translated in an accurate and timely manner.

[This is a placeholder for TABLE 9: Type of Care and Time Frame]

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

The BHRS standard is for each beneficiary to be offered a first appointment within 15 days of referral or request for service for non-urgent services. To improve timely access to services for all beneficiaries BHRS will collect baseline data **IY1** to identify problem

areas and solutions, with the goal of all beneficiaries being offered an appointment within 10 days of a request for non-urgent services by **IY3**. A first appointment may be provided in any appropriate community setting, in-person, by telephone, or by telehealth.

Urgent conditions require immediate attention but do not require inpatient hospitalization. At the time of first contact, each beneficiary will be triaged to identify the presence of an urgent condition or emergent condition. Once BHRS or one of our network providers is made aware of the beneficiary's urgent condition, the urgent condition must be addressed (or the timeframe in which a beneficiary with an urgent condition must be seen) is within 24 hours.

BHRS offers beneficiaries access to screening and assessment as part of "Same Day Assistance". Beneficiaries can walk into a BHRS operated clinic (to be expanded to contract providers) or be referred to a clinic for a same day appointment by the BHRS Access Call Center.

All beneficiaries experiencing a medical or psychiatric emergency will be directed to the nearest hospital for services.

After hours care can be accessed by calling the 24-hour BHRS Access Call Center, where callers are screened and triaged for risk and appropriate referrals are made. In addition, network providers shall maintain a system of 24-hour on-call services for beneficiaries in their programs and shall ensure that clients are aware of how to contact the treating or covering provider after-hours, and during weekends and holidays. Provider contracts will include performance standards that will be measured monthly and reported to assure transparency

Upon request from the beneficiary, BHRS will provide for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.

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

Table 10 is a list of providers DMC certified or in the process of seeking certification as a BHRS DMC network provider. In addition to the providers listed below, BHRS anticipates contracting individually with licensed LPHAs to provide services in the network, especially to meet linguistic needs of beneficiaries in convenient service locations. Each location is identified as being in one of the three priority areas as described later in this section.

[This is a placeholder for Table 10: BHRS DMC Network Provider List]

[This is a placeholder for Table 11: New Beneficiary Caseload Estimates by City for Years 1 and 5 County of San Mateo]

San Mateo County's methodology for estimating the demand for services and projected number of beneficiaries is based on a combination of historical and current population growth data for each city in the county, service and client counts based on local electronic health record data, Medicaid expansion beneficiary data collected by the Health Plan of San Mateo, California Mental Health Prevalence Estimates for 2012 and modified with local experience and data for estimating prevalence. Based on this methodology we have assessed a priority for each city (the lower the score the higher the priority).

The rankings were then grouped into three priorities: Priority 1, Priority 2, and Priority 3. The first priority represents geographical locations with existing large populations and service demands that also scored relatively high for historical and cur-rent population growth rates and prevalence estimates. In Table 12 below, this priority is represented by the red shading for locations that San Mateo County will ensure that beneficiaries have access to all mandated modalities. The second priority represents locations with either fast growth rates or high service and client counts where building provider capacity will be focused. This priority is represented by the beige shading. The third priority represents cities with both slow growth rates as well as low service and client counts. This priority is represented by green shading. Scores for the growth categories were given 1 point above the mean and 2 points below while the AOD client counts and service demand category was give points equal to the numerical rank.

Priority Rank Legend:

- Priority 1 – Good existing network capacity/minimal investment required/all mandated services can be met within IY 1.
- Priority 2 – Fair network capacity/significant investment required/all mandated services can be met in IY 2 and IY 3.
- Priority 3- Poor network capacity/client base insufficient to warrant investment/monitor for changes and dedicate resources as necessary.

[This is a placeholder for TABLE 12: Geographical Location Order Ranked by Historical Growth, Recent Growth, and Number of AOD Clients: Prioritized By Level of Concern]

The Priority 1 cities identified above are geographically spread throughout the County (see County map below) and as a group are adjacent to or within transportation corridors to Priority 2 and 3 cities. During **IY1** mandated services will be available in Priority 1 cities. (The one exception is in the Half Moon Bay area where there are no current residential services so beneficiaries in need of such services will be offered transportation to the nearest and most appropriate residential treatment program). For **IY**2 and beyond BHRS will invest resources to expand network capacity in priority areas 2 and 3 as necessary to ensure capacity is adequate to meet the needs of beneficiaries and will be determined based on actual utilization patterns and the continuous monitoring of access issues.

The County of San Mateo has designated service areas and this map displays each of

the areas. The outline of color of each area indicates the priority under this plan.

- Priority 1 is represented by a RED outline.
- Priority 2 is represented by a BEIGE outline.
- Priority 3 is represented by a GREEN outline.

[This is a placeholder for GRAPH 1: displaying unique clients for the most recent complete fiscal year, 2013-14 by geographic location, representing current service demands that are being met by San Mateo County.]

[This is a placeholder for GRAPH 2: which represents growth of the client population between 2012 and the beginning of the current fiscal year. It also represents the service demand increase over this same period for the cities in which clients seek services in San Mateo County.]

The data in this section supports the geographic locations of San Mateo, Redwood City, East Palo Alto, South San Francisco, and Daly City as high service demand locations that would remain a priority for service delivery in the DMC-ODS implementation in San Mateo County.

Accessing treatment services for persons with disabilities

BHRS requires all network providers to serve persons with disabilities in compliance with SAPTBG and DHCS requirements and the following policies and regulations:

- Americans with Disabilities Act of 1990;
- Section 540 of Rehabilitation Act of 1973;
- 45 Code of Federal Regulations (CFR), Part 84, Non-discrimination on the Basis of Handicap in programs or Activities Receiving Federal Financial Assistance;
- Title 24, California Code or Regulations (CCR), Part 2, Activities Receiving Federal Financial Assistance; and
- Unruh Civil Rights Act California Civil Code (CCC) Sections 51 through 51.3 and all applicable laws related to services and access to services for persons with disabilities.

Regardless of where a person enters the BHRS system, that person will receive an initial screening to determine service needs and will be supported in accessing the appropriate services at an appropriate location. All contracted providers are required to make accommodations to serve persons with physical disabilities, including vision and hearing impairments. In addition, services must be made available to all individuals with mobility, communication or cognitive impairments as required by federal and state laws and regulations. BHRS maintains a reference list of SUD network treatment providers able to accommodate persons in wheelchairs. If a provider is unable to meet the needs of a person with a specific physical disability, they must use the aforementioned list to refer the person to a provider who can meet the needs of the individual. The referring provider is required to contact the new provider to expedite the person's transition to

ensure the individual is successful in accessing needed support and services.

Providers use the DHCS (ADP) checklist for accessibility and BHRS staff monitors compliance with regulations through a biennial desk audit. Beneficiaries are advised of their right to receive services and any complaints and grievances are investigated and appropriate and timely action is taken to ensure access.

G. Wait list for services

Current wait lists for services for FY15/16 are seen below and highlight service gaps in the county. With the implementation of the DMC ODS, expanded eligibility and services, and new federal revenues to support services, San Mateo County will proactively work with providers develop needed capacity.

[This is a placeholder for Adult Waiting List, SUD Services 1/1/15-11/30/15]

[This is a placeholder for Youth Waiting List, SUD Services 1/1/15-11/30/15]

H. Addressing Service Gaps

San Mateo County monitors timeliness of first appointment, and average length of stay, language and geographic access among other measures as part of our utilization management to identify and address service gaps. The county has already identified new providers through an RFP process to close existing gaps in youth treatment. Within the past year, a new outpatient treatment facility has opened providing youth and adult services. The county continues to look for an appropriate site with a provider partner for a new youth treatment facility in the southern part of the county. San Mateo County has actively worked to ensure access to youth residential treatment, and is pleased we now have an identified provider. We will expand the use of telehealth to provide timely access and to expand services to rural areas and for other clients who could benefit.

9. **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.

BHRS system-wide trainings are determined on an annual basis and offered to staff and community-based providers throughout the year. An annual employee and provider training survey assesses training needs and results are incorporated into an annual training plan. These trainings are held to the National CLAS Standards, Department of Health Care Services' guidelines as well as specific professional association standards (such as APA, CAADE/CAADAC, BBS, etc.) related to effective service provision including clinical and counseling care as well as responsiveness to working with diverse

communities. Training identified as evidenced- based, community-defined as well as promising practices will be highlighted in the training curriculum. Annually, BHRS offers two evidence-based practice topics among the following areas: motivational interviewing, relapse prevention, trauma informed care, psycho-education and cognitive behavioral therapy. Training and technical assistance on an ongoing basis will also be available for providers who will need additional support in issues related to DMC certification.

[This is a placeholder for the SMC BHRS Mandatory Trainings including: training topic, training description, training frequency, required or optional training]

SMCBHRS will offer a minimum of trainings in two of the areas below annually.

1. *Motivational Interviewing*
2. *Relapse Prevention*
3. *Trauma Informed*
4. *Psycho Education*
5. *Cognitive Behavioral Therapy (CBT)*

Examples of Evidence Based Practice Trainings Provided in the Past *

- Taking the Mystery Out of Relapse: Using the Gorski CENAPS Model
- Essential Motivational Interviewing Skills: Getting Started and Deepening Your Practice
- Trauma-Informed: Understand the Effects of Trauma and Learn How to Provide Trauma Informed Care to Patients
- Pharmacology of Addiction
- Medical Marijuana
- Synthetic Drugs
- Medication Assisted Treatment
- Family System and Addiction
- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Crisis Management and Safety
- Co-Occurring Informed Care

Examples of Organizational Trainings offered to Providers if Needed: (optional)

- Evaluating Critical Incidents
- Treatment Planning and Co-Occurring Disorders
- Narcotic Replacement and Therapy
- Medical Marijuana
- Relapse and Discharge
- Substance Abuse and Mental Health: Psychopharmacology
- Substance Abuse and Teens for Professionals
- Parenting and Teenagers
- Medical Necessity
- Leadership and Management Training for AOD and MH Managers

- Continuous Quality Improvement
- Handling of Prescription Drugs
- Introduction to Substance Abuse and Treatment
- Prescription Drugs and Prescription Drug Abuse
- Integrating Smoking Cessation into AOD Treatment Programming
- Introduction to Substance Abuse for Mental Health Professionals

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

BHRS requests technical assistance in the following areas:

- ASAM training, resources, and tools. A train the trainer model would be preferred to build internal system capacity and meet ongoing training needs to accommodate new staff and providers, to ensure inter-rater reliability for placement decisions, and for utilization management.
- Fidelity assessment for evidence based practices
- Provide a current list of all California licensed and DMC certified youth residential facilities by ASAM level.
- Assist BHRS in care coordination with acute services, we request DHCS provide a list of facilities licensed in California to provide Levels 3.7 and 4.0 residential and withdrawal management services. On this list, please indicate which facilities accept full scope Medi-Cal and which Medi-Cal aid codes are billable by facility based on their DRG and NPI numbers for both 3.7 and 4.0 residential and withdrawal management services. Please also distinguish facilities which can provide services to youth, and which serve adults.
- Standards associated with Cost Report and audit principles

11. 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 BHRS Quality Management Department will provide an array of oversight activities to ensure compliance with DMC regulations including review of incident reports, oversight of site certifications, monitoring though auditing charts and policy development.

<u>Monitoring Process:</u>

Monitoring will occur on several levels: agency/program monitoring by assigned BHRS contract monitors will be ongoing and frequent (not less than quarterly); chart audits, 10% of charts will be audited yearly; and site certifications visits will occurs as required. Formal annual programmatic and fiscal audits will be conducted for all treatment and providers. Copies of annual audits will be submitted to DHCS within 2 weeks of

issuance.

The Quality Improvement Plan:
The BHRS Quality Improvement Plan is a comprehensive document that serves as a guideline for annual QI activities. Components of the 2014-15 plan include: monitoring client satisfaction; improving active participation in QI activities by clients, family members, staff and other stakeholders; updating policies and procedures to improve clinical practice and reduce audit disallowances; improving training participation, documentation and quality of care; implementing, assessing, and reporting on performance improvement measures. The QI Plan and year-end report are reviewed and approved by the BHRS Executive Committee.

The QI Plan will include reviewing data on the following performance measures: number of days to first DMC-ODS service at appropriate level of care after referral; existence of a 24/7 telephone access line with non-English language capacity; access to translation services in the threshold non-English languages; number, percentage and time period of prior authorization requests approved or denied (currently collected to meet CMS audit standard). Utilization review activities will include at a minimum: beneficiaries have access to substance use disorder services; medical necessity has been established and the beneficiary is at the appropriate ASAM level of care; and that the interventions are appropriate for the diagnosis and level of care. Utilization review will also include review of data collected, maintained, and evaluated for accessibility to care and waiting list information, including tracking the number of days to first DMC-ODS service at an appropriate level of care following initial request or referral for all DMC-ODS services.

Quality Improvement Committee:
The BHRS Quality Improvement Committee (QIC) has been in existence for over 20 years. This committee is responsible for reviewing and recommending to the BHRS director new and updated policies, discussing urgent QI issues including critical incidents and client complaints, monitoring audit results and information, obtaining input from standing or ad hoc subcommittees. Over the past three years the QIC has been addressing SUD policy and quality issues and will further integrate requirements as part of the DMC-ODS. The QIC meets 6 times per year.

Membership & Structure:
Membership is representative of a broad and inclusive of BHRS staff, managers, consumers, family members, and health plan representatives. The Quality Management Manager leads the committee and QM staff members provide support with meeting agendas, follow up, minutes, etc. Subcommittees may be appointed (or volunteered). The members include:

Holly Severson, (BHRS QM)
Tim Holecheck (BHRS – North County clinic)
Rosamaria Oceguera (BHRS – Access Call Center)
Judy Davila (BHRS Deputy Director Adult/Older Adult Services)
Stephane Coates, (BHRS East Palo Alto clinic)

Scott Gruendl, (BHRS Assistant Director)
Kathy Mackin, Consumer of Services
Diana Hill, (BHRS SUD)
Paula Nannizzi, (BHRS SUD)
Marcy Fraser, (BHRS QM)
Mark Korwald, (BHRS SUD)
Marilyn Pearson, (Community Family Member)
Josephine Thompson, (Mental Health & Substance Abuse Recovery Commission)
RF, Client (Health Policy Advocate)
Jairo Wilches, (BHRS Office of Consumer/Family Affairs)
Kathy Koeppen, (BHRS QM)
Bob Cabaj, MD (BHRS Medical Director)
Pamela Grant (BHRS South County Clinic)
Julia McLaughlin (San Mateo Psychiatric Emergency Services)
Hung-Ming Chu, MD, (BHRS Deputy Medical Director)
Jeannine Mealey, (BHRS QM Manager)
Justin Francis, (BHRS Office of Diversity and Equity)
Suzanne Aubry, (BHRS Office of Consumer/Family Affairs)
Jei Africa, (BHRS Office of Diversity and Equity)
Selma Mangrum, (BHRS ACCESS/Call Center Manager)
Marshall Gonzalo, (Patient Rights Advocate)
Doris Estremera, (BHRS, MHSA Coordinator)
Lilian Montoya, (BHRS QM)

A SUD Subcommittee has been established to participate in the quality management effort on issues and items pertaining to the requirements of the DMC-ODS. SUD Subcommittee membership includes quality management staff and SUD management and staff.

Grievances & Appeals:

BHRS and its providers take appropriate action to quickly resolve concerns or problems expressed by clients. Providers inform Medi-Cal beneficiaries that they have the right to file a grievance or appeal an action and explain how to do so. The Office of Consumer and Family Affairs at BHRS assists clients in resolving problems, filing grievances and appealing actions.

BHRS has conducted an evaluation of existing organizational policies for grievances and appeals for compliance with 42 CFR 438. Existing policies substantially comply and as part of this implementation plan BHRS policies will be amended in the following areas to bring into full compliance within 120 days of implementation:

- Clarification of State Hearings information to be included in the county review process, notice language for State Hearings used in these processes, and whether or not the beneficiary must complete the county process prior to requesting state review.
- Validate the actions that can be appealed. The county currently includes denial or limited authorization of a service or type of service; reduction, suspension, or termination of existing service; denial of payment or any portion of payment; timeliness in service; and failure to act timely on a grievance or appeal including expedited cases.
- Review of written notices of adverse action for compliance. The county notifies beneficiary or provider both orally and in writing. The county is already reviewing written notices for CMS compliance and that process will be extended to the DMC-ODS.
- The review of written notices will include format and ease of understanding; correct languages; format for special needs; content (action being taken, reason(s), right to appeal, State Fair Hearing process, how to appeal, expedited requests, and continuation of benefits); timing of notice issuance; exception to timing requirements including extending and expediting; and circumstances that require a written notice.
- Add the time frame for the filing of an appeal and validate time frames for expedited appeals as well as consideration of health condition in determining time frame.
- Modify the county disposition time line for appeals and expedited appeals.
- Review grievance and appeal policy for procedure that covers an estate acting on behalf of a deceased beneficiary.
- Update record keeping procedures for grievance and appeal logs to assure compliance with minimal information required and reporting requirements that may be different than what is in existing policy. The county is currently developing a CMS compliant grievance and appeal database.
- Review policy for language related to the continuation of benefits and noticing beneficiary of liability for continued benefits.
- Review all sections of 42 CFR and determine the extent to which any section applies the BRHS model.

The QI Committee will analyze performance reports to monitor compliance with the minimum data requirements of the DMC ODS STC's at least twice per year. In implementation year one, reports will be developed, where needed, and baseline data will be established. Data elements to be reviewed include but may not be limited to:

- The number of Medi-Cal beneficiaries serviced
- Utilization of DMC ODS services
- Geographic location of providers and Medi-Cal beneficiaries
- Timeliness of first face-to-face visit and follow-up appointment
- Timeliness of services for urgent conditions and other appointment standards
- Access to after-hours care
- Treatment initiation and engagement rates
- Length of stay analysis for individualized care and compliance with residential LOS standards
- The number and type of beneficiary complaints and grievances
- Utilization of interpreter services
- Timely and seamless client transitions between SUD levels of care
- Client satisfaction
- 24 hour call center measures
    - Call time
        - Call duration
        - Caller's name
        - Call type
        - Disposition
        - Person who answered the call
        - Insurance type
        - Disposition type (Specialty, Network, AOD, PCP, Community Resources)
        - Total calls received
        - Total calls answered
        - Abandonment rate
        - Average answered hold time (in seconds)
        - Average abandoned hold time (in seconds)

12. **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?

BHRS adopted "Standards of Care (SOC) in the Treatment of Substance Abuse Disorders" in October 2010 and are contained in the contractual agreements between BHRS and all providers. These standards establish guidelines for treatment providers to implement evidence based practices (EBP) with demonstrated effectiveness in the treatment of individuals with SUD. New requirements under the DMC- ODS will be incorporated into the county monitoring practice to ensure every program provided within the network implements a minimum of two evidence based practices. Network providers already are required by BHRS to use the following EBPs: Motivational Interviewing, CBT, Relapse Prevention, Trauma-Informed Treatment, and Psycho Education. BHRS provides training and technical assistance to providers to support

staff development and to help ensure fidelity to the EBP models. An annual training survey of providers guides the allocation of training resources.

Contracted providers are monitored by BHRS staff analysts to ensure compliance with Standards of Care and implementation of minimum EPB requirements. Providers report annually, as part of County monitoring procedures, which EBP's are currently being utilized by the program and how the provider complies with the Standard of Care. Compliance is verified by the analysts through annual on-site visits and chart reviews. Non-compliance with Standards of care and minimum EBP requirements results in a Corrective Action Plan (CAP).

The SMC BHRS Standards of Care (SOC) include:

SOC 1: Welcoming Environment: *Programs will provide for a client's physical and emotional safety and create an engaging and predictable environment.*

SOC 2: Engagement & Retention: P*rograms will utilize strategies specific for engagement and retention of clients and their families.*

SOC 3: Client-Centered Care*: Programs will provide individually tailored and client-driven treatment, while balancing the health, safety, and integrity of the program.*

SOC 4: Culturally Competent Care*: Providers are responsible to be culturally fluent and responsive to the historical and cultural experiences and needs of each client.*

SOC 5: Co-occurring Capable Care: *Programs will be engaged in continuously improving their co-occurring capability. Policies, procedures and programming and staff competencies are designed to meet the anticipated needs of individuals with co-occurring disorders.*

SOC 6*:* Stage-matched Treatment Planning: *Treatment Plans must consider the stage of change of each client for each problem, and be informed by the integrated assessment of substance use and mental health symptoms.*

SOC 7: Effective Treatment based on Evidence-based Practices: *AOD and COD providers will provide effective treatment for clients with COD and AOD problems. Evidence-based practices (EBP's) and promising practices will be utilized during all phases of treatment. Eight Core Treatment Components have been identified and include;* 1) Cognitive-Behavioral Therapy; 2) Relapse Prevention, 3) Trauma-Informed Treatment, 4) Continuing Care/Recovery Management, 5) Psycho-education, 6) Contingency Management, 7) Smoking Cessation; 8) Family Relations/Parenting.

SMC BHRS will amend SOC 7 to include 9), Motivational Interviewing as required by the DMC- ODS. This practice is already used consistently within the BHRS SUD system of care and as part of client-centered care planning.

SOC 8: Medication Related Services: *Programs will ensure that clients' needs for*

medication, both psychotropic and otherwise (including narcotic replacement therapy), are assessed and attended to and that clients are not discriminated against due to their use of prescribed medication.

SOC 9: Recovery-Oriented Care: *Recovery management is introduced and integrated as part of the primary treatment phase, and as part of continuing care planning for each client.*

13. **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?

When an individual requests and is screened for treatment, s/he shall be offered an appointment within timeliness standard established by BHRS. This first appointment, also called the intake, is when the beneficiary receives an initial comprehensive assessment which shall be a face-to-face review or via telehealth by the DMC ODS network provider.

BHRS requires the use of the Addition Severity Index (ASI) Lite by all contracted providers in the assessment process. The ASI is a validated tool which screens for problems and impairments that commonly accompany substance use disorders. These include, among others, interpersonal difficulties with family, friends, and co-workers; medical conditions such as hepatitis B and C, HIV/AIDS, sexually transmitted diseases, and legal troubles. The ASI provides information that clinicians can use to address these problems with appropriate interventions or referrals. The ASI evaluates patients' functioning and lifetime experiences in seven domains: (1) medical conditions, (2) employment/support, (3) use of alcohol and drugs, (4) legal issues, (5) family history, (6) family/social relationships, and (7) psychiatric disorders. Altogether, the ASI takes approximately 45 to 60 minutes to administer.

A certified counselor may perform the initial assessment, which shall be reviewed by either the network provider's Medical Director or the LPHA to ensure the beneficiary has at least one DSM diagnosis of a qualifying Substance-Related and Addictive Disorder. For youth under age 21, the beneficiary may be assessed as at risk for developing a SUD for medical necessity. Once the diagnosis is established, the ASAM Criteria will be applied to match placement to the level of assessed services.

The ASAM criteria provide comprehensive guidelines used for placement, continued stay, and discharge/transfer of clients with SUD according to the client severity in each of six ASAM dimensions: (1) acute intoxication and/or withdrawal potential, (2) biomedical conditions and complications, (3) emotional, behavioral, and/or cognitive conditions and complications, (4) readiness to change, (5) relapse, continued use, or continued problem potential, and (6) recovery/ living environment. Providers shall ensure ASAM the client is admitted to the appropriate level of care based on ASAM results. This may require a referral to the BHRS Access Call Center if residential services are needed. Case management to facilitate a smooth transition process will be provided.

When the assessment indicates the client needs referrals for services such as mental health, housing, employment, psychiatric or medical services it is the expectation that the provider assist the beneficiary in addressing these needs.

BHRS will ensure beneficiaries receive the correct level of placement through its utilization management process by conducting chart audits of at least 10% of open client charts through an on-site review based on ASAM's multidimensional assessment. On-site reviews by BHRS staff occur annually, at a minimum, to ensure: all services are provided under the direction of a physician or LPHA; there is a completed medical history questionnaire and documentation of a physical exam; and that each client treatment plan is signed within the required time frames. Additionally there must be evidence the care is individualized, the program counselor and physician/LPHA meet regularly to review client progress, and the physician or LPHA reviews the treatment plan at least every 90 days to validate the continuation of services a referral to an alternative level of care is initiated.

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

    Youth residential treatment will likely require a regional model. There have been some early discussions among Bay Area Counties about this possibility since facility and program costs could achieve economies of scale through this type of approach.

15. **Memorandum of Understanding.** Submit a signed copy of each Memorandum of Understanding (MOU) between the county and the managed care plans. The MOU must outline the mechanism for sharing information and coordination of service delivery as described in 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).

    San Mateo County is a "one plan county" for Medi-Cal managed care and as described earlier the plan is administered by the Health Plan of San Mateo. BHRS has a long standing partnership with the HPSM and maintains a number of agreements with the HPSM. HPSM has been provided the standard terms and conditions of the DMC-ODS Waiver. This information is currently under review by executive staff at HPSM.

    BHRS and HPSM will be finalizing details to amend the existing agreement to address the coordination of service delivery specific to the implementation of the DMC-ODS. The amendment to the current agreement is expected to be completed by January 31, 2016. A copy of the agreement will be sent to DHCS when approved and will become an addendum to the Implementation Plan.

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

BHRS has implemented a telehealth pilot project based out of the BHRS Coastside Clinic in Half Moon Bay. This provides behavioral health services for the rural and hard to reach populations along the coast. Services include consultative and "direct" care including medication evaluation and management. Based upon the early success of the pilot the plan is to expand the services throughout the County including consultation to substance use treatment providers on issues such as co-occurring mental health concerns, mediation assisted treatment, physical health co-morbidities, and other categories. Below are applications of telehealth currently under consideration.

- Consultation to evaluate clients in SUD treatment programs. In lieu of a client coming to a BHRS site or a psychiatrist providing on-site services at multiple locations telehealth would be used to centralize the services thus improving client access, minimizing travel time, and maximizing the use of the psychiatrists' time. The psychiatrist would operate out of one central site; meet with clients or staff over the telehealth network providing direct care and consultation to the providers.

- Advanced service delivery using innovative technology. Utilizing telehealth services through mobile devices (tablets, mobile phones, and laptops) that would allow provision of services regardless of the location of the client. Staff could have complex case discussions while each member of the team is in a different location and view presentations together. Equipping clients with self-care applications that could connect them with their case managers beyond "office hours" and locations.

  BHRS will monitor telehealth equipment and service locations to ensure 42 CFR part 2 and confidentiality are strictly protected. The technology we currently use is compliant.

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

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

BHRS complies with the San Mateo County policies and procedures for the selection and retention of service providers as described in the County contract manual. These policies and procedures apply equally to all providers regardless of public, private, for-profit or non-profit status, and without regard to whether a provider treats persons who require high-risk or specialized services

The method to acquire a service varies by the dollar amount and complexity of the services. Services under $100,000 can be acquired by a solicitation process that includes a minimum of three firm quotes and a description of how services will be delivered. A formal Request for Proposals (RFP) process may be used but is not required. The provider that best demonstrates the capacity and capability to deliver quality services, has a strong financial portfolio, and has a realistic implementation plan will be chosen.

For contracts greater than $100,000 a formal RFP process is required. This process includes the publishing of the projects/program scope of work, the requisite provider organizational characteristics, a description of how services will be delivered that aligns with the terms and conditions of the RFP, and a budget that is sufficient to deliver the services and achieve the desired outcomes. Once proposals are received BHRS convenes a review panel that typically includes content experts, members of the Mental Health and Substance Use Commission, and consumers/clients and family members. The panel is given criterion to evaluate each proposal and make recommendations to the BHRS Director for funding. If necessary in order to make a final recommendation, the panel may choose to interview one of more of the applicants. Once approved by the BHRS Director, a formal recommendation for approval is recommended to the San Mateo County Board of Supervisors. Once approved by the Board the contract is officially executed.

Per County policy the RFP process for contracts above $100,000 may be waived only by a Board of Supervisors resolution when it is determined to be in the best interest of the County. Situations in which an RFP may be waived include, but are not limited to, emergency situations or those in which an independent contractor is the “sole source” of a particular service. Contracts for physicians and BHRS’ “any qualified provider” are except from the RFP process. Services included in the “any qualified provider” category include:

- Long-term locked facilities without specialized treatment programs
- Residential treatment providers
- Individual private psychiatrists, psychologists, therapists and group practices
- Psychiatric inpatient hospital services
- Housing services and related supports
- Services required for specific clients placed in out-of-county facilities by other agencies
- School-linked services in which mental health services are a component of

services in school placement made by the school district and parents through the Individual Education Program process.

Contract Term

The County has a 3-year contract term limit. A standard waiver process is in place to request the extension of a contract beyond the 3-year limit. The request requires the review and approval of the County department head, the Contract Compliance Committee, and if over $100,000, the by the Board of Supervisors..

Appeals Process

The County has a formal appeals process. This is documented in the contracts manual and in the BHRS' standard RFP form that the proposer completes and submits to the County when proposing to perform services.

If a proposer desires to protest the selection decision, the proposer must submit by facsimile or email a written protest within five (5) business days after delivery of the notice about the decision. The written protest should be submitted to the Chief of the Health System as outlined below. Protests received after the deadlines are not accepted. Protests must be in writing, must include the name and address of the Proposer and the Request for Proposals numbers, and must state all the specific ground(s) for the protest. A protest that merely addresses a single aspect of the selected proposal (for example, comparing the cost of the selected proposal in relation to the non-selected proposal) is not sufficient to support a protest. A successful protest will include sufficient evidence and analysis to support a conclusion that the selected proposal, taken as a whole, is an inferior proposal.

The Chief of the Health System will respond to a protest within ten (10) business days of receiving it, and the Department may, at its election, set up a meeting with the proposer to discuss the concerns raised by the protest. The decision of the Chief of the Health System will be final.

If an existing contract provider is not awarded a county contract for DMC-ODS services at any time through the selective provider contracting process, the county and the provider shall work together and develop a plan to transition the care of existing clients to other appropriate DMC ODS service providers. Our foremost consideration is that treatment is not interrupted, that the sharing of treatment information between providers occurs in a timely manner, that the client is informed of the provider change at the earliest appropriate time and that they are actively involved in the transition of care.

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

BHRS currently offers medications beyond the NTP requirements to ensure beneficiaries have access to a full complement of medications to support SUD treatment and recovery. BHRS will extend the use of MAT interventions by expanding the use of the following medications.

- For reduction of alcohol craving: naltrexone, both oral (ReVia) and extended release injectable (Vivitrol), topiramate (Topamax), gabapentin (Neurontin), acamprosate (Campral), and disulfiram (Antabuse)
- For opiate overdose prevention: naloxone (Narcan)
- For opiate use treatment: buprenorphine-naloxone (Suboxone) and naltrexone (oral and extended release) (Note: Methadone will continue to be available through the licensed narcotic treatment program)
- For tobacco cessation/nicotine replacement therapy, nicotine patches, nicotine gum, nicotine lozenges, buproprion SR (Zyban), varenicline (Chantix), and nortriptyline (Pamelor), or any combination of which proves most effective

BHRS integrates the use of MAT into primary care clinic settings and mental health clinics. A set of guidelines have been created for both behavioral health and primary care providers to follow. BHRS trains primary care providers, psychiatrists, and nurses on the use of medication for the treatment of substance use disorders and we educate our clients and county partners on the impact of MAT. Our philosophy is that clients in need of MAT are best served within the clinic setting where the SUD was identified and where the client already has an established relationship with care providers.

HealthRIGHT360, a BHRS provider is currently in the process of establishing a specialty MAT clinic also to be, licensed as a primary care clinic, which will serve as an induction center for MAT, serving high risk, high need beneficiaries who are not connected to an existing primary BHRS program. These beneficiaries often are frequent visitors to the emergency department or psychiatric emergency services, and/or have high levels of criminal justice involvement. The MAT clinic will coordinate with traditional SUD providers, physical health care and mental health care providers to connect the beneficiary to needed services. Once stable, MAT clinic clients will be transitioned to primary care clinic physicians, or a psychiatrist for continued medication services, as needed.

BHRS has a team of specialty MAT counselor/case managers who are embedded in the Emergency Department, Psychiatric Emergency Department, and Primary Care Clinics, to screen, motivate, engage, refer and case manage the most complex individuals into the most appropriate SUD treatments, including MAT services.

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

All providers shall obtain authorization for residential services prior to admitting a beneficiary. Residential authorization processes are completed to assure beneficiaries access medically necessary services in a timely manner. All authorization and reauthorization are tracked through Avatar, the BHRS electronic health record. There are four primary pathways that will support beneficiaries in accessing and receiving timely authorization for residential services.

Path 1: Access Call Center - BHRS Care Coordination Team Authorizations

Beneficiaries are advised to contact the Access Call Center (ACC) to inquire about services. When the ACC screening yields a residential withdrawal management need, an authorization and referral for Level 3.2 Withdrawal Management is created. When the ACC screenings yields a residential treatment need, an appointment is made by the ACC with the BHRS Care Coordination Team, provided the caller is open to exploring a residential placement. A beneficiary shall be offered an evaluation appointment within 24 hours of the initial call with a BHRS care coordinator staff. Evaluation appointments may be provided face-to-face, by telephone, or by telehealth, and may be provided anywhere in the community.

The BHRS County Care Coordination Team (CCCT) is staffed by certified AOD counselors and case managers who work under the directions of an LPHA. County Care Coordinators will evaluate beneficiaries using ASAM and will authorize individuals for residential withdrawal management or residential treatment, or refer the client to a non-residential network provider. Time –limited case management services will be provided by the CCCT to ensure smooth and timely admissions to care including referrals to other needed services such as mental health, housing, employment, psychiatric or medical services. If ongoing care coordination of the client is required outside of the direct treatment provider, it will be provided by the CCCT.

In the event that an evaluation appointment cannot be made within 24 hours, such as on weekends or holidays, the ACC after-hours provider shall complete an additional residential evaluation with the beneficiary, and when indicated, shall provide the beneficiary with a preliminary 7 day authorization for residential treatment. Once admitted to care, the network provider must request a re-authorization (see below) for treatment for continued care at a residential level.

Path 2: Residential Detox/Withdrawal Management Authorizations

BHRS contracts with Horizon Services Inc., a provider of stand-alone ASAM level 3.2 nonmedical residential detoxification and withdrawal management services.

Beneficiaries authorized and receiving 3.2-WM services from a stand-alone provider will be assessed for further care needs and the 3.2-WM provider may provide an initial authorization for clients to a residential treatment facility, when medically necessary. The client shall be referred to a network provider offering the needed ASAM level of care and case management is provided to ensure smooth and timely

admission to the next appropriate level care. The 3.2 WM provider and beneficiary shall consult with the BHRS Care Coordination Team regarding bed availability as needed.

Path 3: Residential Provider Initiated Authorization

Prospective clients often are referred directly to residential treatment providers by family members, friends, clergy, social service and health providers. In order to ensure timely authorizations and admissions, the provider will conduct an initial ASAM screening. If the results from the screening indicate the likely need for residential treatment the provider will enroll the client and within 24 hours inform the BHRS Care Coordination Team who will provide an ASAM evaluation to validate and authorize services. If the client is not eligible for that level of care the CCCT staff will facilitate a “warm hand off” to the provider that best matches to the client’s needs. If housing is an issue the CCCT staff will work to ensure the client is not discharged into homelessness working with Shelter Care providers, family and friends or other temporary housing options.

Path 4: Outpatient Provider Initiated Authorization

Outpatient provider initiated residential authorization requests are made to the ACC including those made on weekends or holidays or after-hours for evaluation and authorization. When indicated, the beneficiary shall be granted a preliminary 7-day authorization for residential treatment. Once admitted to care, the residential provider shall request a re-authorization for treatment for continued care at a residential level (see below).

Residential Treatment Re-Authorizations

Residential providers shall request a re-authorization, based on the results of the ASAM assessments, from the BHRS via the Avatar (electronic health record) system, at least 7 calendar days from the initial authorization expiration date. This will allow time for the provider to transition the client if the request is denied.

Maximum Residential Treatment Duration

The maximum duration of residential treatment for adolescents is 30 days on an annual basis. For adults, the residential service maximum is 90 days. A one-time extension of up to 30 additional days may be authorized, when medically necessary. Only two non-continuous 90 day residential regimens may be authorized in a one year period for adults. Perinatal and criminal justice involved adults may be considered for a longer stay based on medical necessity and with advance authorization from the BHRS Care Coordination Team.

Denials of Service – Appeals Process

If medical necessity is not demonstrated during the authorizations or reauthorizations process, the residential authorization shall be denied. The provider shall be notified of the denial in writing with the denial reason.

Clients or providers advocating on the client's behalf may appeal the service denial. Appeals may be done orally or in writing to the Call Center within the time frames established by the STC's and 42 CFR 438, including requirements for expedited appeals and consideration of health condition

See Grievances & Appeals earlier in this plan.

20. **One Year Provisional Period.** For counties unable to meet all the mandatory requirements upon implementation, describe the strategy for coming into full compliance with the required provisions in the DMC- ODS. Include in the description the phase-in plan by service or DMCODS 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.

County Authorization

The County Behavioral Health Director (for Los Angeles and Napa AOD Program Director) must review and approve the Implementation Plan. The signature below verifies this approval

_____	_____	_____
County Behavioral Health Director (*for Los Angeles and Napa AOD Program Director)	County	Date