DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER IMPLEMENTATION PLAN

SANTA CLARA COUNTY April 8 2016

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Behavioral Health Services Department

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Part I Plan
Questions

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

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

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

2. How was community input collected?

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

_____

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

☐ ✔ Monthly
☐ Bi-monthly
☐ Quarterly
☐ Other: _____

Review Note: One box must be checked.

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

☐ ✔ SUD, MH, and physical health representatives in our county have been holding regular meetings to discuss other topics prior to waiver discussions.

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

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

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

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

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

REQUIRED

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

How will these required services be provided?

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

OPTIONAL

☐ ✔ Additional Medication Assisted Treatment
☐ ✔ Partial Hospitalization
☐ Recovery Residences
☐ ✔ Other (specify) Transitional Housing

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

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

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

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

☐ ✔ Yes (required)
☐ No

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

☐ ✔ Yes (required)
☐ No

PART II

Drug Medi-Cal Organized Delivery System Waiver

County Implementation Plan

Santa Clara County

Substance Use Treatment Services Division

Behavioral Health Services Department

April 2016

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INTRODUCTION

The goal of Santa Clara County's plan for an Organized Delivery System (ODS) is to create a fully articulated continuum of care for substance use treatment that is *client-centered, quality driven and recovery-focused*. The proposed ODS is based on the premise that substance use disorders are a chronic condition that require a disease management approach throughout the recovery process - beginning with treatment and continuing beyond discharge from active treatment. In fact, it is our belief that the application of an acute care model to substance use treatment has worked against recovery and created significant disincentives for treatment systems to develop responses appropriate for treating a chronic condition.

Santa Clara County's ODS plan proposes to build on the foundation of a service delivery system that has functioned effectively for nearly two decades. The core of the delivery system consists of a few critical components: *single point of entry, a comprehensive bio-psychosocial assessment for patient placement, individualized treatment, multiple levels of care distributed across community providers, centralized management of referrals, capacity and authorization for extensions of stay, and a common set of protocols for all treatment providers in the system*.

The organizational structure constitutes only one part of the service delivery approach; operational principles are based on a specific organizational philosophy that favors a willingness to experiment with different solutions. Santa Clara County (SCC) was an early adopter of the ASAM (American Society for Addiction Medicine) Criteria and worked closely with the developer of ASAM standards to create a level of care placement protocol for the Santa Clara County system of care. Over the past decade, the system of care has also implemented several pilot projects such as the Client-Driven Outcome Informed approach, the Continuous Recovery Monitoring project, and protocols for improving placement times. In fact, the acknowledgment of the need for continuous quality improvement creates an underlying dynamic that favors change over stasis.

Although SCC believes the ODS will be constructed on a firm foundation, this plan contains significant refinement from the current delivery system to fully achieve the quality goals for a substance use treatment system that reflects the intent of the 1115 Waiver. Therefore, SCC proposes to expand the continuum of care and fill in the system gaps in the current treatment continuum to the extent feasible. By expanding the continuum of care, it will be possible to more closely match client needs with the appropriate intensity of treatment. At the same, expanding the continuum by adding more levels of care, with additional services for each level will greatly increase the system's complexity. Managing a complex system with multiple levels of care and individualized treatment will require a different set of rules for managing placements, transitions from level to level and authorization for extending lengths of stay. As a consequence, the Quality Assurance plan proposes more careful treatment monitoring with multiple data points to produce a valid 'current state' measure of the delivery system.

In addition to changes in the delivery system for substance use disorders, SCC is also in the process of integrating services with the Mental Health system of care. Integrated treatment will require significant retooling of current practices in order to accomplish the larger goal of providing high-quality integrated treatment for beneficiaries. SCC is aware of the need to train clinicians across the system not merely in integrated treatment methods but also best practices for client-centered treatment.

This proposal offers a state-of-the-art Organized Delivery System for substance use treatment. SCC believes there are significant operation/system barriers to realizing this goal. This plan will be feasible provided significant changes in the regulatory and financial landscape can be affected to reshape service delivery for substance use. From the perspective of a delivery system based on a *client-focused, recovery-driven continuum of care*, the current rules for reimbursement and reporting act as a constraint to the full development of a good and modern behavioral health delivery system. A 21st century behavioral health system must incorporate findings about the nature of addiction, its chronicity and high potential for relapse into treatment services that respond to the nature of the condition as understood by modern science.

SCC has attempted to identify those aspects of the current regulatory and financial regime that will require significant modifications to incorporate the concept of chronic care as a central principle of substance use treatment. Five specific areas are discussed below:

- Adopting the ASAM Criteria as the basis for treatment decisions will require a major change in substance use treatment service philosophy and service delivery. The ASAM Criteria is based on a dynamic view of the progression of substance use treatment in which clients have access to a continuum of care where service intensity is provided depending on the clients' stage of recovery. Progress is seldom linear- indeed the expectation is that it is not- which provides the rationale for building in different levels of care within major treatment modalities such as outpatient and residential services. As a result, programmatic approaches with fixed lengths of stay are fundamentally incompatible with the central precepts of ASAM and individualized treatment is the preferred model.

- An acknowledgment of substance use disorders as chronic conditions that require management, rather than curative strategies, requires a major shift in treatment approaches. The concept of chronic disease management is built into the DNA of ASAM. In SCC, two decades of experience managing a system of care has provided ample evidence that the path of recovery is not linear and that successful recovery involves relapses and returns to treatment. Consequently, delivery systems must be designed with a realistic concept of the process of recovery while embracing the values of recovery-oriented care.

- Current regulations are based on an acute model of care for substance use disorders, with clear points of entry and exit from treatment. Further, regulations require key clinical tasks

such as treatment plans and other documentation to be completed within fixed intervals after admission. Fixed timelines for documenting key tasks impose a structure and urgency for completing paperwork that is often incompatible with client engagement and a focus on client needs. Regulations will need to become more flexible to accommodate a person-oriented treatment approach, by shifting the focus from paperwork to the person.

One critical regulatory adjustment is the current timelines for treatment planning. Treatment plans are central to the engagement process. In behavioral health treatments, where commitment is an essential component to successful outcomes, forcing important clinical tasks into inflexible time frames that are insensitive to the client's process force providers to forego clinical strategies such as engagement in order to comply with programmatic requirements. While SCC is well aware of the need to establish regulatory requirements around key clinical tasks to ensure compliance and measure a level of quality for services provided, SCC is interested in having an open discussion with the State and CMS regarding implementation of the treatment system that incorporates the chronic care model (CCM) and the disease management approach to providing treatment in our field. This would be most reflective in extending the period of time in which a treatment plan can be developed - the current thirty-day maximum does not allow for the CCM to be realized.

- Mandatory reporting of treatment services data is also based on an acute model of care rather than a continuum of care. For example, the California Outcome Measurement System (CalOMS) requires an admission and discharge form to be completed for every modality in which a client receives treatment, even when these transitions occur within a single episode of care and merely involve movement from one ASAM level of care to another.

  In the SCC continuum of care a single "episode" of treatment is typically made up of multiple stays at multiple modalities. At this juncture, this requirement imposes a considerable burden on the providers for admitting and discharging clients who are merely being transferred from one level of care to another. In the SCC system of care, only a continuum of care form is required to transfer a client from one level of care to another. SCC recommends that CalOMS modify the entry and exit requirements from levels of care, and explicitly incorporate the concept of level of care (in addition to the treatment modality). SCC would like to establish a pilot in which CalOMS is open at the initiation of treatment and only a discharge entry would be made at the termination of treatment. An example would be client enter at the residential treatment point, steps down to an outpatient continuum (Partial Hospitalization, Intensive Outpatient, Outpatient, Case Management and Recovery Services) and completes Recovery Services at which point CalOMS discharge data is entered. This situation better characterizes a Chronic Care model.

- A final proposal Santa Clara County recommends piloting is the use of Recovery Services as a pre-treatment modality. ASAM allows for this modality. The Department would establish

a "Discovery" track of services that allows an individual to explore their involvement with substance use and reflect on their motivation to initiate treatment services. With this pre-treatment experience clients would be prepared to more fully engage in the treatment program and consequently a higher level of successful treatment completion within the beneficiary population would result. This modality would also be appropriate for the "Mild and Moderate" population as required in the Affordable Care Act. The Department has a program already developed for implementation if accepted as part of this proposal.

The SCC-ODS proposal was developed with an implementation plan embedded in the narrative. The proposal endeavors to provide directions as to how an ODS system can be created, provided a baseline system already exists. The Collaboration section provides historical details about the two decade-long effort to create the current System of Care.

The SCC system-of-care features ASAM based placement and a continuum of care, managed by Quality Improvement staff supported and funded by the county leadership. The system of care was built with local dollars to provide Santa Clara County residents with a compassionate and progressive substance use treatment system. Over the years, the Substance Use Treatment system has demonstrated its commitment to its role as a safety net provider that has served the neediest clients in the community, irrespective of their ability to pay. As this system transitions to an Organized Delivery System, the county's Substance Use Treatment system has resolved to create a system that balances the needs of a new system and its mission of serving everyone in the community.

1. COLLABORATIVE PROCESS

Santa Clara County has a long history of collaborating with other county agencies and the contract treatment agency network to develop solutions for systemic problems. When the Santa Clara County Department of Alcohol and Drug Services developed its "managed system of care" in 1996, both county and contract providers collaborated to create a system of care (SoC) that brought together a disparate and fragmented delivery system under a single umbrella. The system of care comprises the foundation on which the Organized Delivery System (ODS) will be built. We refer to the development of Santa Clara County's system of care as Phase I. The collaborative process that produced the Organized Delivery System for Medi-Cal waiver demonstration plan constitutes Phase II.

Phase I: Development of the current system of care

The original plan for the current system of care was developed over a six-month period, during which representatives from prevention, residential, outpatient, and detoxification providers, departmental staff, the courts and probation attended weekly meetings with the goal of developing an integrated continuum of care for the adult population. The goal was to create continuum of care based upon established benchmarks for length of stay and intensity of services, and movement within the continuum, in which clients could move into more intensive or less intensive services based on recovery needs. ASAM Criteria was adopted as the method for making placement and treatment decisions, based on clients functioning on six ASAM dimensions. In addition, it was determined that the system should include two other key components: a telephone-based assessment and placement function, with a toll-free number and a robust Quality Improvement Team with extensive Care Coordination responsibilities.

Once the plan was vetted and finalized by key stakeholders, a week long Strategic Planning session was held. Representatives from community providers, key stakeholder, labor unions and management staff attended the Strategic Planning session to develop a vision/mission statement that embraced the concept of a public managed system of care that provided access to the community and monitored outcomes for continuous quality improvement. The Hoshin Planning methodology was used by eighty-five participants over the course of a week to identify the key elements for successful operation of the new system of care. The participants coined the term "Innovative Partnership" (IP) for the new system of care. In the new system of care, *all* members shared equally in the implementation and improvement of the treatment and recovery services and contributed equally to this treatment partnership. (See Attachment I for an example of the Hoshin methodology).

The decision to implement five key components of the system of care emerged from these efforts: a centralized telephone-based portal (call-center), continuum of care, quality improvement, knowledge driven system and client satisfaction. These remain the treatment system's principal components today and are incorporated in the Medi-Cal waiver demonstration plan.

Centralized Call-Center:
Today, most clients enter the treatment system through the centralized Call Center via a toll-free number. Call-center staff conducts brief clinical screening based on the ASAM criteria and places clients directly in available outpatient slots, based on a daily capacity report provided by treatment agencies in the network. As a result, the practice of clients walking into an agency for services, without a referral from a central location, occurs only rarely today. In the first year of operations, the Call Center received over 30,000 calls and today fields over 50,000 calls. The centralized Call-Center has functioned with relative efficiency for nearly two decades.

System of care:
The need to provide clients with a high quality of treatment was a critical driver in the design of the system of care. The redesign had a major impact on residential treatment services.

Residential providers were required to completely reconfigure the existing delivery system. Prior to the system redesign, residential services averaged between six and nine months in length and few residential clients were referred to outpatient treatment. Residential providers had to offer a full continuum of stabilization and rehabilitation services, and often kept clients in residential treatment for lengthy periods due to the lack of housing. The design team determined that residential services should provide "stabilization and discharge" and then, refer to an outpatient setting for continued rehabilitation and recovery services in the community.

The redesign of residential services was based on research that indicated long residential stays without connection to community recovery services did not produce long-term sobriety. An average length of stay of thirty-five days for residential care was agreed upon. A key factor in facilitating reduced length of stay in residential treatment was the development of community housing for outpatient clients. Local funds were used to create Transitional Housing Units (THU's) for clients receiving treatment in outpatient services, thus making it possible for residential providers to refer clients to outpatient treatment and short-term housing. Over time, the number of THUs has expanded to play a critical role in the functioning of the system that was envisioned nearly two decades ago.

A second element of the redesign was the development of a continuum of care. The continuum allowed clients to receive the appropriate level of care and move within different levels of care within the same system in a coordinated way. Thus, the continuum made it possible for clients to be briefly upgraded to a higher level of care from within the treatment system. Movement within the continuum of care was to be coordinated by the Quality Improvement Division.

The system of care functioned as a single entity in part because of the county's decision to purchase residential and outpatient beds from contract agencies, and take on the responsibility for referral and placement of clients. This solution resolved a long-standing financial problem, in which contract treatment agencies were paid only when a bed or slot was filled. By removing responsibility from the providers to fill beds/slots, the department was able to manage

placements in the residential system and accomplish two goals simultaneously: placement of clients into residential treatment based on a treatment assessment and appropriate treatment for clients with complex issues.

The IP embraced a philosophy of recovery in which clients would, over time, develop their capacity to recover and remain abstinent from the substances that negatively affected their lives. The treatment philosophy was informed by a key concept of recovery as an incremental improvement in acceptance, action and change in the client's relationship with substance of use and their philosophy of life. As part of recovery, client needed to understand that they would occasionally experience obstacles that triggered old thinking and accept this as a normal part of recovery. When these episodes occurred, the client would have immediate access to services from the system to help to address the "here and now" situation and work out a new "recovery plan" that would mitigate a return to the old substance use and dysfunctional behaviors.

Client Satisfaction:
Another component of the system redesign was coined "Delighting the Customer." The planning group identified the importance of engaging the client in treatment from the initial appointment and providing a high level of care throughout the treatment episode. Motivational Interviewing was regarded as a key method for engaging clients. Another underlying philosophy of treatment was that the system needed to be client- focused, and provide services individualized to their needs, rather than providing a one-size-fits all, program-based treatment regimen. Thus, individualized treatment plans were based on individual client's acceptance level (stage of change). The redesign moved the department from a "canned" and "structured" delivery system to one that was configured to be agile in delivering service to clients.

Knowledge-based change: The Learning Organization
The redesigned system of care was based on the concept of a "Learning Partnership." The IP comprised a system of care that was based on "knowledge work." Staff at all levels of all organizations needed to combine mastery of highly specialized technical and clinical skills with the ability to work effectively in multidisciplinary teams, form productive relationships with clients, and reflect critically upon and change their own organizational practices based on new knowledge. The idea was to promote new ways learning and working, and replacing traditional practices with new ways. Two additional features of the learning organization - system measures and 'Hot Groups' - served as the principal mechanisms for receiving feedback from the system and correcting system problems.

"Learning" required the system to develop measureable processes and outcomes. Standard outcome and process measurements were identified based on review of learning organizations. System measurements were used to monitor how well the system assessed, referred and moved clients through the "continuum of care." As the system matured, additional outcomes measures were added. These will be found in the Quality Assurance section. Thus, the system

was designed to function as a data-driven entity, in which decisions were based on systematic information rather than anecdotal experiences.

Hot groups constituted a process in which everyone was empowered to identify issues, and develop solutions for improving or adjusting a system element that was reducing the effectiveness of client services. A staff person at any level of the IP - clerical, clinical, management, executive - had the power to call for a Hot Group. When an issue was raised, the initiator met with departmental representatives to discuss the matter further. If the problem warranted further solution, a Hot Group team of 5-7 staff was assembled. The Hot Group had up to six weeks to develop a plan of correction and six additional weeks to implement that plan. The 'Hot Group' concept embraced the Continuous Quality Improvement (CQI) model.

Hot Groups have democratized the IP and made every staff a vital member of the system. The essential difference from the past was a change from a narrow view to a focus on the whole "system of care" and how each treatment component supported the overall delivery of services.

Quality Improvement Care Coordination

Finally, it was determined that the delivery system required a strong Quality Improvement team with a robust care coordination component to support the other objectives. The Quality Improvement Division was to be staffed by a team of clinicians who were dedicated to monitoring the system and assessing how well it was serving client needs. The Quality Improvement Division was designed to provide clinical oversight and training to assist the IP members develop expertise, and effectiveness in meeting client needs. To accomplish these goals, each Quality Improvement Coordinator (QIC) was assigned specific programs to work directly with their provider teams.

In the system of care today, the Quality Improvement Division, along with the Research & Outcome Measurement Unit, reviews the established benchmarks for system throughput. The Quality Improvement Division works directly with providers to ensure that client movement within the system of care is based on the individual's recovery attributes and ASAM criteria rather than program-driven considerations. The Quality Improvement Division is an integral aspect of each provider's clinical team. Each QIC develops a strong working relationship with the assigned providers and the relationship is critical to efficient management of the system. This relationship has nurtured a vibrant feedback loop for identifying and addressing aspects of the system of care that do not serve client needs.

Phase II-Innovative Partnership (IP)-Collaboration on the Medi-Cal Waiver Plan

The Medi-Cal Waiver plan – also referred as the Drug Medi-Cal Organized Delivery System – DMC-ODS – was developed through collaborative process that included contract providers and other county agencies. The Department has utilized the IP as the main platform to develop the Medi-Cal waiver plan. Monthly and most recently, bi-monthly meetings have been held with members of the Innovative Partnership. (*See Attachment II*) These meetings have been

facilitated by senior staff from community-based contract treatment providers, who are responsible for generating agendas and coordinating monthly meetings. County, contract, community stakeholders and labor unions representatives attend the monthly waiver meetings and staff the sub-committees working on various aspect of the waiver application. All attendees, including the county representatives, submitted agenda items for discussion.

Department representatives and community provider staff were assigned to work on specific components of the Waiver plan and each group contributed to the development of the plan. The final Waiver application has been reviewed and agreed on by this group and reflects the work and vision of the IP as related to client recovery services. The Department will continue collaborating with the IP and stakeholders through regular monthly provider meetings to address ongoing issues of services coordination and technical assistance.

Other collaborative efforts

In addition to the IP meetings, meetings have been held with other county agencies and stakeholders to vet and receive feedback on the Medi-Cal Waiver plan. The Substance Use Treatment System staff consulted with many of its major partners- the AB109 Steering Committee, the Dependency Wellness Court and stakeholders in the youth System of Care.

The county's Chief Executive Officer (CEO) serves as the lead agency for the AB 109 realignment program, which oversees programs from prisoners released from the California prison system. In Santa Clara County, the CEO's office created a Re-Entry center to provide a range of services to integrate prisoners into the community. Substance use treatment services were allocated a budget for services to re-entry criminal justice clients. The AB-109 Executive Steering Committee, composed of representatives from County Executive Office, Courts, Sheriff's Department, Adult Probation, District Attorney, Public Defender, Social Services Agency, Californian State Department of Corrections and Rehabilitation, meets monthly to review policy issues.

The AB109 Steering Committee has reviewed the current proposal for creating an organized system of care and its' ability to address the complex issues of criminal justice clients, paroled from the State prison system and those serving in the county correction's system. The committee has endorsed the department's System of Care and has added treatment capacity for AB109 clients. The department staff has also reviewed the Waiver plan with the AB 109 Steering Committee and the additional services that will be offered through the Medi-Cal Waiver plan. The AB 109 Steering Committee fully supports the continuation of the System of Care as developed by the department.

Court partners have also been consulted. The Substance Use Treatment System (SUTS) provides integrated case management and screening for parents with substance use disorders for parents in the Dependency System who require substance use treatment as a condition for re-unification. The Court has endorsed the department's Medi-Cal Waiver plan.

Key stakeholders have been involved with designing a Youth System of Care (YSOC) since the beginning. County staff, substance use treatment providers, Juvenile Hall and Mental Health staff have been engaged throughout the process. Youth Stakeholder Subcommittee meetings held on September 15, 2015 and October 14, 2015, provided input on the proposed services for the Med-iCal Waiver plan. The stakeholders included the Mayor's Gang Prevention Taskforce, community-based organizations that provide youth treatment and services, and the Probation Department. In addition, monthly stakeholder meetings are held with Probation, Juvenile Treatment Court judges and Juvenile Hall staff to coordinate care and improve processes for the assessment and placement in youth in appropriate levels of care. The Courts, Probation Department and community advocates, and community-based treatment providers will be involved in the review and development of the youth System of Care over the next three years.

2. CLIENT FLOW

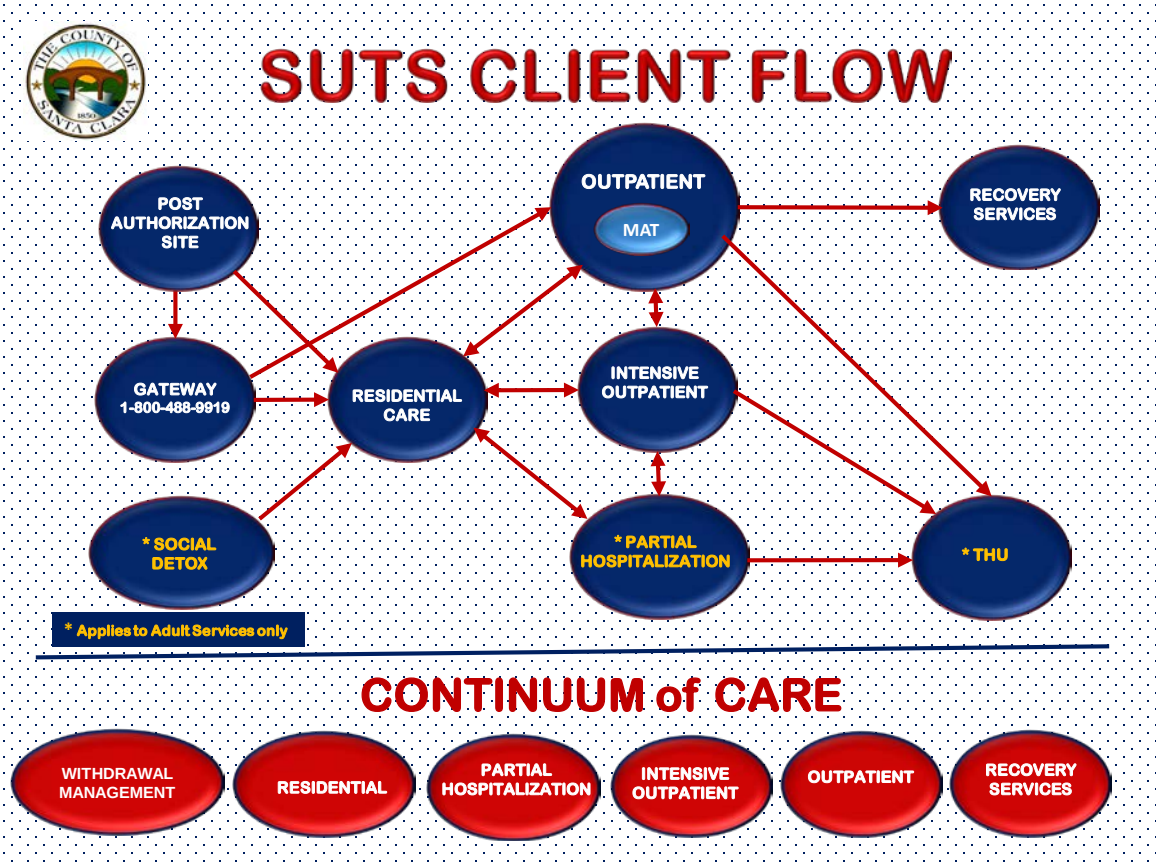
Movement through levels of care in the continuum of care-Overview

The Santa Clara County System of Care (SCC SoC) consists of different points of entry and levels of care, organized as a continuum. Any given episode of treatment may involve multiple levels of care with several transfers from one modality to another or within a single modality. Thus, a client's pathway through the system will depend on their starting point, initial level of care placement and clinical needs during a treatment episode. The key point is that the client remains within the System of Care, irrespective of the level, modality or service received during the entire episode of care.

At present, the adult SCC SoC consists of four modalities; detoxification, residential, outpatient and Medication Assisted Treatment- and 6 ASAM levels. The youth system has outpatient and residential modalities for youth. When the ODS is implemented, two additional ASAM levels of care will be offered to adult clients in the second year of the Waiver demonstration: ASAM Level 3.1 Clinically managed low intensity residential services and ASAM Level 2.5 Partial Hospitalization. Two levels of care will also be added to the youth system: ASAM Level 3.2 Withdrawal Management in the first year and ASAM Level 3.5 in the second year. Recovery services and Suboxone treatment will be added during the first year for youth and adolescent clients.

A brief overview of the client flow is shown in Figure 1. On the left hand side of the diagram, the three main avenues into SoC are shown: Gateway, Post-Authorization sites and detoxification services. (Note: Direct QIC referred admissions are not shown in the diagram). Following an initial screening or service (in detoxification services), clients are placed in an appropriate level of care. In the flow diagram, the spectrum from the most to the least intensive level of care moves from left to right, residential to outpatient treatment. Transitional housing and recovery services that serve as key ancillary support services are shown on the right-hand side of the diagram. Arrows between each system component indicates the direction of referral flows, which can be uni-directional or bi-directional. (See Figure 1)

In the remainder of this section, the client flow and the referral process through the system is described in more detail, with particular emphasis on the referral process which varies depending on clients' circumstances. Separate sections are devoted to discussions about ASAM assessments, admissions to recommended level of care, frequency of re-assessments, transition through the levels of care, role of case managers in care coordination, and timelines for movement between levels of care.



Client flow

Call center: Typically, a client's first contact with the System of Care occurs with a phone call to the toll-free line at the Gateway call center, which conducts a brief screening and refers the client to an initial level of care (residential, outpatient or Medication Assisted Treatment/MAT). A comprehensive ASAM assessment is subsequently conducted at the treatment site. All provider sites are assessment sites. Thus, a client may be admitted to the level of care to which they were referred by Gateway or be moved to a higher or lower level of care. For example, a client who received an initial placement in outpatient treatment may be moved to residential treatment if the comprehensive ASAM assessment, conducted by the outpatient counselor, indicates more intensive treatment. This basic referral process is mirrored in in the Youth System and Medication Assisted Treatment (MAT) systems with some variations required by the specific needs of the target population.

Referrals: The System of Care has a comprehensive process for managing client entry into the treatment system. The referral process is more structured in the adult System of Care Compared to the youth System of Care to permit more flexibility in in terms of entering

treatment. Some flexibility in the referral process is needed to accommodate special populations and circumstances, and this practice will continue in the Medi-Cal Waiver demonstration project.

Currently, referrals for service are made in four different ways: (i) Appointment Based referrals – offered currently in the System of Care and will continue to be offered in the ODS, (ii) Post-authorization referrals - offered currently in the System of Care and will continue to be offered in the ODS, and (iii) Care coordination referrals determined by the Quality Improvement Division - offered currently in the System of Care and will continue to be offered in the ODS, (iv) Same day Intake or Walk-In referrals – *offered on a pilot basis and will become a* regular referral option in the ODS.

I) Appointment-based referrals*:* Entry into the adult System of Care occurs mainly through the centralized Call Center (Gateway). A brief substance use and risk screening is administered and an initial level of care (LOC) placement is made. Residential referrals are routed to the Residential Placement Coordinator, Quality Improvement & Data Standards (QIDS) and Outpatient referrals are made directly to treatment agencies. The date of Gateway call, date of referral to OP or Residential, and actual date of first service (defines the "intake show rate") are all recorded in the EHR (Profiler) and are used for Performance Objectives measurement. Treatment providers are required to attempt to reschedule "no shows" to the initial appointment.

In-Custody clients have access to two dedicated phone lines in the jails that connect directly to the Call Center at no cost to in-custody callers. In-custody callers receive the same standards of service as other callers to Gateway.

Appointment-based referrals will continue to be offered in the ODS. Experience shows that many clients prefer to be able to schedule their admission into treatment. By providing the opportunity to schedule an appointment (as opposed to being scheduled for admission with no consideration to their affairs), the system seeks to be welcoming and engaged with the customer.

ii) Post-authorization referrals: A minority of clients enter through other sites referred to as 'post-authorization' sites. A post-authorization site is generally located in agencies that require the capacity to directly screen and refer clients to treatment providers. Post-authorization locations for the adult system include specific courts, a centralized facility for serving criminal justice clients and withdrawal management services providers.

Clients access post-authorization sites as walk-ins or referrals from the courts or other agencies, such as the Probation Department. Clients can be directly referred to outpatient provider sites for treatment. Some post-authorization sites have dedicated

capacity at certain providers and manage their own capacity to a limited degree. The primary purpose of post-authorization sites is to provide better services for clients by not requiring them to repeat information to the Call-Center, already collected at a post-authorization site.

iii) Care Coordination referrals: Clients with special needs or that present with special circumstances, such as high use of treatment services, are reviewed by the QICs and placed in an appropriate LOC. Clients with special needs are referred to the Quality Improvement Department by the Gateway Call Center and Mental Health Department. Clients identified as high users enter the System of Care via Care Coordination service through the QIDS division.
(See Attachment #III – for example of High Utilizer clients referred by QICs).

iv) Same-day referrals: The SCC System of Care has been piloting a number of different versions of same day intake and referral for over three years. The goals were to improve access, and to decrease "No Shows" and early drop-outs. Many outpatient and residential providers currently perform a "same day" intake. Clients are registered, assessed and meet with their counselor for an intake session to begin the treatment process the same day as their initial call to the Call-Center. *(See Attachment IV Same Day Access Outpatient & Residential)*

Several different pilots have focused on residential treatment access and reducing "no shows." Currently, when clients call the residential placement coordinator (after their Gateway screen), they are offered a bed for intake that same day (if capacity permits) until all beds are occupied on that day. The system offers transportation, medication pick-up and delivery, and other assistance to attempt to improve the chances of placing clients into residential beds. Same day intakes will be expanded to improve access and client engagement strategies in early residential treatment to reduce early terminations.

The SOC intends to also expand same-day access in outpatient to include a scheduled rotation of "on-call" OP providers. Clients referred by the Call-Center to an "on-call" outpatient treatment provider would be offered an intake/assessment appointment on the same day.

This basic referral process is mirrored in the Youth and Medication Assisted Treatment (MAT) systems with some variations required by the specific needs of the target populations. In some circumstances, clients enter the youth system directly through the Quality Improvement Coordinator who manages the treatment referrals for youth and transitional aged youth (up to 21 years), rather than the Gateway Call Center. Referrals are received directly from a client or from a third party such as the Probation Department, Social Services Department, Juvenile Justice System, community based organizations, high schools, parents and family members. Referrals for youth outpatient services are

distributed to the appropriate county or community provider, based on the transportation needs, geographic needs, and gang affiliation.

As part of the implementation of the ODS, referrals to the youth system will continue to receive individualized assistance through the post-authorization referral coordinator or will be channeled directly through the Call-Center. When the substance use treatment and mental health treatment systems are merged, a single Call-Center will screen for both conditions and refer clients to the appropriate level of care.

Clients are currently screened and referred to MAT through the Gateway Call-Center. Adult clients are screened for eligibility appropriateness for MAT and referred to one of methadone clinics depending on the client's place of residence.

Location and staff conducting ASAM assessments

Intake is the first session at all treatment sites across the system of care. An in-depth level of care assessment is conducted with each client using the American Society of Addiction Medicine's (ASAM) Criteria at each treatment site. The ASAM 6-dimensional assessment, which is conducted by licensed, licensed-Waivered, or state certified AOD counselors working under the direction of clinic LPHAs. LPHA staff will review and sign all placement decisions that meet the medical necessity criteria.

Transition between levels of care

The Quality Improvement Department manages transitions among different levels of care, as described below. The Quality Improvement Department also authorizes extensions of stay in residential treatment and transitional housing for outpatient clients. This function includes successful transitions of clients that have been designated as "high utilizers" and other clients that have been transition to lower levels of care that need upgrades back to more intensive services. The QIDS staff managed these designated clients to ensure appropriate placement in treatment and assessment of additional case management services necessary to address the individual special needs of this population.

At present, the adult continuum of care has four treatment modalities - detoxification, residential, outpatient and Medication Assisted Treatment- and 6 ASAM levels. The youth System of Care has outpatient and residential modalities. Movement within the continuum of care is classified into two types: routine and non-routine movements.

(I) *Routine movement:* Once a client is admitted to the SoC, movement from within the continuum is a routine matter when a client is discharged from one level of care and referred to another. Providers are responsible for moving clients between providers (direct referral), which typically occurs when clients are discharged from a higher level of care to a lower level of care. Direct referrals are also the normal practice when a client wishes to move to a different provider within the same level of care.

(ii) *Non-routine movement:* Consultation and authorization from QICs is required to move a client to a higher Level of Care (e.g. outpatient to residential). ASAM 6 DIM and LOC Criteria are used to determine whether the move should be authorized.

Extension of residential and transitional housing stays requires consultation with and authorization by a QIC prior to the transfer. ASAM 6 DIM and LOC Criteria, along with relevant clinical information, are used to determine authorizations for extensions of lengths of stay.

Care Coordination is offered by the Quality Improvement staff in special instances where there are provider-client issues, client-specific needs, or other unique circumstances. In all these instances, transfers require prior consultation and authorization with Quality Improvement Coordinators. *(See Attachments #V and #VI – Residential Authorization and THU Authorization)*

Admissions to the recommended level of care
A client is referred to an initial level of care by the Call-Center or a post-authorization site, or a QIC (in the case of youth residential referrals). At the initial level of care, a clinician conducts a comprehensive ASAM assessment to confirm that the level of care is appropriate for the client's condition. Thus, the final decision about placement at a particular level of care is made by a licensed or credentialed clinician in both the adult and youth System of Care. If the clinician determines that the client's individual needs would be better served at a different provider site or a different Level of Care, the clinician makes arrangements to refer the client to the proper placement.

The Medication Assisted Treatment system follows a different procedure for transfers in compliance with State Title IX regulations. Clients referred to Medication Assisted Treatment are screened by phone within 24 hours of the initial call and brought in for an intake appointment. Clients who meet the admission criteria established by State Title IX are admitted within 72 hours of the intake appointment.

When a client needs a Level of Care not currently available in the System, such as partial hospitalization or medically monitored Intensive Inpatient Treatment, they are referred to the most appropriate level available or given community referrals. This practice will continue in the Medi-Cal Waiver demonstration project.

Frequency of assessments
Clients can be assessed as often as necessary; however, an ASAM assessment is generally valid for 180 days. Clients who return to the system following a break in treatment (discharge) require a re-assessment before they are placed in a level of care.

Role of case managers in managing client flow
In the Santa County SOC the Quality Improvement Department is responsible for managing client flow between levels of care after admission for all clients, including routine and non-

routine transitions. Quality Improvement Coordinators (QIC) oversee the client transfer process, authorize extensions of stay in treatment, trouble-shoot for solutions for specific client problems and other client-related issues that arise during treatment. The actual decision to move from one level of care to another is overseen by a QIC.

Case managers are not involved in decisions related to transition between levels of care. Case managers may be involved in transporting clients from level to level. The case management program focuses on providing linkages to community services, assisting clients with applications for benefits & housing, and assisting clients meet instrumental needs (food stamps, medical & dental care, clothing, transportation and the like).

Timelines for movement between levels of care

The philosophy of the treatment system is to provide individualized treatment, tailored to a client's treatment needs based on ASAM criteria and stage of change. There are no fixed lengths of stay for any program, although there are guidelines for determining length of stay for most modalities. The SoC has accumulated nearly two decades of data on the utilization patterns for each modality that serves as guidance for extending the length of service.

Table 1. System benchmarks for standard lengths of stay by modality and system of care

	Adult	Youth
Withdrawal management	**5-7 days**	**N.A.**
Intensive Outpatient	**90 days**	**~ 42 days**
Outpatient	**60-90 days**	**~ 90 days**
Residential	**35-45 days**	**30 days**
Transitional housing	**90 days**	**N.A.**

A range for the length of stay serves as a guidance for extending length of stay for each modality. Different standards are used for youth and adult systems of care. (See Table 1) In the adult system, the duration of stay for detoxification services varies between 5 and 7 days, residential treatment approximately 35-45 days for adults, outpatient services between 60-90 days, and intensive outpatient 75-90 days. In the youth System of Care, residential treatment stays average about 30 days, intensive outpatient about 40-60 days and regular outpatient around 60-90 days.

The benchmarks for lengths of stay for all modalities were established 20 years ago, and have been confirmed by system experience and ongoing data collection. Treatment is individualized and benchmarks for each modality is based on the average length of stay. The average length of stay in residential treatment covers the period of time needed to stabilize clients for step down to outpatient treatment. Length of stay in residential treatment can be extended, based on an assessment of client need. (See Chapter 19-Residential authorization for further details) All providers in the Adult System and residential providers in the Youth System are required to seek authorization from the QIC to continue treatment beyond these

benchmarks for all treatment modalities. These benchmarks will be applied to outpatient treatment in the Youth System as part of the Medi-Cal Waiver demonstration project.

3. BENFICIARY ACCESS LINE

The Behavioral Health Services Gateway Call Center is the entry point for clients seeking Substance Use Disorder Services (SUDS). Clients call a toll-free line as the first step toward admission in the substance use treatment system. Clients may be referred to Gateway from, the courts, probation, parole, doctors, social workers, CPS, friends, family, and word of mouth.
Under the waiver, the county will collect relevant data for all referrals to both DMC approved and out-of-network providers. The Call Center will provide 24/7 access with the implementation of the Waiver. At present, the Mental Health Call Center is available 24/7 and once the SUTS call-center merges with it by 2017, the integrated will have the same standard for access.

Number of calls: The Gateway Call Center receives an average of 35,000 calls from the community and 24,000 calls from in-custody clients each year. Of the total average 59,000 annual calls, approximately 47,200 are referred to Substance Use Treatment services.

Wait times: The Gateway Call Center adheres to the benchmarks developed by the National American Quit-line Consortium (NAQC) and Covered California. Gateway is staffed in order to reduce or eliminate call wait times. Currently the Gateway Call Center is staffed with 5.0 FTE Clerical (Health Service Representatives) staff and 2.0 FTE Clinical (Certified Rehabilitation Counselors) staff to handle the current level of calls. It also utilizes a pool of extra help staff for sick, vacation and/or emergency leave of absences.
Performance standards are as follows:

- Average Speed of Answer – 30 seconds (Current average at Gateway is 33 seconds)
- Hold times are minimized – Less than 2 minutes (Current average at Gateway is 2.18 minutes)
- No busy signals (Gateway had an Interactive Voice Response system that eliminates busy signals)
- Real time coverage (With the IVR, calls are directed to available staff)

Call abandonment rate: The benchmark rate for call abandonments is 3%, which is on par with Current abandoned rate of 3%.

Language availability and disability services: The Substance Use Treatment System is part of the Santa Clara County's Health & Hospital System, which offers language services. Santa Clara County's Health & Hospital System maintains a language bank, which covers approximately 65 languages including the county's threshold languages - Spanish, Vietnamese, Mandarin and Tagalog. Language assistance is available through the Health and Hospital System's language bank to the Gateway Call Center.

The Gateway Call Center's new telephone system is also able to handle TTY calls. This feature will be implemented as part of the demonstration project.

4. TREATMENT SERVICES

The Santa Clara County ODS proposes to maintain its population-based delivery approach, which consists of three distinctive and interrelated delivery systems: the Adult System of Care (ASOC), the Youth System of Care (YSOC) and Medication Assisted Treatment (MAT). ASOC focusses on the adult client population (18 and older) and pregnant and parenting women, YSOC on the youth population (for ages up to 21 years) and MAT on opioid addicted persons of all ages, including pregnant and parenting women. If necessary, the department will establish MOUs to provide out-of-network coverage or opt-out counties. Currently, the department has determined that the surrounding counties are choosing to opt-in.

The three systems will have *common points* of entry, admission procedures, ASAM based level of care assessments, individualized treatment plans, management of client flow through the system, quality metrics, and performance goals. The System of Care will also adhere to common practice standards:

- NIDA's thirteen principles of best practice for SUDS.
- Use of DSM-5 and ICD-10 diagnostic criteria
- Implementation of evidence-based practices and therapies

Medical necessity throughout the system is established by current DMC [51341.1(a) & (h)], except in the case of MAT for which additional requirements are required. The use of ASAM Criteria for treatment placement will continue in the Medi-Cal Waiver demonstration project. All treatment will be provided by credentialed or certified staff in accordance with clinical standards set by the California Department of Health Care Services (DHCS).

The three delivery systems contain elements tailored to meet the needs of the three target populations: adults, youth and opioid addicted persons. Some differences in current approach, based on the needs of the target population, are noted below. Within each level of care, youth and adults present differently, and modifications are noted where appropriate.

In the Youth System, DMC-ODS benefits will be available to all Santa Clara County beneficiaries under age 21 who meet ASAM Placement criteria or/and are at risk for developing a substance abuse disorder. Therapists will also continue to serve as youth advocates in the justice system, schools and the family. In the Adult System of Care, DMC benefits will be available to all eligible persons above 18 years of age if they meet the ASAM Criteria.

The Adult System of Care's continuum of care *currently* consists of four modalities - detoxification, residential, outpatient and Medication Assisted Treatment- while the Youth System *currently* consists of two modalities- residential and outpatient. The present youth and adult systems of care <u>combined</u> contain all 6 ASAM Levels of Care <u>required</u> for the Medi-Cal Waiver demonstration project: Withdrawal management, at least <u>two</u> levels of residential

treatment, outpatient treatment, medication-assisted treatment, and physician consultation and recovery services (for adults).
When the Organized Delivery System (ODS) is implemented, four new ASAM levels will be added to the existing continuum of services.

- Two new ASAM levels of care will be added in the Adult System the second year of the Medi-Cal Waiver demonstration project:
  - ASAM Level 3.1 Clinically managed low intensity residential services
  - ASAM Level 2.5 Partial Hospitalization (Day Treatment).
- Two new ASAM levels of care will also be added to the youth system in the first and second years of the Medi-Cal Waiver demonstration project:
  - ASAM Level 3.5 services
  - Recovery services will be added the first year for youth and adolescent clients.

In this section the current delivery of treatment services in the context of ASAM levels of care (LOC) and their application for the adult, youth and opioid addicted clients served by ASOC, YSOC and MAT services is described. Proposed changes in the current system are noted under each level of care. A table summarizing the ASAM LOCs and services by target population – youth, adult, opioid addicted, and pregnant/parenting women- is provided at the end of this section.

REQUIRED SERVICES:

Santa Clara County has been providing an ASAM-based ODS and anticipates no problem in providing the following services.

I. Withdrawal management:

ASAM Level 3.2 (Social model or non-medical detoxification) is currently available for adults who are admitted to the Adult System of Care and services will continue under the Medi-Cal Waiver plan.

Withdrawal Management (ASAM Levels 3.2)

Adult system: ASAM level 3.2-WM will be available to adult clients who meet the necessary ASAM criteria. The components of withdrawal management services include: intake and observation (Clinical Institute Withdrawal Assessment/CIWA). At discharge from ASAM Level 3.2, clients will be referred to either residential or outpatient services based on an assessment of individual needs.

II. Residential treatment:

In the current System of Care, two levels of ASAM residential services are available to adults- ASAM Levels 3.3 and 3.5. The Adult System proposes to offer Level 3.1 in the second year of the ODS implementation. Currently, the youth system offers only ASAM Levels 3.1 for residential

treatment. The Youth System will offer Residential Level 3.5 as part of the ODS implementation.

Clinically Managed Low-Intensity Residential Services (ASAM Level 3.1)-

Residential Services ASAM Level 3.1 is available for youth 18 years and younger. The goal of the residential therapeutic milieu is to promote the development of: (a) a youth's interpersonal and independent living skills at a pace that matches the youth's cognitive abilities and (b) behavior patterns and habits designed to help youth successfully re-integrate back into the community. Residential treatment services involve a minimum of five hours of clinical services each week during the 30 day average length of stay.

Following residential treatment, youth are stepped down to Wraparound Services, Full Service Partnership (FSP) services, intensive outpatient, outpatient services, or other community services, based on individual needs to ensure the appropriate level of support for maintaining sobriety after discharge from treatment.

Clinically Managed Medium-Intensity Residential Services (ASAM Level 3.3)

Residential ASAM Level 3.3 is recommended only for adults, and is not a part of the adolescent continuum of care in the ASAM continuum. The adult System of Care will continue to provide Level 3.3 residential services to clients who have cognitive limitations, medical conditions, and/or are elderly and require treatment at a slower pace. Services are slower paced, more concrete, and more repetitive. Medical, psychiatric, psychological, laboratory, and toxicology services are available through consultation or referral.

Clinically Managed High/Medium-Intensity Residential Services (ASAM Level 3.5

Residential ASAM Level 3.5 services are currently available in the adult System of Care. ASAM level 3.5 focusses on stabilization of signs and symptoms of high risk addiction, initiation or restoration of the recovery process and preparation for ongoing recovery in the broad continuum of care. This level of treatment is characterized by reliance on the treatment community as a therapeutic agent. (See Table 2 for services by level of care)

Medically monitored intensive inpatient services – Adult/High Intensity inpatient services – Adolescent/Medically Managed Intensive Inpatient services (Adult & Adolescent) (ASAM Level 3.7 and 4.0)

The department will seek to establish an MOU with a local provider who can provide ASAM 3.7 and 4.0 services. Beneficiaries will receive services from these providers until they can they can be discharged to a lower level of care provided by the department's network.

Table 2. Residential Treatment Services in the Youth and Adult Systems

Clinically Managed Low-Intensity Residential Services (ASAM Level 3.1) **Youth only**	Clinically Managed Medium-Intensity Residential Services (ASAM Level 3.3,) **Adult Only**	Clinically Managed High/Medium-Intensity Residential Services (ASAM Level 3.5,), **Adult (including perinatal women) & Youth (Please insert services)**
-Intake *-Treatment Planning.* *-Individual Counseling* *-Group Counseling* *-Family Therapy -Collateral Services.* *-Patient Education* *-Crisis Intervention* *-Transportation Services* *-Safeguarding Medications - Discharge Planning*	*-Intake,* *-Treatment planning* *-Individual counseling* *-Group counseling,* *-Client education,* *-Family therapy/education,* *--Policy and procedures for safeguarding and disposing of medications,* *-Collateral services with significant others* *-Crisis intervention* *-Transportation, for medically necessary treatment outside of the residential facility,* *-Discharge planning and linkage to needed services in the community.*	*See ASAM Level 3.3 for services*

Both gender-specific and mixed-gender residential services are offered. Perinatal residential treatment for women, and children under age 5, are provided at ASAM Level 3.5. This program complies with the Perinatal Services Network Guidelines. In addition to recovery, treatment focuses on parenting and child development. Length of stay can extend up to 6 months when necessary. Adult clients in residential treatment are typically discharged into a lower level of care – usually outpatient treatment, as the residential level of care is designed primarily to provide stabilization services.

ASAM Level 3.5 services will be added to the continuum of care for youth in the first year of the ODS implementation. ASAM Level 3.5 provides 24-hour care by clinical staff for clients in a therapeutic milieu. Level 3.5 Services will be used to provide services to youth and young adults, who face imminent danger with co-occurring issues, require stabilization of their symptoms and services to re-integrate into the community with adequate levels of support.

III. Outpatient treatment services:

ASAM Levels 1 & 2.1 are currently offered in the ASOC, YSOC and AMT systems. ASAM Level 2.5 (Partial Hospitalization Treatment) will be offered in the Adult System in year 2 of the ODS implementation. ASAM Level 1 services will be offered as described in this section. A new service, Level 2.5, is described in a separate section.

Outpatient Services (ASAM Level 1)

There are minor differences in the ASAM Level 1 services provided to youth and adults, and age-appropriate treatment will continue to be provided under the ODS plan. Outpatient services are available for youth under age 21 who have a substance use diagnosis or are at risk for developing a substance use disorder. The frequency of *Individual Services*, documented in the treatment plan, is based on the ASAM assessment and individual needs. ***Group Counseling*** will be recommended for clients and will be included in the Treatment Plan, based on individual needs. These services are delivered in person, by phone or a tele-health medium.

ASAM Level 1 services for adults are currently provided in regularly scheduled sessions of fewer than 9 contact hours a week. Treatment addresses major lifestyle, attitudinal and behavioral issues that have the potential to undermine the goals of treatment or to impair the individual's ability to cope with major life tasks without the use of alcohol, and/or other drugs. These services are tailored to each client's level of clinical severity as determined by the ASAM 6 dimension treatment assessment and are focused on helping the client make changes in their drug use or addiction. With the additional of individual counseling, family therapy and case management, the array and intensity of services will be significantly enhanced through the ODS waiver.

Under current guidelines, a minimum of one treatment session per month is required for a youth to remain in treatment with the exception of a youth attending a school site closed for the summer or who is placed in a lock-out situation. As part of the waiver, it is proposed that this restriction be removed. For instance, if a youth is detained in Juvenile Hall he/she will be kept open in order to maintain continuity of care. Modifications of this treatment standard will be clinically determined based on client progress, as documented in the clinical record. Youth may be referred to ancillary services, such as educational support, when indicated by their ASAM assessment.

In keeping with the Santa Clara County Co-Occurring Joint Action Council Youth Committee recommendations, treatment for youth with co-occurring disorders will integrate both

substance use and mental health services and offer a full range of comprehensive services including psychiatric medication as part of treatment. The treatment team will include the psychiatrist, and consult with the primary care physician, AMT physicians and other specialists as needed.

Intensive Outpatient Services (ASAM Level 2.1)

ASAM Level 2.1 provides adult outpatient services for between 9 to 19 hours per week and between 6 and 19 hours per week for youth and young adults. Youth, transitional aged youth and adults who exhibit more severe symptomology and needs that do not respond to less than 6 hours per week of treatment in outpatient settings are offered Level 2.1 Intensive Outpatient Services (IOP). Services may be provided up to 6 days a week for youth (including weekend activities) for up to 19 hours per week.

The target population includes youth and adults who exhibit impaired functioning at home, school (for youth), work, or in the community but do not require treatment in a residential setting. Comprehensive treatment that includes counseling and education about addiction-related and co-occurring disorders are provided. This program is offered during regular business hours and after-school/work hours for school-aged and employed clients. Clients can be stepped down to ASAM Level 1 or up to Residential Treatment as needed. (See Table 3)

Perinatal services: The primary counselor coordinates the treatment episode for clients and will provide targeted case-management for services such as housing, psychiatric or primary medical care. Perinatal clients will receive appropriate intensity of care within the outpatient spectrum, based on assessment and discussion with the clients. Clients may be referred to other more intensive treatment levels such as Women's Residential and Detoxification Services, based on client need and ASAM assessment.

Partial Hospitalization –Day Treatment (ASAM Level 2.5)

Partial hospitalization (ASAM Level 2.5) is not currently available in the System of Care but will be added to the continuum of care as part of the Medi-Cal Waiver demonstration project. Partial hospitalization is designed for clients with unstable medical and psychiatric problems.

Partial hospitalization differs from IOP with respect to intensity of services and the availability of additional medical and psychiatric services. A minimum of 20 or more hours of service per week is provided in Level 2.5. Clients will have access to medical, psychological, psychiatric and toxicology services through consultation or referral. Psychiatric and other medical consultation will be available within 8 hours by phone and within 48 hours by person. Emergency services will be available 7 days a week and 24 hours a day, when the treatment program is not in session. Clients may live in a 3.1 Level residential facility or in transitional housing with 24 hour supervision. (See Table 4)

Table 3 Outpatient Treatment Services - Youth and Adult Systems

Outpatient Services (ASAM Level 1) Youth	Intensive Outpatient Services (ASAM Level 2.1) Youth	ASOC Services combined for Levels 1 & 2.1 (Adult)
-Intake *-Treatment Planning* *-Individual Counseling* *-Group Counseling* *-Family Therapy* *-Collateral Services* *-Patient Education* *-Medication Services* *-Crisis Intervention Services* *-Discharge Services* *- Case Management Services*	*-Treatment Planning,* *-Individual counseling* *-Group counseling,* *-Family Therapy* *-Collateral Services* *-Patient Education,* *-Crisis Intervention Services,* *-Discharge Planning,* *-Case Management services* *-24-hour crisis coverage* *-Transportation assistance.*	*-Intake,* *-Individual counseling,* *-Group counseling,* *-Family therapy/education,* *-Client education,* *-Medication services or referral for medication services,* *-Collateral services with significant others,* *-Crisis intervention,* *-Treatment planning* *-Discharge planning* *-Services linkages*

Table 4a. ASAM Level 2.5

ASAM Level 2.5 Partial Hospitalization
-Intake, *-Individual counseling,* *-Group counseling,* *-Psycho-educational groups* *-Family therapy* *-Medication management* *-Referrals to medical, psychological, psychiatric and toxicology services* *-Crisis intervention,* *-Treatment planning* *-Discharge planning* *-Services linkages*

Table 4b. Perinatal Services

Perinatal Services
-Individual & group counseling
-Pregnancy Education
-Urine testing –
-Post-Partum PTSD and educational groups
-Health and nutrition counseling
-Medical consultations with program physicians
-Co-ordination of care OB-GYN
-Smoking cessation program
-Onsite daycare for children under 5
--Transportation
-Psychiatric Referrals and care coordination
--Vaccination for Flu, Hepatitis A and B, Tetanus
-Case management - housing, legal, primary and medical care assistance
-Referrals to self-help meetings and patient advocacy groups

IV. Narcotic Treatment Program (ASAM OTS Level 1)

In the Santa Clara County System of Care, the Narcotic Treatment Program is referred to as Medication Assisted Treatment (MAT), which provides treatment using approved medications for treating substance use. Clients referred to the Medication Assisted Treatment program must be screened for eligibility for medication assisted treatment. Both adults and youth will continue to receive MAT services if they meet the criteria for admission.

The MAT division has been serving Santa Clara county residents since 1969. MAT services are provided in clinics licensed and accredited by Commission on Accreditation of Rehabilitating Facilities (CARF) and staffed by board certified physicians specializing in Addiction Medicine, and licensed master's level clinicians or certified counselors. MAT currently offers a variety of medications (eg. methadone, naloxone, disulfiram Suboxone and VIVITROL), counseling, case management, medical consultation, confidential HIV & TB testing and counseling to clients who meet the medical necessity criteria. MAT prescriptions will be provided through the patient's local or county pharmacies. The MAT Division also houses the county's Perinatal Substance Abuse Program that serves pregnant and parenting women and it will continue to provide services in accordance with relevant state and federal guidelines.

Clients referred to methadone must meet the admission and medical necessity criteria established by the State of California Title IX regulations and federal regulations. Clients who meet admission criteria are required to be admitted within 72 hours of the intake appointment.

Admission to the methadone program involves two phases: *Induction* (including titration) and *Stabilization*. The induction phase (initial methadone dosing) is designed to attenuate withdrawal symptoms as quickly as is medically appropriate. In the stabilization phase, the goal is to establish the dose of daily methadone that provides clinical efficacy, along with a margin of safety, for an appropriate duration of time. Methadone stabilization dosages are determined individually, within the limits stipulated by State and Federal regulations and MAT Policy & Procedures. If medically appropriate, higher initial dosage maybe prescribed.

Admission to the Suboxone program also requires an evaluation by a program physician to establish medical necessity. Induction phase occurs during the first week of treatment and involves onsite treatment and monitoring. Individuals are required to keep a follow up appointment for refilling their prescription. Individuals can be referred to counseling in accordance with State and Federal regulations.

For the Medi-Cal Waiver project, youth will be referred to Suboxone services. Assessment using ASAM criteria will be used to determine whether youth above 16 years of age are eligible for Suboxone treatment and if the following criteria are met: diagnosis of opioid dependence or opioid use disorder, at least a one year history of opioid dependence, and parental permission and involvement. Opiate- addicted youth who are referred to MAT are then evaluated by a MAT physician to determine if the youth meets the criteria for addiction medicine treatment.

V. Recovery Services

Clients will be offered this service if they have relapsed, or are at a risk of relapse. Currently, only limited recovery services are offered and Santa Clara County expects to provide an array of services as part of the waiver. Recovery services will address the needs identified in Dimension 6, and services will be provided face-to-face, by phone or via a tele-health medium. Relapse education and warning sign identification will occur throughout the duration of Recovery Services. Youth will be linked to services that will address their psychosocial issues, help them develop self-management skills, and reinforce skills gained during treatment.

Recovery Services will be available for adult clients who have a substance use disorder in remission but exhibit a high risk for relapse potential on ASAM dimensions 3 to 6. Post Treatment Recovery services will be available for clients after completing the course of treatment if they are struggling with triggers, if they have relapsed, or as a preventative measure. These services may be provided face -to -face or by telephone and may include, but are not limited to, Wellness Recovery Action Plan (WRAP) groups, Continuous Recovery Monitoring (CRM), drop-in support groups, and relapse prevention groups. WRAP is a wellness and recovery approach that is self-directed that involves peer-led groups. Continuous Recovery

Monitoring was a pilot project that provided telephone check-ups after discharge for treatment to clients who had completed treatment successfully. (See Table 5 for services offered)

Recovery services will be added to the youth System of Care in the first year of the ODS project. Adolescents relapse at a much higher rate than adults, making Recovery Services a high priority for youth. Recovery services are highly recommended during the first six months of recovery, which is a critical period for maintaining long-term abstinence. Recovery services will be available to beneficiaries upon the completion of treatment to prevent relapse.

Table 5 Recovery Services in the Youth and Adult Systems

Youth system	Adult system
Individual and Group Counseling *Recovery Monitoring or coaching Substance Abuse Assistance* *Linkage to Support Groups, Educational Services, Job Skills Services, Family Support Services, and Ancillary Services (housing, transportation, and case management or service coordination services)*	*Individual counseling* *crisis counseling,* *relapse prevention groups,* *psycho-educational groups,* *Wellness Recovery Action Plan (WRAP) groups,* *case management,* *family wellness,* *Life skills groups.*

VI. *Case Management*

Case management services are currently available for adult criminal justice clients and youth. The Targeted Case Management model will be adopted for the ODS implementation. Programs at all ASAM Levels of Care for youth and adults will offer **case management services** by on-site staff. Services will include but will not be limited to linking clients to other levels of care for substance use treatment, primary care, mental health, vocational, legal and housing resources, as well as case consultation services. Because the county provides individualized treatment at all levels of care, there is no designated length of stay for case management services. Individual needs will be periodically assessed to determine the need for continued case management services.

Case management services will be provided by licensed or credentialed staff persons. Case management services for all clients will be integrated with the treatment plan. Case management services will focus on addressing tangible needs such as shelter, employment, transportation and academic needs, and support clients engagement and treatment progress.

The Youth System of Care will utilize a clinical/rehabilitation approach to case management in which the therapist provides the therapy as well as the case management activities.

In the adult system, the primary treatment counselor/therapist may also provide case management services. When the case manager is not the primary treatment provider, he/she will work closely with the primary counselor to support the treatment plan. Specific tasks such as transportation, assistance completing applications, or accompanying the client for appointments and other tasks will be assigned to a community-worker or peer mentor. Adult system community-workers and peer mentors will work under the direction of the credentialed or licensed counselor to provide a range of services, depending on the client's needs.

VII. Physician Consultation

Medication Assisted Treatment Services (MAT) will launch a Physician Consultation services in the fall of 2016. Medication Assisted Treatment specialty consultation services will be offered by staff physicians who specialize in Addiction Medicine. Consulting physicians are board certified physicians, many certified by both ABMS and ABAM (American Board of Addiction Medicine). Physician Consultation services will be available to clients in adult, youth, MAT services and primary care physicians.

Physician consultation services for adult and youth systems will include (a) consultation on treatment for youth and (b) coordination of discharges from outpatient and residential to MAT. The majority of physician consultation services will involve coordinating with primary care physicians and hospital on client care related to MAT services. Physician consultation services will be available to (a) consult with primary care clinics or primary care physicians in the community need advice from addiction specialists for treatment or referral; (b) consult on discharges from hospitals for patients referred to MAT; (c) consult with hospitalist or a specialist for starting patients on medication assisted treatment or tapering them off; (d) coordinate care between primary care services and MAT; (e) MAT dosage and treatment consultation with physicians in the community; (f) consult with community physicians for pregnant clients and MAT services to them, and (g) consult with clients on methadone/buprenorphine for treatment of acute pain.

Services will be delivered by phone, fax or email at the present time. In near future, onsite and live, interactive videoconferencing will be available. During the consultation hours (Monday – Friday 2:30-4:30Pm), the physician on call will be available to take phone calls or follow up on any requests. The on-call physician service will be rotated among MAT staff physicians.

(See Table 6 for a summary of required and optional Services under ODS)

Table 6. Required and optional treatment services by System of Care component- Santa Clara County Medi-Cal Waiver Demonstration - 2015

ASAM LEVEL	YSOC	ASOC	MAT	PSAP
Required services				
Withdrawal				
3.2 Clinically managed Residential detoxification services		**X**	**X**	**X**
Residential treatment				
3.1 Clinically managed low intensity residential services	**X**	**2nd yr.**	**X**	**X**
3.3 Clinically managed medium intensity residential services	**NA**	**X**	**X**	**X**
3.5 Clinically managed medium/high intensity residential services	**2nd year**	**X**	**X**	**X**
Outpatient Services				
Intensive outpatient				
1.0 Outpatient services	**X**	**X**	**X**	**X**
2.1 Intensive outpatient treatment	**X**	**X**		
2.5 Partial Hospitalization – Day Treatment		**X**		
OTS Level 1-Narcotic Treatment Program			**X**	
Recovery Services	**X**	**X**		
Case management	**X**	**X**	**X**	**X**
Physician consultation	**1st yr.**	**1st yr.**	**1st yr.**	**X**

Optional Services

One optional service will be provided in the Medi-Cal Waiver demonstration: an Early Recovery Services for youth only. Youth and young adults who are eligible for the early recovery services are either vulnerable to future substance use problems or at immediate risk for meeting criteria for a substance use disorder.

Referrals for service will be made by the client, school staff (MST coordinator, discipline officer), parent or other third parties such as truancy court. Primary Care Physicians will screen young adults age 18 and older for substance use issues. Following the referral, the clinician will meet with the youth or young adult to assess substance use related risk factors such as possessing substances on the school campus or home environment, associating with known substance users, sudden poor academic performance and other problematic behaviors.

Early recovery services for youth will be delivered in clinic and/or school settings. Services in this level are individualized-brief intervention sessions. Content includes *counseling* interventions and psycho-education regarding the harmful effects of substances. Youth may be

seen for up to ten sessions and then *referred* to mental health or substance use disorder services as is medically necessary.

5. COORDINATION WITH MENTAL HEALTH

The Substance Use Treatment System (SUTS) will coordinate services with Mental Health to provide clients with integrated care for co-morbid conditions. The two departments merged formally in July 2015, and the Medi-Cal Waiver demonstration project offers an opportunity to integrate services on an accelerated schedule. Services coordination between Mental Health services and call-center, youth, adult and Medication Assisted Treatment are discussed in this section.

Coordination with MH with beneficiaries with COD

The Santa Clara County Mental Health Department (MHD) and Department of Alcohol and Drug Services (DADS) have begun their integration efforts with the goals of: (1) improving and increasing services, (2) centralizing the access point for clients and (3) improving efficiencies and reducing redundancies. An integrated services plan was developed jointly by staff from both departments and approved by County Board of Supervisors in 2014.

The integration plan covered all major system components: *administrative functions*, *quality assurance and quality improvement, youth, adult and co-occurring treatment*. As the size and complexity of the integrated department increased substantially after the merger, the plan called for a phased approach to integration. (The combined departments served over 30,000 clients annually through a network of 40 or more CBOs (Community-Based Organizations) and 500 county staff in the past fiscal year). The integration plan envisioned integration of the main administrative functions, the Call-Center and some treatment services during the first phase of the merger.

The integration of administrative functions will minimize and possibly, eliminate current problems with providing integrated care. Administrative integration will increase access to mental health services through *internal referrals, development of common standards for documentation of treatment such as treatment plans and progress notes, a shared understanding of reimbursement requirements and greater ease of cross-training and placement of dually-trained clinicians at specific clinics*.

Four functional areas are being given priority in the *Call-Center integration* process: Registration, Screening, Referral and Information Technology. Currently, clients who required Substance Use Disorder services are handled by the Gateway Call Center, while those needing Mental Health Services are processed by the Mental Health Call Center. The two call centers will be fully integrated to become the Behavioral Health Services Call Center (BHSCC) by the beginning of Fiscal Year 2016-2017. At that point, it will become the common point of entry to all clients needing Substance Use, Mental Health, and Co-occurring (Integrated Treatment) services. Suicide and Crisis Services (SACS) will also be placed under the auspices of the BHSCC.

The call-center workgroup has developed an Integration Framework and Recommendation for the Call-Center that will focus on: (1) the overall structure of the Call-Center integration; (2)

Integrated Treatment services plan for the Mental Health and Substance Using populations; (3) policies and procedures for implementation of services; (4) an integrated workflow; (5) a technology plan to support the workflow and to track data; (5) a centralized location for the combined staff and; (6) a plan for cross training staff to pilot test the proposed integration. Call-Center clerical staff will be cross trained to gather demographic and insurance verification data, and clinicians will be trained in screening and referral protocol. The goal of an integrated Call-Center is to create a seamless access point for clients, while reducing wait times for better customer service. In creating a common point of entry, clients with co-occurring disorders will be able, for the first time, to receive an appropriate referral for treatment from one source.

Integration of mental health and substance use services: In anticipation of a merger of the two departments, the leadership convened a number of workgroups that were tasked with producing recommendations on a range of integration issues such as administrative functions, quality assurance and best practices for clinically integrated services. The work group responsible for identifying the best integration model recommended the adoption of a hybrid clinical model composed of CCISC (Comprehensive Continuous Integrated System of Care) and SAMHSA's Evidence Based Treatment kit (for co-occurring disorders). The guiding principles for all future services integration were to be derived from the key principles of integrated treatment shown in the box below.

Key principles of integrated treatment
Co-occurring conditions are an expectation, not an exception.
Clients must receive treatment that emphasizes empathy, hope, integration and a strengths-based approach
Treatment for co-occurring disorders must be tailored to the needs of the population.
Treatment of both mental illness and substance use disorders must be concurrent
Recovery involves moving through stages of change
Progress occurs in an environment in which a client is adequately supported and rewarded for skill-based learning for each condition
Recovery plans and interventions must be individualized

The four quadrant model will be used to recommend the location of treatment for clients with different combinations of severity of mental health and substance use disorders. Quadrant I clients will to be served in primary health care settings, Quadrant II clients in substance-use focused treatment settings, Quadrant III clients in mental health settings and Quadrant IV clients in fully integrated service settings. Another goal of integration is to align clinical documentation practices so that there will a single standard for care and documentation of treatment plans and progress notes. Moreover, a single quality improvement plan will be developed for the integrated system.

Youth substance use and mental health treatment services staff have been collaborating to create an integrated youth treatment system for clients up to the age of 21 years. Services for

youth and transition-age young adult admitted to the integrated Behavioral Health Services Department will be organized according to the Four Quadrant Model. The youth Behavioral Health system will be made up of specialty Mental Health, specialty Substance Use, and Co-Occurring Disorder treatment providers. County and contract provider staff will be trained to assess and place youth with co-occurring disorders into the appropriate modality and level of care. Both substance use and mental health treatment providers will use ASAM Assessment for placement. All outpatient youth providers will be BBS licensed or licensed-waivered clinicians with the ability to provide integrated substance use and mental health treatment.

Minimum initial coordination requirements or goals for providers:
As the integrated Call-Center will serve as the primary portal for entry into Behavioral Health Services, the initial screening and placement will be conducted by staff trained to handle clients with co-occurring disorders. Thus, at a minimum, clients will be referred to the appropriate providers, that is, those who have been identified as capable of providing treatment for co-occurring disorders. (The Adult System of Care conducted a DDCAT assessment to determine co-occurring capability of all providers within the current system). Youth with co-occurring disorders will be referred to the co-occurring disorder provider or the provider that is most conveniently located to their home or school.

Monitoring coordination requirements
Monitoring of integration activities are still under discussion as the two departments work through their merger plan. The integration between mental health and substance use treatment services is occurring in phases, with specific programs slated to begin integrated services. These include the Call-Center and the Juvenile Justice Assessment Center, both of which serve as points of entry into the System of Care. The Behavioral Health Services Department's executive management is overseeing integration efforts and developing benchmarks for progress toward services integration. Department-wide integration benchmarks will be used to monitor services coordination during the initial period of ODS integration.

Current structure for delivery of SUD & MH services;
Currently, youth can access care through the Mental Health Call Center, on school sites where substance use treatment is offered, or through the specialty Substance Use Treatment Referral Coordinator call number. Thus, while youth currently receive treatment in both systems, only a limited amount of care coordination is available.

In the adult system, Substance Use Treatment Services collaborates with Mental Health Services primarily through the courts and specialty systems such as the Mental Health Urgent Care department. Mental Health Drug Treatment Court has Mental Health staff who assess for both mental health and substance use treatment. The Behavioral Health Team, at the Re-Entry Center for AB109 clients (criminal justice clients), is composed of mental health and substance use treatment staff and managed by a Substance Use Treatment System manager. Behavioral Health Team staff use an integrated instrument to assess clients and refer clients to mental

health and substance use treatment services. Clients also have access to Mental Health Urgent Care and the Mental Health Call Center for assessment and referral into the Mental Health System of Care.

6. COORDINATION WITH PHYSICAL HEALTH

The Substance Use Treatment system routinely admits clients with co-morbidities that include chronic and other medical conditions that require treatment as well. Coordination with physical health providers involves a combination of case management and care coordination, and tasks that range from linkage with health insurance to transportation to medical appointments.

Coordination with physical health services:
Both the adult and youth system refer clients to the *county's health care system* where a full complement of medical services, from urgent care, emergency department, ambulatory clinics and an inpatient facility, is available. Currently, health evaluations are integrated into the assessment process and are initiated during admission in the youth, adult and MAT systems. Clients complete a Health Screen Questionnaire at admission in the youth and adult systems to identify any physical health symptoms. ASAM Dimension II (physical health issues) is used to identify potential medical problems. As the function of health assessments will vary by the type of service provided, the disposition will vary correspondingly.

The *Youth System of Care* treatment services currently collaborates closely with a physician as part of overall treatment for a youth and this practice will be continued. Out of the 28 treatment sites in the Youth System of Care, four are co-located with physical health services, which facilitate ongoing care coordination and treatment of substance use disorders while promoting health and healthy lifestyle choices. Youth system treatment staff also has direct access to the program's Medical Director, a contracted physician or on-site medical staff for consultation regarding medical issues related to a client's treatment.

When the Medi-Cal Waiver demonstration project is implemented, assessments will be reviewed by the youth program's physician, who will work with the clinician to coordinate with the client's primary care physician. The client's primary care physician will have access to information about the client's substance use and be able to consult with the youth system's specialty physicians to better treat youths' health conditions that are affected by substance use.

The *MAT Division* will continue to provide coordinated care to clients enrolled in treatment. The complete plan of care for MAT clients is based upon laboratory results, physical exam and the ASAM bio-psychosocial assessment. ASAM Dimension II findings are sent to the admitting physician, who initiates an in-depth substance abuse history evaluation and a full physical exam in order to determine the best plan of care. In the case of pregnant patients (in the PSAP program), the primary care physician and obstetrician/gynecologist is informed about the admission and treatment services.

The MAT Division physicians will continue the current practice of coordinating care with a client's primary care physician if any abnormal laboratory test results, EKGs or other urgent medical problems are found. MAT physicians will also continue to coordinate care for patients who are prescribed controlled substance medications by their primary care or other physician outside of MAT. The purpose is early identification of a problem with patients known to be abusing their medication or if they are potentially at risk of overdose, or if their prescribed drug interferes with their treatment in addiction medicine

In addition, the MAT Division has assigned licensed staff to primary care clinics in the Santa County Health and Hospital System, where clinicians work directly with primary care physicians and on specialty medical teams such as the Heart Failure Clinic. Patients are referred directly to the clinician if they are identified as having a potential substance use issue. The on-site clinician provides assessments, brief intervention and referral to within the system of care where indicated.

The department employs a department-funded, full-time psychiatrist, whose function is to stabilize clients on psychiatric bridge medications, and then, refer them to the primary care system at Santa Clara County-operated ambulatory clinics for follow-up care.

The department through the waiver plan is working on collaboration with primary care and will propose a plan for coordination with physical health during the second year of the ODS implementation. Currently, clients have multiple entry points into the primary care system. The Santa Clara County Health & Hospital System through the 1115 Bridge to Reform waiver is working to create a seamless network that provides beneficiaries with access to a PCP and a full range of healthcare services.

Minimum initial coordination requirements:
In the System of Care, one primary goal of care coordination is to promote the physical health of clients while they are in treatment. Medical issues are integrated into the client's treatment plan under the ASAM's Dimension 2. The minimum requirements for coordination with physical health involve: (a) linking clients without a primary care physician to health services for immediate needs and (b) linking clients to a primary care physician if they do not have one at admission. When a client does not have health insurance, treatment programs are expected to provide case management to assist with linkage to health insurance benefits and a primary health care service provider.

In Perinatal treatment linking pregnant and parenting clients to physicians will continue to be a priority for the program. Currently, if a pregnant women does not have an obstetrician/gynecologist or another source of prenatal care, the MAT physician will initiate the linkage of their care with an appropriate obstetrician/gynecologist in the Santa Clara County Health and Hospital system through OBGYN nurse managers.

Plan for monitoring:

The QIC currently conducts audits for specialty stakeholders and payors such as the Valley Health Plan (VHP) - the county operated managed health plan. The audit involves utilizing additional and/or specialized criteria such as measuring the effectiveness of the communication between the primary care physician and the substance use treatment provider. For the ODS implementation, we are proposing to document clients' access to primary care at admission and discharge, to assess the system's effectiveness in linking clients to a primary care physician. The Quality Improvement Department's audit tool is shown as an attachment.

(See *Attachment VII for Audit Score sheets for insurance plan*).

7. COORDINATION ASSISTANCE (NA)

8. ACCESS

Access to all service modalities:
Clients will access treatment services through the centralized Call-Center, or one of the post-authorizations sites which include detoxification service providers. Clients who are admitted to the System-of-Care are automatically offered any service within the System of Care, based on their treatment needs. Santa Clara County has a continuum of care that provides the levels of care described in Section 4- Treatment Services. The Continuum of Care will be expanded to 8 Levels of Care across both the youth and adult systems of care. (See Table 6) Routine transfers between levels of care are governed by policies and procedures that are common across the provider network. Thus, when a new treatment agency contracts with Substance Use Treatment Services, it is contractually required to follow the care principles and philosophy of the System of Care. Care is coordinated by the Quality Improvement Division that authorizes residential treatment, extension of stays and provides consultation on other client care issues.

Maintenance of network
Santa Clara County's current treatment network consists of 6 ASAM levels of care, distributed over 4 treatment modalities and several treatment providers. Treatment providers in the system have applied for Medi-Cal certifications for the appropriate levels of service. Once approved, they will be able to offer services in facilities certified for specific levels of service.

Anticipated number of Medi-Cal Clients
The projected number of admissions by modality for the System of Care in FY 2016-17 are shown in Table 7. In the first year of the Medi-Cal Waiver, the department projects that the overall Medi-Cal client population will be between 41%-45% of the total admissions for outpatient, residential and detoxification services, and 72% of clients served in the MAT division, based on data gathered from open clients served in the system from July 1 2014 to June 30 2015. Projections for detoxification and treatment services assume: (a) an annual growth in admission based on the population growth rate for the county and (b) distribution of admissions by modalities based on historical trends. Projections for recovery services are based on the number of outpatient clients who complete treatment and are referred to recovery services.

Number & type of providers needed for Medi-Cal services:
The current continuum of care is adequate to meet the projected needs of the Medi-Cal population. Services are provided throughout the county by contract providers. The current providers with county contracts have submitted certification applications to the state Medi-Cal office, and it is anticipated that contract providers will be Medi-Cal certified by the beginning of the next county fiscal year (July 1 2016). The county system is currently capable of handling each year -approximately 6400 outpatient admissions, 1800 residential admissions, 900 detoxification services admissions, over 600 MAT admissions and 1400 transitional housing placements. Recovery services are offered to a limited number of clients and will need to be

expanded to include a larger percent of outpatient services. Dosage of Recovery Services will be individualized to client needs, as indicated in the economic model.

Table 7. Projected total admissions by modality and percent Medi-Cal-2016-17

	Projected admissions	Medi-Cal Expansion	Medi-Cal Traditional	Other payors
Withdrawal management ASAM 3.2	**927**	304	130	494
Residential treatment ASAM 3.1, 3.3, 3.5	**1863**	494	262	1106
Outpatient ASAM 1, 2.1, 2.5	**6643**	1493	1308	3481
OTS (MAT)	**655**	210	260	184
(Subtotal)				
Recovery Services	**2657**	597	523	747
Total (all services)				

- Note: Numbers may not add up to the projected admissions due to rounding.

Hours of operation:
For new referrals, appointments will be made five days a week during normal business hours. Outpatient providers are open Monday through Friday from 8 a.m. to 6 p.m. Evening outpatient services are provided. During the first year of the Waiver, the Department will review hours of operation and make changes that best meet the needs of the Medi-Cal beneficiaries.

The SCC plan will provide for entry to treatment 7 days a week. While SCC will strive for 24 hour placement standard, the capacity to fulfill this condition will depend on provider network capacity and future network expansion.

Language capability – Threshold languages:
The threshold languages for Santa Clara County include Spanish, Vietnamese, Mandarin and Tagalog. The department provides Spanish and Vietnamese language services as part of the required core of clinicians at select provider sites. Contract providers have bilingual staff that can provide services in other languages. Substance use treatment services also hires interpreters in special cases. The Cultural & Linguistically Appropriate Services plan (currently under development) requires signage and informational brochures to be provided in threshold languages. Hearing impaired clients are provided sign-language interpreters by the department.

Timeliness in face to visit and access to urgent and after hours care

As previously described, Gateway (the call-center) provides callers a referral to outpatient treatment provider, based on availability of slots. A maximum of fourteen days between

referral and first face to face visit is the standard for outpatient placements as set forth in Niatex recommendations-the Department will work with the Waiver implementation to reduce the maximum time to less than 7 days. All outpatient providers will be expected to provide an initial treatment service (intake) within fourteen days of the referral from the call centers. As described in the Quality Improvement plan, the department will require all outpatient treatment agencies to provide at least four face-to-face recovery sessions within the first thirty days of admission of the average 90 day length of stay for outpatient services. Additional sessions may be scheduled based on individual needs. Residential treatment currently has a wait list, which is actively managed to reduce wait times. The Department will work to improve the timeframe for placement in Residential Treatment through development of additional capacity. Another factor in the timeframe is with individuals that are being released from the county jail-beds are held for individuals pending release-due to delays in release has pushed the average timeframe for filling beds .Residential treatment capacity will need to be expanded to reduce wait times as demand currently exceeds supply of treatment beds. The MAT division has the capacity to take on additional demand (up to 100 clients), provided the clients meet state and federal criteria for admission. At this point the current capacity meets community demands. If additional demand develops the department will increase to meet the needs.

Currently, detoxification services are available 7 days a week. Clients that need afterhours care will be referred to an on call clinician for immediate clinical disposition and/or care coordination. Clients with an urgent condition receive services or attention from Care Coordination staff within 24 hours. Residential providers are contractually required to take weekend admissions and evening admissions for client convenience.

Geographic distribution of services:

The department has developed services within the major geographic locations of the county North, Central, East, and South where Medi-Cal beneficiaries are most located. Most treatment sites are on or near a major transportation line with Santa Clare County. The quality improvement team will review the county's census tracts to determine if there are adequate treatment locations are adequate to meet the Medi-Cal population service needs.

9. TRAINING PROVIDED

Training for agencies participating in the Waiver demonstration
Trainings are offered routinely through the Behavioral Health Services Department's training arm- The Learning Institute. Learning Institute makes trainings available at no cost to all county and contract providers of substance use, co-occurring disorders and mental health treatment services. Trainings offered in through the Learning Institute cover a range of topics, from new clinical models to client confidentiality.

The Santa Clara County System of Care has worked with Dr. David Mee-Lee for nearly two decades to train its network in ASAM placement criteria. ASAM trainings are offered regularly to contract provider staff through the Learning Institute. As a result, clinicians are trained to use ASAM routinely in their practice. The use of ASAM is reinforced by the use of ASAM-based assessment for client placement, which has established ASAM as the basis for making placement decisions throughout the system.

For the demonstration project, trainings will be offered on COD symptoms and diagnoses and Motivational Interviewing. Additional training will be provided to the provider network at no cost to ensure that, at a minimum, every program offers evidence-based practices. These trainings will include, but will not be limited to, Breaking Barriers, Framework for Recovery, Seeking Safety, 12 Step Facilitation Therapy, Matrix, Anger Management, Thinking For A Change, Relapse Prevention, Helping Women Recover Healing the Trauma, Living in Balance. Other trainings include Seven Challenges, family therapy and CBT. Additional training that address critical system issues such as client engagement will also be offered as part of the implementation of the ODS.

Training topics for which assistance is needed (NA)

Frequency of training & required versus optional trainings
Trainings will occur each month, with topics rotating throughout the year based on need. As noted, Motivational Interviewing is offered twice each year, with a minimum of three other EBP trainings offered annually for all Behavioral Health County and Contract Providers. Treatment providers will be required to provide at least two Evidence-based Practices (EBPs) such as Seeking Safety and the Matrix model.

10. TECHNICAL ASSISTANCE

Santa Clara County does not require technical assistance at this time.

11. QUALITY ASSURANCE

Description of county's QA activities:
The Quality Improvement and Data Support Division (QIDS) is responsible for Quality Assurance (QA) and Improvement across the entire System of Care. The QIDS manages the System-of-Care by: (a) overseeing placements, (b) managing transfers within the system, (c) troubleshooting care coordination issues raised by contract and providers, and (d) conducting QA activities such as DMC audits, Clinical chart audits, and monitoring data quality and integrity. QIDS is also responsible for monitoring client flow and problem-solving either through direct assistance by QICs or by using the Hot Group option.

QUIDS manages system capacity, client flow and through-put, authorization and placement for Residential Services and Transitional Housing Units (THUs), authorizations for increased level of care requests, and increased length of stay (LOS) in Residential Services and THUs. Monitoring and authorizing extensions for length of stay in residential treatment and transitional housing is major function of QIDS. In addition, non-routine movement of clients from one provider to another are also reviewed and authorized by QICs. QICs also review the appropriateness of treatment plans and expected completion times that are longer than the system benchmarks for treatment. Finally, providers are expected to consult with QIDS before "administratively discharging" clients, whenever possible. Provider staff has direct access to the QICs responsible for authorization and extension decisions and therefore, can question, escalate, and appeal decisions made by QICs. Examples of authorization forms are shown in Attachment V & VI.

Policies and procedures for operating within the system are standardized and all activity in the Continuum of Care (CoC) is overseen continually by QIDS. By operating as a single System-of-Care with standardized policies and procedure and system-wide clinical practice standards (e.g.: ASAM criteria), accountability for contractual obligations, standards of practice and service, and the expectation of improvement has become ingrained behavior within the system.

The QIDS is staffed by eight Quality Improvement Coordinators (QICs) (5 licensed and 3 CADAAC II), six data analysis/data management staff, one project manager, two trainers, and four support staff. QIDS is managed by a Division Director who is licensed clinician and a senior member of the county's substance use treatment system management.

Each QIC is required to be on-call on a rotating basis to provide immediate assistance to the system. The QIC on-call number is made available via the QIDS Division's main phone number. QICs are available during business-hours five days a week for technical assistance, trouble-shooting system issues, provider and stakeholder generated issues, and client generated issues. Each QIC is directly responsible for specific providers in the system and maintains a 1:1 working relationship with the provider staff.

The basic framework for quality improvement will continue under the Medi-Cal Waiver demonstration project, with modifications where necessary. The current operational procedures and responsibilities of the Quality Improvement and Data Support Division are described in more detail below.

Quality improvement plan

The System-of-Care relies on data to monitor and manage the client flow and maintain treatment quality. Quality improvement activities currently fall into three broad categories: *system audits, client grievance monitoring and regular reports from the department's electronic health record*. QIDS proposes to continue these activities, and augment these efforts with additional metrics that capture system functioning at multiple points in time.

System audits: The QIDS Division conducts *formal audit reviews* of provider performance on an annual basis. The annual audit involves a review of a provider's business operations to determine whether services are provided in accordance with the contract. Focusing a system improvement lens on these aspects of contract performance (applied equally to both county and contract providers), supports the network to function as a unified System of Care

In addition to annual performance audits, QIDS also conducts a yearly DMC and Clinical Performance Measures audit. QICs review a random selection charts from all providers for this audit. Results of the audit are reported to the providers. Corrective Action is required for outstanding issues of non-compliance or areas determined to need improvement. Disallowances are referred on to the Finance Division if appropriate. The QIDS also conducts audits for specialty stakeholders and payors such as the Valley Health Plan (VHP) - the county-operated health plan. Additional and/or specialized criteria such as measuring the effectiveness of the PCP to SUTS provider communication are used for specialty audits such as the VHP review. *(See Attachment VII for Audit Score Sheet).*

Client grievance monitoring: The Quality Improvement Division coordinates with the Adult System-administered one-point of access patient rights and grievance process. The process consists of a "client rights advocate" panel, made up of clinicians trained as advocates and overseen by the Clinical Standards Coordinator. Many QICs serve as client advocates. Using a "clients' rights advocate," clients are able to report complaints anonymously and file grievances that are investigated by the county. Advocates have full access to provider staff and pertinent records required to investigate client grievances.

The grievance procedure is posted at provider locations and also given to clients at admission. Clients have the right to grieve if they have been treated unfairly, including an unfair discharge or have experienced a breach of confidentiality. When clients submit a complaint directly to the county (as opposed to the treatment provider), typically via telephone, the complaint is directed to a member of the Clients' Rights Advocacy Panel, who reviews the complaint with the client to determine the need for action. A determination is made within 24 hours whether

the complaint warrants further investigation. The panel works to resolve the complaint as soon as possible. For the demonstration project, panel members will be required to resolve complaints within 10 working days.

For the grievance review, panel members gather together relevant documents such as treatment plan, progress notes, TSRs, facility manager notes (for residential treatment), in addition to a written description of the complaint. The final resolution is communicated via a letter to the client (if an address is available) or verbally. No changes in client benefits are made until the grievance is resolved. If the client is not satisfied with the outcome of the grievance process, they are entitled to take their grievance to the state.

Performance measurement monitoring: Program data for the System of Care is currently entered in an electronic health record called Profiler™ from CoCentrix. At present, county and contract providers enter data into Profiler within a common timeframe, as specified in policy and procedures for system operations and contracts between the county and CBOs. Routine reports are available for all providers to manage their operations. Quality Improvement staff run multiple reports on a regular basis and monitors both provider and system performance. Independent review of performance measures is conducted by the Research and Outcome Measurement unit.

One set of Provider Performance Measures currently in use is the Provider On-Going Performance (POP) Indicators. QIDS compiles data on individual provider performance each quarter on the following metrics: (1) monthly average percent of Operational Capacity, (2) Number of Days Closed to Referrals, (3) Provider Attendance at Required System Meetings, (4) Timely Submission of Required Reports, and (5) Data Quality and Timeliness Standards.

Data support staff within the QIDS is also responsible for uploading CalOMs data from all providers in the system on a monthly basis. CalOMS error and rejection rates are monitored and training is provided to CBOs who require technical assistance to meet their corrective action objectives. CalOMS data are used to outcomes and system monitoring reports, ad hoc management and policy reports, specialized reports by department's analysts, and system and performance improvement projects.

DMC-ODS Waiver Quality Improvement Plan: The Quality Improvement plan for the Santa Clara County Medi-Cal Waiver demonstration project is oriented toward measurement of system functioning. The QI plan proposes to measure <u>five</u> outputs (measures of system functioning): (i) Access to services, (ii) Engagement in services, (iii) Client Outcomes, (iv) Care Coordination and (v) Communication (intra-system, extended Health and Hospital system). The first three measures listed above will be the focus of quality improvement efforts during the first two years of the Waiver demonstration. The Department has engaged the primary health system in development of referrals for individuals that present with substance abuse issues at either the emergency department or through the primary and specialty health system. Currently the

department provides License Clinical Social Workers as contact for patients that need placement with the adult system of care. Each of three broad areas of focus for quality improvement cover a range of measures that attempt to quantify different aspects of access, engagement and client outcomes. The QIDS will work closely with the Research and Outcome Measurement unit to test and implement the measures proposed below.

Access to services is divided by service modality; there are three outpatient access measures, three residential treatment access measures, two Medication Assisted Treatment access measures and one Intensive Outpatient access measure. Access measures are primarily focused on wait-times, intervals between key clinical events such as intake, first treatment session and completion of treatment plan, utilization rates and re-admissions. (See Table 8) Chapter 8 – Access describes how clients may access treatment in the SCC Substance Use Treatment System.

For *engagement*, three separate sets of measures are proposed: one set for outpatient, intensive outpatient and Medication Assisted Treatment; a second set for residential treatment and Partial Hospitalization; the third, for utilization of the continuum of care:

- **For outpatient, intensive outpatient and MAT,** the engagement is measured as the *percent of clients with 4 services provided in the first 30 days of admission*, *number and type of treatment services*, and *customer services Key Performance Indices* (which are yet to be determined). In addition, the QI team will monitor the interval between admission and the next clinical appointment to ensure that it falls at or below 5 days post-admission. For MAT, measures will include percent receiving same day dosing (upon admission), when consistent with medical evaluation and state and federal regulations.
- **For Residential Treatment and Partial Hospitalization**, engagement is measured as the *percent of clients who receive an intake, assessment or a treatment plan within 14 days of admission*, *number of treatment services, and Customer Service Key Performance Indicators* (which are yet to be determined)
- **For the continuum of care**, *engagement is measured as the percent of client who use the step down components of the Continuum of Care*.

Table 8. Quality Improvement Measures for Access & Engagement

Measures – system functioning	Metrics	Data Requirements
ACCESS		
Access to treatment system	Responsiveness of beneficiary access line: time to call response, dropped and abandoned calls	CISCO telephone routing system
Outpatient treatment	Date of Screening to First Offered Appt.	
	Date of Screening to initial appointment (intake) at the appropriate LOC	reporting requirement in DMC – ODS Waiver 1115
	% of clients with 3 additional AOD services in first 30 days from the date of intake (4 in 30 metric, including intake as 1st service.	reporting requirement of Quality Measures (CMS letter July 27, 2015)
Residential treatment	Date of Screening to First Placement attempt	
	Date of first Placement attempt to date of Intake (Intakes should occur 24/7)	
	Goal is to a 10% maximum vacancy rate	
MAT	Date of Screening to Induction	
	Date of Walk-in appt to Induction	
IOP from Res Or other transfer	Date referral is received by provider to IOP Intake	
Engagement		
OP/IOP/AMT	4/30 Includes Intake and Assessment, TX Plan, TX Service(s),	
	Treatment services	
	Customer service key performance indices	
Residential and PHP	Intake, Assessment and TX Plan by 9 days	
	Treatment services	
	Customer service key performance indices	
Continuum of care	% clients utilizing multiple step down components of the COC	

For *client outcomes*, value rather than volume of services will be measured. Frequency of data collection for client outcomes is under discussion. A preliminary set of client outcome measures based on the SAMHSA National Outcome Measures (NOMs) is being considered for implementation. (See Table 9) The Research and Outcome Measurement will assist in adapting and testing the NOMs.

Table 9. Client Outcomes – based on SAMHSA's National Outcome Measures

Domain	Outcome	Indicator
Abstinence	Abstinence from substance use at end of episode	Comparison of substance use at beginning and end of treatment episode
Criminal justice	Decreased criminal justice involvement	Arrests 30 days prior to admission versus 30 days prior to discharge from treatment episode
Housing stability	Increased stability in housing	Housing status 30 days prior to admission versus 30 days prior to discharge from treatment episode
Social connectedness	Increased social support/connectedness	To be determined
Perception of care	Client perception of value of care	Client treatment perception instrument under development

In addition, a second option under discussion involves developing an outcome tool, based on the ASAM 6 dimensions. The final outcome measure set would need to complement the system's Practice Standards that includes both clinician and client measurements of outcome. Post-discharge data collection is currently conducted only for grant-funded projects, and expanding these efforts to the larger system will depend on identified funding.

Metrics for *care coordination* will be developed in the future. It is anticipated that these measures will be developed during the second year of the Waiver demonstration. Measures will involve identifying specific populations within the System of Care such as frequent utilizers of high intensity services and care coordination practices to improve treatment outcomes for this group. (See Attachment III "High utilizer")

The last set of measures involves *communication within (intra-system), Mental Health and Physical Medicine*. At present, the System of Care's treatment continuum relies on written, faxed and electronic communications of various sorts to inform county staff, treatment providers and others about a client's status. The new Quality Improvement plan calls for establishing formal tracking of different system communication and utilization processes. This will provide Quality Improvement staff with organized system for identifying gaps in communication within the system. A list of the communications forms that will be used for tracking and measuring the effectiveness of communications are shown below. (See Table 10)

Table 10. Quality Improvement Division: Type and purpose communications

Communication	Purpose	Type
Continuum of Care	Authorizations, Transitions in LOC	Document stored
Treatment Status Report	Communications with CJS	Document stored
QICs on –call log	System troubleshooting	Document stored
Clinical Supervision Mtg	Regular meeting with clin supervisors	Meeting
Criminal justice Mtg	Regular meeting with CJS	Meeting
Medi-Cal Collaborative	Regular meeting with providers DMC	Meeting
DWC /QI weekly meeting	Regular meeting with DWC	Meeting
Drug TX Court weekly meeti	Regular meeting with Drug Tx Cour	Meeting
IP meeting		Meeting
THU providers meeting	Regular meeting with THU provide	Meeting

Quality Assurance 'inputs'

Quality Improvement metrics proposed in the previous section are directly tied to the processes the Quality Improvement Department uses to monitor the system, authorize extensions of lengths of stay in residential and transitional housing units, and the quality of client services. These activities constitute system 'inputs,' which refer to standards used by the Quality Improvement Department to conduct its day-to-day work. We describe each 'input' activity separately below.

Audits: Audits are conducted annually to assess the extent to which the system complies with the standard operational protocols as part of contractual obligations. Two types of audits are relevant to this discussion, (1) Clinical Chart Audits which include both the annual DMC audit and the system Clinical Performance Measures audit, and (2) Programmatic audits which look primarily at contractual and system-wide provider operational requirements. Elements of expected program performance, such as the interfaces with psychiatry and primary care, are included in these audits.

The purpose of *the audit of MHD coordination* for services is to assess the status of coordination of care. This type of feedback enables us to assess the effectiveness of client services, identify care management issues and improve service delivery. The documentation in the Health Record is audited for the items shown in Table 11.

Table 11. Items for Audit for MHD Coordination

Item	Item description
A	Psychiatrist or Primary Care Physician (PCP) prescribing medications for problems noted in Dimension #3
B	Evidence of coordination between providers and the prescriber based on the beneficiary's need
C	For moderate to severe ASAM dimension 3 assessment, care coordination with the PCP included in the treatment goals and documented in the treatment plan
D	Evidence for beneficiary declining to consent to care coordination between behavioral health provider & PCP (in progress note)

PCP communication with other providers is audited mainly for the contract with the county-run health plan. The audit involves reviewing documentation in the Health record. Specifically, the review examines whether (i) the PCP's name was documented, (ii)whether there was evidence of care coordination between PCP and other providers based on beneficiary need, (iii) whether moderate to severe assessment of ASAM Dimension 2 (Physical Health) was documented, and coordination with PCP noted in the treatment plan and treatment goals, and (iv) whether the beneficiary's consent or refusal to coordinate with PCP was documented in the progress note and evidence for motivational enhancement interventions was recorded. (*See Attachment VII for Audit Score Sheet*)

System monitoring: A significant proportion of Quality Improvement efforts is focused on maintaining client flow through the System of Care and customizing care based on individual clients' needs, as determined by ASAM criteria. In the System of Care, 'flow' metrics are monitored routinely for detoxification services, residential and outpatient lengths of stay.

Detoxification service stays over 7 days are monitored through reports submitted by service providers. QICs follow up with detoxification service providers when significant deviations in the length of stay are observed. In the future, 'avoidable admissions' to detoxification services will also be monitored.

Residential stays over 45 days are also monitored as extensions require authorization from the Quality Improvement Department. Residential providers request extension on behalf of the clients and the Quality Improvement Department provides authorization based on clinical needs. In the future, 'avoidable admissions' to residential treatment will also be monitored.

Stays in *outpatient treatment* in excess of 180 days and intensive outpatient stays over 90 days are monitored as well. Outpatient providers are required submit justification for extensions

beyond 90 days. Typically, outpatient length of stay is monitored with a standard report, which triggers action by the Quality Improvement Department when unusually lengthy stays are found. Quality Improvement staff also routinely monitor client 'no shows', which providers are required to record in the electronic health record.

The QID also monitors length of stay *in transitional housing units (THUs),* which refer to housing provided to clients in outpatient treatment. Stays over 90 days (over 180 days for DWC beds) in transitional housing units are monitored by the Quality Improvement Department. As a client has to be open in an outpatient program to be eligible for housing, outpatient providers are responsible for requesting extensions on behalf of clients. The QID extensions of stay based on client treatment needs.

Utilization Management: The QID has been authorizing extensions of lengths of stay in residential treatment and transitional housing (for outpatient) clients for nearly two decades. As part of the Medi-Cal Waiver demonstration project, QID proposes development of a system to track authorizations by service modality. The data points in the authorization process that will be tracked are shown in Table 12.

Initial authorization for residential treatment refers to the first placement during an episode of treatment. For the initial authorization of residential services, three measures will be tracked: (i) Number of authorization requests submitted and processed, (ii) percent denied, (iii) percent of initial authorizations provided within 24 hours of a request.

Re-authorization for residential services refers to the system policy that requires providers to seek authorization for extension of stay from the QID. Three measures will also be used to track re-authorizations: (i) Number of authorization requests submitted and processed, (ii) percent denied, (iii) percent of re- authorizations provided within 3 days of a request. (See Table 12)

Initial and reauthorizations will also be tracked for *stays in transitional housing units.* For the <u>initial authorization</u>, three measures will be tracked: i) Number of authorization requests submitted and processed, (ii) percent denied, (iii) percent of initial authorizations provided within 3 days of a request. The period for the turn-around for an initial authorization is still under discussion and to be determined. Similar measures will be tracked for <u>re-authorization</u> for transitional housing: (i) Number of authorization requests submitted and processed, (ii) percent denied, (iii) percent of initial authorizations provided within 3 days of a request. The turn-around period for re-authorizations is still under discussion and will be determined before the Waiver is implementation.

Table 12. Authorizations to be tracked – Medi-Cal Waiver demonstration project

	Residential initial authorization	Re-authorization of residential services	Transitional housing initial authorization:	Re-authorization of THU services
Number of authorization requests submitted and processed,	X	X	X	X
percent denied	X	X	X	x
percent of initial authorizations provided within 24 hours of a request	X	NA	Percent of authorizations over a specified period (TBD)	NA
percent of initial authorizations provided within 3 days of a request	NA	X	NA	% of initial authorizations provided by 3 days of request

Customer Service Based Performance Indicators

In our experience, feedback from customers must cover three domains; (i) *the degree to which services were tailored to help clients meet their needs, (ii) organizational efficiency and customer friendliness and (iii) customer satisfaction*. The first domain covers actual treatment experience with a particular emphasis on the utility of the services provided, specifically whether they served to attenuate the condition for which a client sought services. The second domain covers organizational components of treatment such as cleanliness of the facilities, the admission process, food quality in residential treatment settings and so on. Customer satisfaction gauges how the clients' rated the overall quality of services.

The System of Care has gathered customer satisfaction data using the CSQ-9 in the past. However, satisfaction data alone was not able to offer much guidance for improving services, in part due to the self-selected nature of respondents, who were mainly those who completed treatment. In the next iteration, clients' view of services will be elicited in two different settings: one at exit from the program and a second, at periodic intervals during treatment. The Research and Outcome Measurement unit will be involved in piloting the next iteration of a client satisfaction survey. Periodic feedback from clients who are in treatment will allow providers to re-calibrate treatment in real time and enhance the effectiveness of services for clients in treatment.

Quality Improvement Committee (QIC) activities & membership

As the current System of Care operates on a collaborative basis, the system does not have a formal QIC. Issues for system improvement can be raised at any time by stakeholders, providers, consumers (through the grievance process), and administration. The Hot Group process is used for quality improvement projects. A cross-system Hot Group is formed when a problem is identified and a solution is generally proposed by next system meeting. The Hot Group process is based on the PDSA principle with a short-cycle problem solving approach. A formal QI Committee made up of stakeholder, family and consumer, provider, and administrative participants will be created as part of the transition to an Organized Delivery System in the first year of the demonstration project.

Compliance with 438

The Medi-Cal Waiver demonstration will require the provisions of the 42CFR part 438 regulations to be integrated into the department's current Policy and Procedures. The existing infrastructure provides an established and grounded foundation that can readily incorporate additional specifications as required by part 438 regulations. The county's effort to comply with the provisions of 438 will include developing a formal QI plan (see Quality Assurance section), and Memoranda of Understanding with Managed Care Organizations (MCO) that operate in Santa Clara County. (We do not have an agreement with a PIHP).

The formal Quality Improvement plan described above is designed to monitor every component of the continuum of care: managing transitions between levels of care, utilization management, system performance monitoring using audits and other metrics, client outcome measurement and client satisfaction. The current quality improvement protocol that involves using 'Hot Groups' will be augmented with a Quality Improvement committee.

The MOUs with health plans will contain language that covers (a) plan for a fair hearing for denial of service, and (b) provisions for a protocol to resolve issues related to denial of coverage or payment of services rendered. The grievance system will include required elements such as: (i) procedures for clients, providers and MCOs to file and appeal grievances, (ii) time frames for reasonable action, (iii) fair hearing procedures, and (iv) methods for filing grievances. The Memoranda of Understanding with MCOs must be approved by county counsel and the template for future agreements is currently under counsel review.

How each QA activity will meet the minimum data requirements?

The System of Care currently has metrics for the majority of the minimum data requirements as outlined in the STC (08-06-15 version).

Number of days from referral to first level of care

The System of Care uses an integrated electronic health record (Profiler™) to record client data such as screening and referral data, admission and discharge dates, client services, and other clinical information. The interval between the referral date and admission date will be computed using these data.

Non-English language access -24/7

There are four threshold languages in Santa Clara County (other than English): Spanish, Vietnamese, Chinese and Tagalog. The Call-Center has Spanish and Vietnamese-speaking staff available during regular business hours. Spanish and Vietnamese represent the most commonly requested threshold languages, while the demand for Tagalog and Chinese is met through the county's language services. The Call Center gathers data on the preferred language metrics and date of first contact can be associated with date of first appointment, by the caller's language. The upcoming Integrated Behavioral Health Call Center will provide 24/7 access. Thus, the system will be able to provide metrics by language of caller.

Authorization: As noted in other sections on Quality Assurance, authorization for services will be redesigned for the Medi-Cal Waiver demonstration. Authorizations will be handled by the Quality Improvement division and recorded in the electronic health record. The minimum metrics required for authorization activities has been built into the process and is described in a separate response in this proposal.

12. EVIDENCE BASED PRACTICES

Substance Use Treatment System of care providers have been trained in a number of Evidence Based Practices (EBP). Clinicians in the Adult System and MAT have been trained in Motivational Interviewing and Seeking Safety. In addition, providers in the Adult System have been trained in Breaking Barriers, Framework for Recovery, Gorski's Relapse Prevention and 12 Step Facilitation. During the first year of the Waiver, the substance use treatment system will provide further training in Evidence Based Practices and each provider will be expected to offer at a minimum 2 groups using Evidence Based Practices as well as Motivational Interviewing.

All programs in the Adult System of Care are co-occurring capable as determined by the Dual Diagnosis Capability in Addiction Treatment (DDCAT) score of 3 or above. A DDCAT assessment of MAT programs is scheduled for FY 2016.

County plan for ensuring that providers are implementing at least two identified EBPs
When the ODS is implemented, providers in the System of Care will be required to attest that they are providing at least two EBPs in treatment program.

Actions for non-compliance
Annual audits will be the primary mechanism used to determine compliance with the requirement for using EBPs. A pilot project to improve compliance will be launched during the first year of the Medi-Cal Waiver demonstration project. Non-compliant providers will be asked to provide a recording of a randomly selected treatment session to the Quality Improvement Department. The pilot will involve creating standard ways of coding audiotaped sessions and will be reviewed for fidelity to the EBP. Providers who are out of compliance will be given direction as to the necessary training required to meet standards of care for the system.

13. ASSESSMENT

Santa Clara County has clearly defined protocols for conducting bio-psychosocial assessments of all clients admitted into the System of Care. This process will continue after the Medi-Cal Waiver demonstration project is implemented. The two avenues for entry into the continuum of care that are currently used will be retained and the capacity to admit 'walk-in' clients will be created to broaden access to services.

Clients currently enter the System-of-Care through two entry points: 1) the centralized Call Center known as Gateway and (2) post-authorization sites (see description under Quality Assurance plan). Post-authorization sites operate in locations such as the AB109 Re-Entry Center and the Family Reunification (Dependency Wellness) Court and detoxification services sites.

Clients entering the system through the Gateway Call Center receive a brief ASAM-based screening over the phone, designed to determine the most appropriate LOC for the client. The telephone-based screening tool is referred to as the "Brief Referral for Services" and has been reasonably effective differentiating between different levels of care such as detox, residential, and outpatient. In-custody clients who are seeking treatment while in jail can call Gateway via two dedicated phone lines, provided at no charge to jail inmates. In-custody clients are referred to an appropriate level of care to which they are admitted after leaving custody.

The first session at a treatment site is the Intake. At intake all clients receive a full six-dimension ASAM assessment, a risk assessment, a diagnosis, and an individualized treatment recommendation (a preliminary to the treatment plan). If the intake clinician at the referred to site determines that the referral to that particular modality is appropriate, the client is admitted to the program. If the client's clinical situation has changed since the Call-Center screening, then the assessing clinician refers the client to another provider, at the appropriate level of care within the System of Care.

If a client's first contact with the System-of-Care occurs at a post-authorization site, they receive a screening with a slightly modified version of the Referral for Service screen. Post-Authorization sites located at the courts or criminal justice service centers use a screening tool referred to as the Integrated Justice System assessment. One post-authorization site has dedicated beds/slots for their specific population within the Continuum of Care and assessors located at that site can make direct referrals to those treatment agencies. Detoxification providers provide a second avenue for entry into the substance use treatment system. Only a Continuum of Care form is needed to refer clients to another level of care within the System of Care.

The System-of-Care will continue its current emphasis on clinical best practices for assessment. The requirement is that all clients will receive a comprehensive six dimension ASAM

assessment, a risk assessment, a diagnosis, and an individualized treatment recommendation (preliminary to treatment plan document) at each intake appointment at each new treatment site in their episode of care. All clients, even those who have been previously screened at the Call-Center or a post-authorization site, must be authorized to receive residential and detoxification services. Services are authorized by the QID. Services requiring authorization will have at least two ASAM criteria reviews regarding the appropriateness of detoxification and residential services.

The System-of-Care currently reviews and authorizes Transitional Housing services contracted with community-based housing providers. The department currently manages outpatient services according to length of stay guidelines described in a previous section. Under the Medi-Cal Waiver demonstration project an outpatient authorization and utilization review process will be instituted for all outpatient treatment services to improve system efficiency. The goal of improving system efficiency includes better capacity and utilization management and more accurate ASAM LOC placement. These changes will be implemented within the first three years of the Med-iCal Waiver Demonstration project.

14. REGIONAL MODEL

Santa Clara County is not currently proposing to participate in a regional delivery system.

15. MEMORANDUM OF UNDERSTANDING

The Department is currently developing a Memo of Understanding (MOU), and the required policies and procedures with the two Medi-Cal Managed Care Plans in Santa Clara County, Anthem Blue Cross and Santa Clara County Family Health Plan. The MOU will outline mechanisms for sharing information and coordination of service delivery.

Elements to be covered in the MOU include the following components:

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

Policies and procedures will be incorporated into the MOU and include:

- Information sharing policies and procedures;
- Agreed upon roles and responsibilities for sharing personal health information (PHI) for the purposes of medical and behavioral health care coordination; and
- Coordinating medical and behavioral health care for beneficiaries enrolled in Medi-Cal Managed Care Plans that are receiving Medi-Cal specialty mental health or Drug Medi-Cal services through the Department.

Additional provisions for compliance with 42 CFR Section 438

The MOUs with health plans will contain language that covers:

- Plan for a fair hearing for denial of service
- Provisions for a protocol to resolve issues related to denial of coverage or payment of services rendered.
- The grievance system will include required elements such as
    - Procedures for clients, providers and MCOs to file and appeal grievances
    - Time frames for reasonable action
    - Fair hearing procedures
    - Protocols for filing grievances.

The Memoranda of Understanding with MCOs must be approved by county counsel and the template for future agreements is currently under counsel review.

The MOU and affiliated policies and procedures will be complete prior to the July 1, 2016 start date.

16. TELEHEALTH SERVICES

Tele-health services will be explored for the Medi-Cal Waiver demonstration. However, number issues related to electronic transmission of PHI (Personal Health Information), confidentiality of tele-health sessions and client privacy need to be explored, and policy and procedures developed. As the Behavioral Health Services Department is located within Santa Clara County's Health & Hospital System, policies and procedures must be aligned to the technological capacity and requirements of the county system. A working committee composed of representatives from the Santa Clara County Compliance Office and County Counsel's Office have been reviewing procedures for tele-health modalities to ensure that all programs comply with confidentiality regulations.

17. CONTRACTING

Selection of provider contracting process

All county departments are required to follow the Board of Supervisors policy, Chapter 5 -on soliciting and contracting. (See Attachment IX for Board of Supervisors policy)

Length of term of contract

Services must be re-bid every 5 years through a competitive procurement process that involves publishing Request for Proposals (RFP). Contract awards from RFPs are renewed every fiscal year and are in effect for a maximum of 5 years. Under specific circumstances, the Board of Supervisors may allow a contract to be extended beyond the prescribed period.

Local appeals process

County policy (Section 5.6.5.3 Protest Process) provides contractors an opportunity to submit a protest. This protest procedure is spelled out in the RFP to allow non-selected contractors a process to appeal.

Options for continuing service for beneficiaries if a particular contractor is not selected

If current DMC providers are not awarded a DMC-ODS contract, the county will ensure that beneficiaries are referred to other DMC-ODS contract providers that provide comparable services.

18. ADDITIONAL MEDICATION ASSISTED TREATMENT (MAT)

The Medication Assisted Therapy Division has recently begun to provide VIVITROL (®) treatment to out-patient clients. VIVITROL (®) treatment will be expanded to all MAT clinics. Vivitrol is an injectable naltrexone for opioid addition. Patients may refer themselves for VIVITROL (®) treatment, but admission will require an assessment by a licensed physician to determine whether the client is a good match for this medication. VIVITROL (®) will be administered to volunteers from SUTS treatment programs who have alcohol and/or opiate dependency and have consented to VIVITROL (®) treatment. The VIVITROL (®) Treatment Program will provide monthly assessments (reassessments) and medical services including evaluations, monthly injection and follow up visit, and counseling.

19. RESIDENTIAL AUTHORIZATION

Residential capacity in the System-of-Care is managed by the QIDS division. When clients call the Call Center, they are triaged to the most appropriate modality using the Gateway screening tool. A decision tree with demonstrated effectiveness in differentiating between the four modalities (detox, residential, outpatient, and MAT services) is used for referrals in the current System-of-Care. The triage determination at the Call Center constitutes an authorization for Residential Treatment and the client is referred to the Residential Placement Coordination List managed by QIDS.

The Residential Placement Coordinator and support staff are responsible for matching clients on the list to appropriate residential beds as soon as possible. Current placement data indicate that the overwhelming majority of clients are placed into residential treatment during the first 30 days, with the highest percentage being placed in a bed between the 15th to 30th days, following the initial call. Placement times in residential treatment depends on capacity and client choice. With the implementation of the Waiver the department will move to placement within 7 days. This will be accomplished through development of additional residential capacity within the network. The department is also pursuing turning on an electronic bed census management module within its EHR to manage residential bed capacity with greater efficiency. Referrals for residential treatment from the call-center and post-authorization sites are maintained centrally by QIDS staff, which manages a waitlist following SAPT standards for prioritizing residential admissions. QIDS proposes to reduce the placement window by retooling the residential waitlist process and other tools used for system improvement.

Clients are offered same day admissions when they call, if beds are available. Some clients prefer the convenience of an appointment and choose to schedule their admission day up to a few weeks in advance. Post-authorizations sites offer assessment and screening on-site (e.g.: Re-Unification Court, AB10, Juvenile Justice Court, and Parolee Re-Entry Centers, etc.) and can directly refer clients to a residential bed (offering them an appointment based or same day intake appointment).

The QIDS coordinates placement of clients in residential treatment when the initial assessment requires it. If the recommendation involves an “upgrade” to a more intensive level of care, then the provider obtains authorization through the QIDS division. In instances where transfer cannot be arranged on the same day, the first provider is required to admit the client and provide them with the intensity of services necessary to prevent their condition from deteriorating until the transfer can be arranged. Upgrades from outpatient to residential are given a high priority in the System of Care and these transfers are routinely coordinated by QICs. Transfers between levels of care are documented both on paper and in the electronic health record.

The ODS Waiver has created the opportunity for the SUTS System of Care to revise the residential placement process. In the future, authorization will occur following a face to face session in which an ASAM six-dimension assessment is conducted (at the referred treatment site). Providers will contact QIDS after completing a standardized intake assessment and request a formal authorization. The intake assessment will be electronically transmitted to the QIDS unit for record keeping and utilization management.

In the Adult system, the current 45-day benchmark for an initial authorization for a residential length of stay will continue. At present, residential treatment is initially authorized for 45 days, and stays beyond 45 days must be authorized by the Quality Improvement Division. This protocol will continue under the demonstration project. The same full six- dimensional ASAM assessment used at intake will be used on the 35th day to determine re-authorizations for stays anticipated beyond 45 days. In the Youth System of Care, the residential length of stay will be 30 days. Extensions will be granted by QIC consultation based on an individual's current clinical needs and ASAM assessment in keeping with a chronic care management philosophy where clients are stabilized at higher levels of care and then moved to lower levels of care within the community. The SCC ODS will manage client benefits by using authorizations, utilization management and data reporting.

20. ONE YEAR PROVISIONAL PERIOD

NA- THE SCC Medi-Cal Waiver demonstration plan meets all mandatory requirements for the DMC ODS.

ATTACHMENTS

ATTACHMENT I

HOSHIN METHODOLOGY EXAMPLE

Example of Hoshin planning
Santa Clara County
Substance Use Treatment System

Background

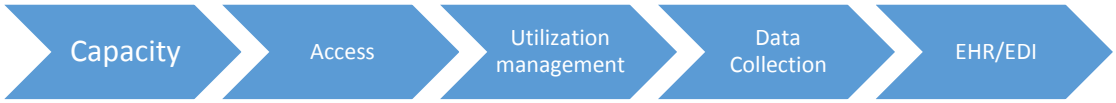
The System Gap Hot Group had been convened to identify the major gaps in the System of Care. In the first phase, Hot Group participants had the freedom to identify the gaps and write them on post-it notes - aka "stickies". Through this process, the Hot Group identified a myriad of system gaps. The next step was to apply the Hoshin Planning approach to organize the numerous stickies generated in Phase I.

Bruce Copley was invited to the Hot Group meeting to facilitate the Hoshin planning process. Following an explanation of the process, participants were organized into small groups with the goal of creating common chains from the stickies generated in a previous session.

The groups operated silently without consultation to create a smaller number of domains numbering between 5 and 7. Five themes emerged from this exercise, each relating to a gap in the System of Care.

1. Barriers to treatment
2. Capacity
3. Quality of Service
4. Communications
5. Staffing and staff development

The next step is to conduct a 'fishnet' analysis, in which each of the 5 domains is broken down into a sequence from the main domain to series of operational objectives. For instance, in the main domain of Capacity, several dependencies can be seen in the example below:



This diagram helps conceptualize how best to prioritize objectives, based on their location in the process flow.

The process is iterative until all of the identified sub-domains have been accounted for and plan of action, created.

ATTACHMENT II

INNOVATIVE PARTNERSHIP (IP) MEETING AGENDAS

INNOVATIVE PARTNERSHIP (IP)

Monday, October 19, 2015 | 2:15 – 4:00 pm

Learning Partnership – Training Rm. 4 | 1075 E. Santa Clara St., San Jose, CA

IP MEETING AGENDA

Facilitated by:

Jeremy Orcutt – Family Children Services (FCS)

Razelle Buenavista – Asian American Recovery Services / HealthRIGHT 360 (AARS/HR360)

TIME	AGENDA ITEM	NOTES
2:15 – 2:25	Welcome /Introductions	
2:25 – 2:30	Review/Approval of 9/14/15 IP Meeting Minutes Overview of Today's Agenda	
2:30 – 2:40	Collaborative Groups Report-Out • Clinical Tools Hot Group – *on hold* • DMC Collaborative *(Steve Lownsbery)* • Outpatient Workflow - *on hold* • 290 referrals *(Gary Montrezza)*	
2:40 – 3:40	1115 Waiver Implementation: -Meeting with Finance to develop service bundles and unit rates *(Bruce Copley)* -Stakeholders Meeting Debrief • Meeting with SVCN Leadership Group on 10/7 *(Bruce Copely)* • YSOC Stakeholder Group Meeting on 10/16 *(Sue Nelson or Sally Lawrence)* -Work Groups Report-Out / Review Draft if completed • Treatment Services – ASOC *(Cheryl Berman)* • Treatment Services – YSOC *(Sue Nelson)* • Evidenced Based Practices *(Cheryl Berman)* • Beneficiary Access *(Martha Martinez)* -Timeline • Week of 10/19 - All DRAFTS due to Bruce • Week of 10/25 - Bruce to compile all Drafts and send out to IP members for review and comment • By 10/31/15 – 1115 Waiver Implementation Plan submitted	
3:40 – 4:00	Announcements/Acknowledgements *(all)* • Provider Acknowledgement *(Linh Hong)*	
	Next Meeting:	November 16, 2015 215pm - 4pm Learning Partnership, Room 3

CONSENSUS BUILDING: Active facilitation | Permission to dissent | Invite all to speak | Speak one at a time | Time keeper – to keep time for each agenda item | Additive points only - stay on track | Avoid "Hyperbole" | Culture of tolerance | Mutual respect | Assume good intent

INNOVATIVE PARTNERSHIP (IP)

Monday, November 16, 2015 | 2:15 – 4:00 pm

Learning Partnership – Training Rm. 3 | 1075 E. Santa Clara St., San Jose, CA

IP MEETING AGENDA

Facilitated by:

Jeremy Orcutt – Family Children Services (FCS)

Razelle Buenavista – Asian American Recovery Services / HealthRIGHT 360 (AARS/HR360)

TIME	AGENDA ITEM	NOTES
2:15 – 2:20	Welcome /Introductions	
2:20 – 2:25	Review/Approval of 10/19/15 IP Meeting Minutes Overview of Today's Agenda	
2:25 – 2:35	Debrief - Substance Use Disorders Conference	
2:35 – 2:50	Collaborative Groups Report-Out • Clinical Tools Hot Group – *(Christine Tronge)* • DMC Collaborative *(Steve Lownsbery)* • Outpatient Workflow - *on hold* • 290 referrals *(Gary Montrezza)* • System Gap Hot Group *(Michael Hutichinson)*	
2:50 – 3:25	1115 Waiver Implementation: -11/10/15 Health & Hospital Committee Meeting Debrief *(Bruce Copely)* -Development of service bundles and unit rates *(Bruce Copely)* -Work Groups Report-Out / Review Drafts • Treatment Services – ASOC *(Cheryl Berman)* • Treatment Services – YSOC *(Sue Nelson)* • Evidenced Based Practices *(Cheryl Berman)* • Beneficiary Access *(Josefina Covarrubias)* • Collaborative Process *(Bruce Copely)* -Timeline *(Bruce Copely)* • 1115 Waiver Implementation Plan submitted by _____?	
3:25 – 3:50	ASOC Capacity *(Bruce)*	
3:50 – 4:00	Announcements/Acknowledgements *(all)* • 1/11/15 IP Meeting Guests *(Michael Hutchinson)* • Contract Monitoring Notifications	
	Next Meeting:	**Monday, December 14, 2015** 215pm - 4pm Learning Partnership, Room 3 **Monday, January 11, 2015** 215pm-4pm Location TBD

CONSENSUS BUILDING: Active facilitation | Permission to dissent | Invite all to speak | Speak one at a time | Time keeper – to keep time for each agenda item | Additive points only - stay on track | Avoid "Hyperbole" | Culture of tolerance | Mutual respect | Assume good intent

INNOVATIVE PARTNERSHIP (IP)

Monday, December 14, 2015 | 2:15 – 4:00 pm

Learning Partnership – Training Rm. 3 | 1075 E. Santa Clara St., San Jose, CA

IP MEETING AGENDA

Facilitated by:

Jeremy Orcutt – Family Children Services (FCS)

Razelle Buenavista – Asian American Recovery Services / HealthRIGHT 360 (AARS/HR360)

TIME	AGENDA ITEM	NOTES
2:15 – 2:20	Welcome /Introductions	
2:20 – 2:25	Review/Approval of 10/19/15 IP Meeting Minutes Overview of Today's Agenda	
2:35 – 2:45	Collaborative Groups Report-Out • Best Practices Hot Group – *(Christine Tronge)* • DMC Collaborative *(Steve Lownsbery)* • Outpatient Workflow - *(Katherine Christian)* • 290 referrals *(Gary Montrezza)* • System Gap Hot Group *(Michael Hutichinson)*	
2:45 – 2:55	Notice of Action *(Chris Barley)*	
2:55 – 3:05	DMC and CPM Audit Process *(Michael Hutichinson)*	
3:05 – 3:40	1115 Waiver Implementation: -Development of service bundles and unit rates *(Bruce Copely)* - Review Drafts – small groups break out • Treatment Services – ASOC *(Cheryl Berman)* • Treatment Services – YSOC *(Sue Nelson)* • Evidenced Based Practices *(Cheryl Berman)* • Beneficiary Access *(Josefina Covarrubias)* • Collaborative Process *(Bruce Copely)* -Timeline *(Bruce Copely)*	
3:40 – 3:50	ASOC Capacity Update *(Bruce)*	
3:50 – 4:00	Announcements/Acknowledgements *(all)* • 1/11/15 IP Meeting - Planning *(Michael Hutchinson)*	
	Next Meeting:	**Monday, January 11, 2015** 215pm-4pm

CONSENSUS BUILDING: Active facilitation | Permission to dissent | Invite all to speak | Speak one at a time | Time keeper – to keep time for each agenda item | Additive points only - stay on track | Avoid "Hyperbole" | Culture of tolerance | Mutual respect | Assume good intent

INNOVATIVE PARTNERSHIP (IP)

Monday, January 11, 2016 | 2:15 – 4:00 pm

Charcot Training & Conference Center | 2310 N. First Street, San Jose, CA

IP MEETING AGENDA

Facilitated by:

Jeremy Orcutt – Family Children Services (FCS)

Razelle Buenavista – Asian American Recovery Services / HealthRIGHT 360 (AARS/HR360)

TIME	AGENDA ITEM	NOTES
2:15 – 2:25	Welcome /Introductions	
2:25 – 2:30	Review/Approval of 10/19/15 IP Meeting Minutes Overview of Today's Agenda	
2:35 – 2:50	Collaborative Groups Report-Out • Best Practices Hot Group – *(Christine Tronge)* • DMC Collaborative *(Steve Lownsbery)* • Outpatient Workflow - *(Katherine Christian)* • 290 referrals *(Gary Montrezza)* • System Gap Hot Group *(Michael Hutichinson)*	
	1115 Waiver	
	DMC and CPM Audit	
	ASOC Capacity Update *(Bruce)*	
3:50 – 4:00	Announcements/Acknowledgements *(all)* • Success Stories	
	Next Meeting:	**Monday, February ____, 2016** 215pm-4pm Learning Partnership

CONSENSUS BUILDING: Active facilitation | Permission to dissent | Invite all to speak | Speak one at a time | Time keeper – to keep time for each agenda item | Additive points only - stay on track | Avoid "Hyperbole" | Culture of tolerance | Mutual respect | Assume good intent

ATTACHMENT III

HIGH UTILIZERS IN THE SYSTEM OF CARE

REPORT

High users – Substance use treatment settings

Defining high users in substance use treatment settings:

Substance use disorders (SUDs) are defined as chronic conditions, with recurring relapses before one year of stable, consistent sobriety is achieved. In keeping with the chronic nature of SUDs, the treatment for SUDs focuses on management of the condition and is designed to minimize the potential for relapse. As with other chronic conditions, return to treatment per se does not accurately capture the meaning of a high user of services in the sense it is used in the medical literature. While the number of treatment episodes is indicative of high use of services, it has to be augmented with other measures that make sense within the context of SUDs treatment.

In addition to the number of treatment episodes, it is necessarily to examine treatment intensity (as indicated by the treatment modality) at the first episode (the index episode), treatment intensity at subsequent episodes and the total number of days in treatment during the observation period.

Counting high users in substance use treatment settings:

Based on an empirical analysis of treatment data from 3 fiscal years (FY 2010 to FY 2012), we developed a profile of the higher user of SUDs treatment services. These findings are applicable to the Santa Clara county-operated SUDs System of Care.

- SUD high users fell in the **top 10th** percentile of clients receiving treatment over a three-year period. The top 10th percentile of treatment seekers consisted of 223 unique individuals in the ages 12 and above. However, the high user group was not homogeneous in terms of service usage. As a result, the high user group had to be analyzed further to identify clients that met the criteria of poor management of their condition. This analysis was designed to identify the appropriate cut-off for the higher user population – 90th, 95th or 99th percentile.
- The concept of avoidable residential treatment was used to define poor management of a SUD. An avoidable residential treatment is defined for analytical purposes as more than 3 residential treatment episodes in a three year period.
- A secondary criterion for poor management of SUDs was defined as more than 2 admissions to detoxification services.

- Admissions to the two modalities were combined to identify high user characteristics in terms of:
  - Treatment intensity (as indicated by the treatment modality) at the first episode (the index episode), specifically whether the first episode was residential treatment or detoxification services
  - Treatment intensity at subsequent episodes: this refers to the percentage of times (of all episodes) client received residential treatment or detox services
  - The percentage of days in treatment during the observation period (out of a total possible number of days) including all treatment modalities and transitional housing
  - Number of drop-outs from residential (short-stays of durations under 15 days)

High user profile – SUDs

Table 1. Profile of high users – SUDs Treatment system (FY 2010-FY2012)

Markers of high users	90th percentile	95th percentile	99th percentile
Ist admission -episode of tx - Detox	40%	49%	82%
2nd admission -episode of tx - Detox	22%	19%	29%
2nd admission -episode of tx - residential	31%	37%	59%
Percent of days in tx to available days*	Median – 42%	Median – 44%	Median – 45%
Mean # of days in tx (total possible = 1095 days)	501 days	574 days	575 days
Range- residential episodes	0-7 episodes – Mean- 2.74	0-7 episodes – Mean- 3.4	1-7 episodes Mean 4.6
Range- detox episodes	0-14 episodes – Mean 3.2	0-14 episodes – Mean 4.4	4-14 episodes – Mean 8.5
Dropout from residential tx	32% dropped out at least 1 X	32% dropped out at 1X	47% dropped out at least 1X

Provisional definition of highest users: A subset of high users

- The highest 10 % (n=223) of the SUDs clients had a number of characteristics in common including
  - First admission in detox or residential
  - High percent of first and second admissions in detox or residential

  - Number of days spent in treatment over three years of observation
  - A wide range of residential and detox episodes with a maximum of 7 episodes of residential treatment and 14 episodes of detox services
  - Dropout from residential treatment
- Within this pool, the highest 1% of clients (n=17) exhibited an even more marked propensity on these key indices:
  - 82% of this group had detox as their primary admission and 29% as the second admission
  - This group had a higher mean number of days in treatment relative to the available days of treatment
  - They had a higher mean number of residential episodes (4.6 episodes)
  - They had a higher mean number of detox episodes (8.5 episodes)
  - They dropped out of residential treatment more often than others

Clients in the top 10th percentile of treatment recipients constitute the current pool of high users of SUD services. Further analysis is needed to further refine the definition of the high user group, specifically to incorporate a more complete description of avoidable residential treatment.

ATTACHMENT IV

Same Day Access Outpatient & Residential

Open Access to Outpatient and Residential LOC:

Outpatient

The SCC SUTS DMC-ODS Waiver proposal includes developing and offering open access to assessment services as an engagement strategy and to help capacity management issues by reducing no-shows for assessments. We are currently determining the system demand and optimal hours of operation. Providers will be allowed to determine their staffing models (Open access days or open access hours) contingency plans and creating a transition plan.

After initial screening at the Call Center, callers (via script) will be invited to walk in for an assessment to a provider of their choice based on the type and level of requested services. They will be given instructions regarding what to bring with them (i.e.: Identification, Insurance Card, Medications, court paperwork). Some paperwork currently completed by the clinician will be moved to the waiting room of the assessment appointment. Our goal is no more than an hour wait for walk in assessment with the next scheduled appointment with the treating clinician within 5 business days.

We are also working on other increased efficiencies to make this model successful such as increasing our current No Show Management Practices including a same day walk in hours for patients with multiple no shows.

Residential

QIDS already provides immediate review and timely authorization within 24 hour window during business hours. We already have a process by which providers may take walk-ins into Residential Treatment after hours and on the weekend and Holidays. Providers then obtain system registration and authorization as soon as possible the next business day. We are working with providers on their staffing plans and access hours in order to improve on beneficiary access to the level of care.

ATTACHMENT V

AUTHORIZATION FOR RESIDENTIAL EXTENSION

SCVHHS Department of Alcohol & Drug Services System

Authorization for Residential Extension of TX

Date: Click here to enter a date.

Agency: _____ **Counselor's Name:** _____ **Phone:** _____

Client Name: _____ **Unicare:** _____

Date Entered TX: Click here to enter a date. **# of Additional Days Requested:** _____

If Prior Extension, date of Last Auth: Click here to enter a date. **# of days Authorized:**

Anticipated Discharge Plan: ☐ Outpatient ☐ IOP ☐ THU

Additional Discharge Plan Details:

Current TX Plan: # of Action Steps assigned: _____ **# of Action Steps completed to date:** _____

Brief summary of AOD-related clinical issues on TX Plan that require continued stabilization in residential. List specific dimensions, progress made and remaining problem areas. Specify actions to be taken for each dimension:

Dim _____ **SOC:** _____

Dim _____ **SOC:** _____

Dim _____ **SOC:** _____

Counselor Sig: **Date:** | **Clinical Sup Sig:** **Date:**

For QI Admin Staff only:

Approved: YES ☐ **NO** ☐ **Date From:** _____ **Date To:** _____

If Denied, List Reasons:

If Denied, List Recommendations:

QI Signature: _____ **Date:** _____

Confidential Patient Information Statement

NOTICE TO RECIPIENT: This communication is intended only for the person to whom it is addressed, and contains information that is protected by federal and state law. If you receive this in error, any review, use, dissemination, distribution, or reproduction is strictly prohibited. Please call 408/ 792-5670 immediately to report the error and destroy this communication. Thank you for your cooperation. **If pages are missing and / or illegible, please call (408) 792-5670**

9/17/15pc

ATTACHMENT VI –

THU AUTHORIZATON FORM

Policy & Procedure 212

Santa Clara Valley Health & Hospital System
Department of Alcohol and Drug Services Adult System of Care
Authorization for Transitional Housing Unit Extension Request Form- PILOT

Client Name: _____	**Unicare #** _____
THU Provider Name: _____	**THU Admit Date:** _____
Address: _____	**Phone #:** _____
OP Provider: **Counselor:**	**OP Phone #:**

Extension requested: From to

Finances:

1. Requires further residency to save additional $ _____ to move into housing.

Employment:

2. Are you working? ☐ Yes ☐ No
   If Yes, ☐ Part –Time ☐ Full – Time
3. Other sources of income (please list):

Housing:

4. Which housing list or Waitlist are you on? _____
5. Client has pending housing and it will be available on
6. Started calling the Shelter on

Explanation: (What is the plan for housing, how much is rent, moving expense, how does an extension help you find housing?)

Housing Exit Plan at the End of THU Extension (Address Client's Plan to transition if Plan stated above fails or if extension is denied. Ex. Establish Plan B such as calling the shelter, living with family, or friends):

1

Confidential Patient Information Statement
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Pilot 10/20/15lh

Outpatient Counselor: (Provide information on client's progress in Dimension 6. Housing search, job search, saving's plan). ***NOTE: All counselors must document both in the Treatment Plan under Dimension 6 and in the progress notes, the client's plan and progress in obtaining housing, savings plan, job search etc.**
Did THU staff notify OP Counselor of THU concerns? Yes ☐ No ☐ N/A ☐

Requirements while a client is on extension:

1. **Follow THU guidelines**
2. **Work actively on exit plan for housing**
3. **Work actively on exit plan for employment**

Client Name (Print) **Date:**

Client Signature _____

Counselor Name (Print) **Date:**

Counselor Signature _____

Approved: ☐ **YES** # of Extension: _____ To

Extension Approved: From To

☐ **NO** If denied, list reasons: _____

If denied, list recommendations: _____

QIC Signature:_____ **Date:**_____

2

Confidential Patient Information Statement
NOTICE TO RECIPIENT: This communication is intended only for the person to whom it is addressed, and contains information that is protected by federal and state law. If you receive this in error, any review, use, dissemination, distribution, or reproduction is strictly prohibited. Please call 408/ 792-5670 immediately to report the error and destroy this communication. Thank you for your cooperation. **If pages are missing and / or illegible, please call (408) 792-5670**

Pilot 10/20/15lh

ATTACHMENT VII

VHP Audit Score Sheet

VALLEY HEALTH PLAN
BEHAVIORAL HEALTH OUTPATIENT MEDICAL RECORD REVIEW PROTOCOL
Medical Record Charting/Documentation

DATE OF REVIEW _____/_____/_____ REVIEWER _____
PROVIDER _____

	Score	Comments
Chart ID No.		
Male/Female		
DOB:		
General Medical Record Documentation		
1) Chart documentation indicates client received HIPAA Notice of Privacy Practices		
2) *Consent for Treatment* is present, signed and HIPAA compliant.		
Behavioral Health Assessment-Clinical		
1) The medical *Health Screen* is present and completed.		
2) The Level of Care Assessment and the Tx assessment clearly formulate the need for treatment, explaining why substance abuse treatment is needed based on current presentation, impairments, symptoms and impact on functioning.		
3) The Level of Care Assessment documents (or rules out) imminent risk of harm, physical, sexual abuse or neglect, aggressive/violent, self-destructive/suicidal behavior for client.		
4) The Tx Assessment documents past and present use of substance/alcohol abuse as well as illicit, prescribed, and over-the-counter drugs for the client.		
5) Cultural factors identified (e.g.: ASAM dim 5 & 6).		
Behavioral Health - Primary Care Interface		
1) Primary Care Physician's (PCP) name is noted in chart.		
2) There is evidence of coordination of care with PCP as stated in TP.		
3) There is evidence of coordination of care with other providers as needed.		
Behavioral Health -Treatment Plan (TP)		
1) Goals are specific, realistic, measurable, and observable.		
2) Goals consistent with symptoms/impairments noted in assessment.		
3) Interventions relate to rationale/expected outcome.		
4) ASAM dim 2 is on TP, if assessed as moderate or severe, & care coordination with PCP is included in treatment goals.		
Behavioral Health -Progress Notes (PN)		
1) Components of comprehensive progress note are present including the following:		
a) Clinician's specific intervention consistent with client's current status (as above).		
b) Client's response to intervention.		
c) Plan for subsequent services.		
2) Progress notes reflect clinician's intervention consistent with treatment plan.		
3) Each PN clearly states the language in which session was conducted, when client's preferred language for treatment is not English.		
Standard: If client terminated treatment abruptly, the chart documents the circumstances and there is documentation of any treatment referrals. If the treating clinician changed during the course of care, transitions have been explained; Significant absences are documented, and treatment non-compliance addressed.		

VHP Outpatient Medical Record Protocol Rev Date 02 02 07 GP & ESR; rev. 03/19/2009 DADS QI

VALLEY HEALTH PLAN
BEHAVIORAL HEALTH OUTPATIENT MEDICAL RECORD REVIEW PROTOCOL

2

Administrative		
1) Entries contain no whiteouts, blank spaces, and are written legibly in ink; cross outs are initialed.		
Chart Review Summary:		
1) Chart documentation provides evidence that services provided are based on client's symptoms and presenting problems.		
2) Chart documentation provides evidence of client's improvement and progress or demonstrates specific interventions to address client's deterioration and continuing impairments.		
3) Chart provides evidence that any special risks (suicide, harm to others, substance abuse) to the client were appropriately managed.		
4) Chart documentation provides evidence of linguistically/culturally competent services where appropriate.		
a) Client's preferred language for treatment documented.		
b) Interpretation services offered, if needed, and/or reasons for not having interpretation services, when preferred language is other than English, documented.		
5) Chart documentation provides evidence of consistent, timely services.		

Total Score:_____

_____ Reviewer Name

_____/_____/_____ Date

Total Score = Total # of points divided by total number of criteria scored (do not count criteria scored N/A).

Scoring Notes:

Audit/Scoring Terminology	**Point Value**	
Substantial Compliance: acceptable and meets the standard.	**1**	
Non-Compliance: standard is not being met/unacceptable.	**0**	
Not applicable: irrelevant or does not apply.	**N/A**	**= No points deducted**

VHP Outpatient Medical Record Protocol Rev Date 02 02 07 GP & ESR; rev. 03/19/2009 DADS QI

ATTACHMENT VIII –

DHCS/DMC Audit & CPM Audit Score Sheet

DADS Medi-CAL CHART UTILIZATION REVIEW OP / IOP

PROGRAM: _____ Client: _____ Client ID #:_____

Primary Counselor: _____ DIAGNOSIS:_____ Medi-Cal Eligibility date: _____

REVIEWED From: _____to_____ ADMIT DATE:_____ DISCHARGE DATE:_____

RE-REVIEW: Yes ☐ No ☐ LAST PEER REVIEW:_____

		Check one ✓	P	NP	N/A
1	Intake and Assessment	Primary Counselor of Medi-Cal services is noted and dated			
2		Assessment meets Medi-Cal medical necessity within 30 days of admission date			
3		YOUTH Notice of parental/guardian's involvement in treatment is justified			
4		Physical Exam completed by M.D./ L.N.P. within 30 days of admission date			
5		OR Client's Physical Exam done within the last 12 months is reviewed by MD			
6		OR Client's Physical Exam expectation is included in the Treatment Plan			
7		Admission Agreement/Program Rules are included and signed			
8		Client Fair Hearing Rights is included and signed			
9		If Physical Exam given; signed by M.D. within 30 days of Admission date			
10					
11		ASAM treatment assessment is completed within 30 days of Admission date			
12	Initial Treatment Plan	Initial Treatment Plan is submitted within 30 days of Admission date			
13		Client's expectation to obtain a Physical Exam is a Treatment Plan goal			
14		All client physical health issues from the HSQ are noted in the Treatment Plan			
15		Treatment Plan is Missing: SUD diagnosis			
16		Treatment Plan Missing: types of SUD services OR frequency OR target dates (circle one)			
17		The Problem Statement identifies areas of impairment or distress of substance use			
18		The Problem Statement is correctly matched with the appropriate ASAM dimension			
19		The client' Stage of Change is correctly matched with appropriate Problem Statement			
20		The Goal(s) directly relate to the Problem Statement & matches the Stage of Change			
21		Action Steps are stated in measurable terms (SMART)			
22		Action Steps help achieve the Goal(s)			
23		Treatment Plan: Client's name is Printed, Signed and dated			
24		TxPlan has counselor's name Printed, Signed, license & dated within 30 days of Admit			
25		TxPlan has M.D. name Printed, Signed, license and dated within 15 days of counselor			
26	Progress Notes	Progress Note has client's response to counselor's intervention(s)			
27		Progress Notes are individualized			
28		Progress Note reflects treatment progress or lack thereof based on Action Steps			
29		Progress Note is missing: topic date/starting OR end time (circle one)			
30		Progress Note is missing: counselor's signature/date (circle one)			
31		Progress Note is completed within 7 days of the counseling session			
32		IOP Progress Note sessions correspond to billing total of 9 hours a week			
33		Crisis session justified in Progress Note			
34		Group ProgNote has 2-12 participants of which 1 must be a MC beneficiary			
35		Second Same Day Service is documented in Progress Note per MC standard			
36		Second Same Day Service DHCS MC7700 Form completed in chart			
37	Group	Group sign-in sheet is: Missing/No topic (circle one)			
38		Counselor's name is Printed and Signed on Group sign-in sheet			
39		Client's name is Signed on Group sign-in sheet			
40		Group sign-in sheet has CLIENT's notation of start and end time of group session			

DADS Medi-CAL CHART UTILIZATION REVIEW OP / IOP

Santa Clara Valley Health & Hospital Department of Alcohol & Drug Services

Quality Improvement Division

		Check one	P	NP	N/A
41	Updated Tx Plan	Updated Treatment Plan is within 90 days of Initial Treatment Plan			
42		Updated Treatment Plan reflects change in treatment status			
43		Client's expectation to obtain a physical exam is an Updated Treatment Plan goal			
44		Counselor's name is Printed, Signed and dated within 90 days of previous TxPlan			
45		The Problem Statement identifies areas of impairment or distress of substance use			
46		The Problem Statement is correctly matched with the appropriate ASAM dimension			
47		The client' Stage of Change is correctly matched with appropriate Problem Statement			
48		The Goal(s) directly relate to the Problem Statement and matches the Stage of Change			
49		Action Steps are stated in measurable terms per (SMART)			
50		Action Steps help achieve the Goal(s)			
51		UpTxPlan has counselor's name Printed, Signed, license & dated w/30 d of Admit			
52		TxPlan has M.D. name Printed, Signed, license and dated w/15 days of counselor			
53	Extension	Bi-Annual Extension of Treatment signed by M.D. between 5th & 6th month			
54		Counselor has adequate clinical justification for Bi-Annual Extension of Treatment			
55		M.D. denotes medical necessity in Extension of Treatment			
56		Extension of Treatment has counselor's name Printed, Signed, license and dated			
57		Ext of Tx has MD name Printed, Signed, license and dated within 15 days of counselor			
58	Discharge & Continuing Care	Treatment Plan is current at Discharge			
59		Discharge Summary completed within 30 days of last face to face			
60		Discharge Summary notes Voluntary or Involuntary discharge			
61		Involuntarily terminated client's Fair Hearing Rights advised			
62		Summary of Treatment has progress and goals achieved or not detailed			
63		Discharge Summary notes client's relapse triggers and how to address/avoid			
64		Discharge Summary states client's diagnosis			
65		Discharge Summary denotes client's prognosis			
66		Discharge Summary details client's Continuing Care Support Plan			
67		Discharge Summary has client's name Printed, Signed and dated			
68		Discharge Summary has counselor's name Printed, Signed and dated			
69		Clinical supervision of staff is documented			
70		Documentation of Peer Review / Utilization Process			

MC DETERMINATION: ☐ IN Compliance ☐ OUT of COMPLIANCE ☐ (NP-Not Present as noted *above)*

DISALLOWNACE Services: # INDIVIDUAL___; Dates _____
GROUP___; Dates _____

CORRECTIVE Action:

_____

_____

Comments and recommendations:

_____

CLINICAL PERFORMANCE MEASURES: ☐ IN Compliance ☐ OUT of COMPLIANCE

CORRECTIVE Action:

_____

_____

Comments and recommendations:

_____

_____

ATTACHMENT IX

SANTA CLARA COUNTY

BOARD OF SUPERVISORS POLICY

POLICIES ON SOLICITING AND CONTRACTING

https://www.sccgov.org/sites/bos/Legislation/BOS-Policy-Manual/Documents/BOSPolicyCHAP5.pdf

DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER IMPLEMENTATION PLAN 2015

County Authorization

Santa Clara County's Behavioral Health Services Department Director must review and approve the Medi-Cal Waiver demonstration project implementation plan. The signature below verified this approval.

Toni Tullys	Santa Clara	2-1-16
County Behavioral Health Service's Director	**County**	**Date**
Toni Tullys	Director, Behavioral Health Services	408-605-7962
Print name	**Title**	**Tel**

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