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1 SUBSTANCE USE DISORDER TREATMENT PRACTICES AND PROCEDURE MANUAL INTRODUCTION

1.1 Practices and Procedure Manual Introduction

1.1.1 The Practices Guidelines and Procedure Manual offers user friendly guidance to all County of Santa Barbara contracted SUD treatment providers, including Drug Medi-Cal (DMC) certified providers, in complying with all Federal, State and County SUD treatment requirements and standards. The Practices and Procedure Manual reflects “best practice” standards and seeks to prevent program deficiencies that can ultimately lead to disallowances and recoupment of monies. This manual has been developed in partnership with SUD treatment providers in the spirit of collaboration and transparency. Required information to both the beneficiaries and contracted providers will be provided in a manner and format that may be easily understood and is readily accessible. The Practices and Procedure Manual is available to providers on the Department website and will be managed to provide required and necessary updates.

1.1.2 Practice guidelines will meet the following requirement:

- Are based on valid and reliable clinical evidence or a consensus of providers in a particular field;
- Consider the needs of the beneficiaries;
- Are adopted in consultation with contracting health care professionals; and,
- Are reviewed and updated periodically as appropriate.

1.1.3 The Practices and Procedure Manual is specifically designed to be used by all administrative and direct service staff to ensure understanding of core values for the SUD system of care and adherence to the clinical and business expectations within Santa Barbara County.

1.1.4 This document was designed in adherence to State, Federal, County Laws and Regulations which govern the delivery of SUD treatment services in Santa Barbara County. An extensive list of laws and regulations that are to be followed are listed in Section 7.

1.2 Substance Use Disorder Treatment Services Program Oversight

1.2.1 The Department of Health Care Services (DHCS) is responsible for administering SUD Treatment in California. The Alcohol and Drug Program, a division of the Santa Barbara County Department of Behavioral Wellness (hereafter “the Department), contracts with DHCS to fund local SUD treatment services. As part of the contract with DHCS, the Department ensures that state SUD treatment requirements and standards are met by maintaining fiscal management systems, monitoring provider billing, conducting compliance visits, processing claims for reimbursement, and offering training and technical assistance to SUD treatment providers.

1.2.2 In the event of conflicts between the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver and Title 22, provisions of Title 22 shall control if they are more stringent.

1.2.3 Contracted SUD treatment providers shall be licensed, registered, AOD licensed and DMC certified and approved in accordance with applicable laws and regulations. Providers shall comply with the regulations and guidelines as outline in Section 7.
1.3 The Disease Concept of Substance Use Disorder

1.3.1 Substance use disorders are often chronic, relapsing conditions of the brain that affect behavior by reinforcing compulsive drug seeking and use, despite catastrophic consequences to individuals, their families, and others around them (National Institute on Drug Abuse). Although most diseases cannot be cured, they can be monitored and managed over time. Examples of manageable chronic diseases include diabetes, HIV infection, asthma, and heart disease. While there is no cure for these diseases, when managed and monitored properly, individuals with such diseases are able to live a fairly normal life. While some individuals may develop a substance use disorder and achieve recovery after minimal intervention over a brief time, others will succumb to an intensified and relapsing course.

Approaching substance use disorders as a disease, assists with framing interventions aimed at managing the condition through a model of care that provides a continuum of services tailored to an individual’s needs. As individuals progress through their recovery journey, the type and intensity of treatment services they receive should change and reflect the severity and nature of the person’s substance use disorder. This approach also highlights the need for person centric care coordination to ensure that service delivery matches beneficiary need. Effective and efficient care for chronic conditions requires productive interactions between beneficiaries, their families, and allied health providers including Substance Abuse counselors and other health professionals.

1.4 Beneficiary Centered Care, Integration and Coordination of Care

1.4.1 Retention in treatment is one of the most important factors that lead to successful outcomes of SUD care. In order to engage and retain beneficiaries in treatment, it is paramount that care be delivered in a client-centered manner. In client-centered care, respect for the beneficiary is the guiding principle that ensures care is responsive to the beneficiary’s individual needs, preferences, and values. Beneficiary preferences and values are considered and used as a guide in any decision making process.

1.4.2 Beneficiaries accessing services through the Department and its providers are entitled to receive services that meet industry standards and are of the highest quality. Contracted SUD treatment providers must make available services that are based on peer-reviewed Evidence Based Practices (EBP) that have undergone stringent evaluation and meet clinical standards. Such practices include, but are not limited to, Motivational Interviewing (MI), Cognitive Behavior Therapy (CBT) and curriculum based concepts such as Matrix Model, Seeking Safety, and Living in Balance.

1.4.3 Additionally, the Department strives to provide integrated care and care coordination. Efforts are made to ensure that primary care and mental health services are easily accessible and that connections or referrals to social services are available. Case management of beneficiaries is also of great importance. It is expected that contracted SUD providers will organize beneficiary care activities and coordinate the sharing of information to ensure that the needs of the beneficiaries are addressed.

1.4.4 Providers shall allow each beneficiary to choose his or her network provider to the extent possible and appropriate.

1.4.5 For a counseling or referral service that the provider does not cover because of moral or religious objections, the provider shall provide information to the beneficiary about where and how to obtain the service.
1.4.6 No State or Federal funds shall be used by the Provider for sectarian worship, instruction, and/or proselytization. No State funds shall be used by the provider to provide direct, immediate, or substantial support to any religious activity.

1.5 Special Populations

1.5.1 The Department and its contractors shall comply with federal and state mandates to provide SUD treatment services deemed medically necessary for Medi-Cal eligible: (1) pregnant and post-partum women, and (2) adolescents.

1.5.2 SUD services are provided to pregnant and post-partum women. Coverage for post-partum women begins the day after termination of pregnancy, plus sixty (60) days, then until the end of the month if the 60th day falls mid-month.

1.5.3 Providers who offer perinatal DMC services are required to be properly certified to provide these services and shall comply with the Perinatal Services Network Guidelines.

1.5.4 The adolescent shall meet the American Society of Addiction Medicine (ASAM) adolescent treatment criteria.

1.5.5 Contracting providers shall follow the Youth Treatment Guidelines in developing and implementing adolescent treatment programs funded through the DMC-ODS Waiver.

1.5.6 Reference: Perinatal Practice Guidelines

1.5.7 Reference: Youth Treatment Guidelines

1.6 Mission Statement

The mission of the Department of Behavioral Wellness is to promote the prevention of and recovery from addiction and mental illness among individuals, families and communities, by providing effective leadership and delivering state-of-the-are, culturally competent services.

1.7 Values

Decisions and service delivery reflect the following values:

- Quality services for persons of all ages with mental illness and/or substance abuse;
- Integrity in individual and organizational actions;
- Dignity, respect, and compassion for all persons;
- Active involvement of clients and families in treatment, recovery, and policy development;
- Diversity throughout our organization and cultural competency in service delivery;
- A system of care and recovery that is clearly defined and promotes recovery and resiliency;
- Emphasis on prevention and treatment;
- Teamwork among department employees in an atmosphere that is respectful and creative;
- Continuous quality improvement in service delivery administration;
- Wellness modeled for our clients at all levels; i.e., staff who regularly arrive at the workplace healthy, energetic and resilient; and
- Safety for everyone.
1.8 Cultural Competency Statement

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.

- “Culture” refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.
- “Competence” implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by beneficiaries and their communities.

(Adapted from Cross et al, 1989).

Through departmental and contracted programs and services, the Department of Behavioral Wellness is committed to involving beneficiaries, clients, family members and individuals from diverse ethnic and cultural groups in developing, implementing and monitoring programs and services. Stakeholders are involved in forums for diverse communities, including the Beneficiary and Family Member Advisory Committee, the Latino Advisory Committee, Beneficiary and Family Member Subcommittee of Quality Improvement, the Mental Health Commission, Peer Recovery Learning Communities and human resources panels.

The Department's commitment to providing culturally competent services is embedded through a wide range of policies and procedures, including telephone access, human resources training and recruitment, bilingual allowances, cultural competence training, interpretation, signage and other areas.

To advance cultural competency, the Department has focused on trainings about ethnically and culturally diverse communities, including Oaxaqueño, Native American, LGBTQ, African American, Filipino, Latino, beneficiaries, families and the military.

Spanish is the "threshold language" in Santa Barbara County. A threshold language is defined as "3,000 beneficiaries or 5% of the Medi-Cal population, whichever is lower, whose primary language is other than English." The Department of Behavioral Wellness seeks to maintain a diverse workforce by hiring and maintaining a departmental and contract staff that is at least 40% bilingual/bicultural (Spanish).
2 DMC-ODS BENEFICIARY ACCESS AND ELIGIBILITY

2.1 Access

2.1.1 Providers will have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal beneficiaries.

2.1.2 All Providers shall post and record the Department 24/7 ACCESS Line (888) 868-1649 during hours of non-operation.

2.1.3 All beneficiaries requesting SUD screening services shall be screened for need and ASAM level of care the same day, or given an appointment for screening the next business day. The beneficiary shall complete the ASAM 6 dimension screening during the initial phone call, initial face-to-face interaction, or during the scheduled appointment.

2.1.4 Once the ASAM predetermination level of care is made through the screening tool, the beneficiary shall be scheduled for an appointment with a Provider for a complete intake and assessment to determine diagnosis and medical necessity.

2.1.5 If the provider determines the beneficiary requires residential or withdrawal management services, they will contact the ACCESS Line staff to request authorization and coordinate the beneficiary’s appointment with a contracted residential provider.

2.1.6 Beneficiaries shall receive an intake assessment within 10 calendar days by Provider after initial screening or request for service.

2.1.7 Beneficiary preferences shall be considered such as cultural, geographical, gender, language and personal schedule. These preferences and special circumstances shall be documented in the Provider beneficiary chart if applicable. CFR_42_431201.

2.1.8 Urgent conditions shall be addressed by ACCESS Line staff or Provider while in contact with the beneficiary. Staff shall reach out to police, the 24-hour crisis behavioral health team, or emergency personnel as the need arises. Additionally, the ACCESS Line staff will be informed of the emergency and details about how the beneficiary accessed any services.

2.2 Screening

2.2.1 Providers shall only admit Santa Barbara County residents directly for County funded programs and work cooperatively with the Department and the Substance Abuse Program Administrator (or designee) to form an integrated network of care for individuals experiencing substance abuse problems.

2.2.2 Provider shall refer all beneficiaries to the Department ACCESS Line in order for beneficiaries to complete the County initial screening tool for the American Society of Addiction Medicine (ASAM) beneficiary placement criteria.

2.2.3 The process for walk-in screenings and call-in screenings shall be identical. When a beneficiary walks in to a Provider, they shall call by telephone the ACCESS Line to receive a complete County approved ASAM screening. Once the predetermination of the ASAM level of care is made, the beneficiary shall be scheduled with a Provider for a complete assessment to determine diagnosis and medical necessity.
2.2.4 The Provider must verify Medi-Cal eligibility of the individual. When the Provider conducts the initial eligibility verification, that verification shall be reviewed and approved by the County prior to payment for services.

2.2.5 Upon determination of ASAM level of care, the Provider will receive notification/referral from the Department as an Authorization of Services via electronic-fax.

2.2.6 Providers shall have a certified substance abuse counselor, or licensed clinician shall be available to facilitate intakes for beneficiaries, enter beneficiary information into the Provider’s EHR system and place the beneficiary in an appropriate ASAM level of care based on the Department screening.

2.2.7 Providers shall admit on a priority basis, pregnant women who are using or abusing substances, women who are using or abusing substances and who have dependent children, injecting drug users, and substance abusers infected with HIV or who have tuberculosis. Beneficiaries shall not be required to disclose whether they are HIV positive. Priority admissions shall be given in the following order:

- Pregnant women who are using or abusing substances,
- Women who are using or abusing substances who have dependent children,
- Injecting drug users,
- Substance abusers infected with HIV or who have tuberculosis,
- All others.

2.2.8 Reference: 42 CFR 431.201

2.3 Placement

2.3.1 Enrollment discrimination is prohibited.

2.3.2 The Provider accepts individuals eligible for enrollment in the order in which they apply without restriction.

2.3.3 The Provider will not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll.

2.3.4 The Provider will not discriminate against individuals eligible to enroll under the laws of the United States and the State of California, and will not use any policy or practice that has the effect of discriminating. See Section 5 – Resources for Laws and regulations.

2.3.5 Placement is conducted in alignment with the ACCESS Line screening.

2.3.6 When a predetermination of placement is conducted and the ASAM level of care is made, the Provider’s MD and/or LPHA must then complete a full assessment to determine a diagnosis and confirm medical necessity.

2.3.7 When applicable, a medical psychiatric clearance will be obtained and noted.

2.3.8 Assessments shall consist of a completed screening, diagnosis, and ASAM Level of Care. This assessment will include an in-person appointment within the timeframe required to determine diagnosis and assess if ASAM level of placement was appropriate. If the ASAM level is determined to be different by the Medical Director, Licensed Physician, or LPHA, the beneficiary will be assisted by the Provider to access a higher or lower level of care.
2.3.9 If the Provider MD or LPHA determines the beneficiary should be in another level of care, they will:

- Contact the assigned Care Coordinator and notify ACCESS Line/Quality Care Management (QCM) staff in order to transition the beneficiary to the appropriate level of care. Additionally, they will fill out the ASAM Screening - Level of Care Form.

2.3.10 Providers are required to provide written notice to the beneficiary of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than the request made by a health care professional who has appropriate clinical expertise in treating the beneficiary's condition or disease.

2.3.11 Department Quality Care Management (QCM) staff are the only staff authorized to place a beneficiary in withdrawal management or residential treatment. This is in accordance with Department of Health Care Services (DHCS) Information Notice 16-042, withdrawal management or residential placement guidelines.

2.3.12 Withdrawal Management and Residential Providers are required to submit bed availability reports daily through email (BWELLQCM@SBCBWELL.org) to identify available bed slots for the day.

2.3.13 ACCESS Line/ QCM staff will complete the ASAM Screening – Level of Care Form for withdrawal management and residential treatment and notify the Provider via electronic-fax regarding an Authorization of Service.

2.3.14 Providers are to collaborate and work closely with Care Coordinators to ensure engagement, re-engagement and warm hand-offs are present as the beneficiary proceeds through treatment.

2.3.15 Reference: DHCS Information Notice 16-042

2.4 Assessment

2.4.1 The Provider shall assure a counselor or LPHA completes a personal, medical, and substance use history for each beneficiary upon admission to treatment.

2.4.2 Assessment for all beneficiaries shall include at a minimum:

- Drug/Alcohol use history,
- Medical history,
- Family history,
- Psychiatric/psychological history,
- Social/recreational history,
- Financial status history,
- Educational history,
- Employment history,
- Criminal history, legal status, and
- Previous SUD treatment history.

2.4.3 The Medical Director or LPHA shall review each beneficiary’s personal, medical, and substance use history if completed by a counselor.
2.5 Re-Assessment (Continuing Services)

2.5.1 Continuing services shall be justified for case management, outpatient services, intensive outpatient, and Naltrexone treatment.

2.5.2 For each beneficiary, no sooner than five (5) months and no later than six (6) months after the beneficiary’s admission to treatment date or the date of completion of the most recent justification for continuing services, the LPHA or counselor shall review the beneficiary progress and eligibility to continue to receive treatment services, and recommend whether the beneficiary should or should not continue to receive treatment services at the same level of care.

2.5.3 For each beneficiary, no sooner than five months and no later than six months after the beneficiary’s admission to treatment date or the date of completion of the most recent justification for continuing services, the Medical Director or LPHA shall determine medical necessity for continued services for the beneficiary. The determination of medical necessity shall be documented by the Medical Director or LPHA in the beneficiary’s individual beneficiary record and shall include documentation that all of the following have been considered:

- The beneficiary’s personal, medical, and substance use history;
- Documentation of the beneficiary’s most recent physical examination;
- The beneficiary’s progress notes and treatment plan goal; and
- The LPHA’s or counselor’s recommendation pursuant to the beneficiary’s progress or lack of progress; and
- The MD or LPHA shall type or legibly print their name, and sign and date the documentation.

2.5.4 If the MD or LPHA determines that continuing treatment services for the beneficiary is not medically necessary, the provider shall discharge the beneficiary from treatment and arrange for the beneficiary to proceed to an appropriate level of treatment services.

2.5.5 Residential Providers shall adhere to the guidelines set forth in the Residential Treatment section.

2.6 Medical Necessity

Medical necessity refers to the applicable evidence based standards applied to justify the level of services provided to a beneficiary so the services can be deemed reasonable, necessary and/or appropriate. It is imperative that medical necessity standards be consistently and universally applied to all beneficiaries.

2.6.1 Physician (or LPHA) shall:

- Review personal, medical, and substance use history;
- Evaluate each beneficiary and diagnose using DSM-5;
- Document basis for diagnosis via face-to-face session with the beneficiary or with the counselor who conducted the comprehensive assessment.
2.6.2 The Medical Director or LPHA shall evaluate each beneficiary’s assessment and intake information if completed by a counselor through a face-to-face with the counselor who completed the assessment or with the beneficiary to determine the beneficiary diagnosis and evaluate whether the beneficiary meets medical necessity criteria or not.

2.6.3 The Diagnostic and Statistical Manual of Mental Disorders, Version 5 (DSM-5) will be utilized by Providers for all beneficiaries accessing SUD services. All beneficiaries must meet criteria for at least one diagnosis from the current DSM-5 for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders.

2.6.4 The Medical Director or LPHA shall document, in narrative format, separately from the treatment plan, the basis for the diagnosis in the beneficiary’s record using the Verification of Medical Necessity Form, expected within seven (7) calendar days and no later than 30 calendar days, of each beneficiary’s admission to treatment date.

2.6.5 Exceptions: Medical Necessity for Withdrawal Management and OTP/NTP must be documented on day one.

2.6.6 Medical necessity encompasses all six (6) ASAM dimensions and takes into consideration the extent and biopsychosocial severity of the various dimensions within the full ASAM assessment. Medical necessity must not be restricted to acute care and narrow medical concerns. The six dimensions are:

- Acute Intoxication and/or Withdrawal Potential,
- Biomedical Conditions and Complications,
- Emotional, Behavioral, or Cognitive Conditions and Complications,
- Readiness to Change,
- Relapse, Continued Use, or Continued Problem Potential, and
- Recovery/Living Environment

2.6.12 After establishing a diagnosis and documenting the basis for the diagnosis, the ASAM criteria shall be applied by the diagnosing LPHA to determine or confirm placement into the appropriate modality or level of assessed services.

2.6.13 Reference: DHCS Title 22 Diagnosis Medical Necessity FAQ

2.6.14 Reference: DHCS DSM-5 Information Notice 16-051

2.7 Physical Examination Requirements

2.7.1 If a beneficiary has a physical examination within a twelve month period prior to the beneficiary’s admission to treatment date, the physician or registered nurse practitioner or physician’s assistant (physician extenders) shall review documentation of the beneficiary’s most recent physical examination within thirty (30) calendar days of the beneficiary’s admission to treatment date. This review shall be documented in the individual beneficiary record progress notes.

2.7.2 If a Provider is unable to obtain documentation of a beneficiary’s most recent physical examination, the Provider shall describe the efforts made to obtain this documentation in the beneficiary’s individual progress notes.
2.7.3 As an alternative to the above, the physician or physician extender may perform a physical examination of the beneficiary within thirty (30) days of the beneficiary’s admission to treatment date.

2.7.4 If the physician or a physician extender has not reviewed the documentation of the beneficiary’s physical examination or does not perform a physical examination, the LPHA or counselor shall include in the beneficiary’s initial and updated treatment plans the goal of obtaining a physical examination, until this goal is met.

2.8 Beneficiary Admission

2.8.1 Each Provider shall include in its policies, procedures, and practice, written admission and readmission criteria for determining beneficiary’s eligibility and the medical necessity for treatment. Minimum documentation criteria shall include:

- DSM-5 Diagnosis,
- Use of alcohol/drugs of abuse,
- Physical health status, and
- Documentation of social and psychological problems.

2.8.2 If a potential beneficiary does not meet the admission criteria, the beneficiary shall be referred to an appropriate service provider as described in Section 202.9.

2.8.3 If a beneficiary is admitted to treatment, the beneficiary shall sign the consent to treatment form.

2.8.4 The Medical Director or LPHA shall document the basis for the diagnosis in the beneficiary record.

2.8.5 All referrals made by the provider staff shall be documented in the beneficiary record.

2.8.6 Copies of the following documents shall be provided to the beneficiary upon admission: Share of cost if applicable, notification of DMC funding accepted as payment in full and consent to treatment.

2.8.7 Access information of the following shall be provided to the beneficiary or posted in a prominent place visible to all beneficiaries:

- A statement of nondiscrimination by race, religion, sex, ethnicity, age, disability, sexual preference, and ability to pay;
- Complaint process and grievance procedures;
- Appeal process for involuntary discharge; and
- Program rules and expectations.

2.8.8 Pursuant to 42 CFR 438.100, Providers shall be responsible for distributing the Beneficiary Brochure to each beneficiary upon initial contact. The Beneficiary Brochure, provided by the County, contains information to enable beneficiaries to understand how to use effectively utilize and navigate through DMC-ODS.

2.8.9 Where drug screening by urinalysis is deemed medically appropriate, the Providers shall:

- Establish procedures which protect against the falsification and/or contamination of any urine sample; and
- Document urinalysis results in the beneficiary’s file.
2.8.10 If any person requests services but cannot be admitted immediately by the Provider due to full capacity status, the Provider shall notify the closest County facility and direct the person to the nearest County Outpatient facility for treatment.

2.8.11 **Attachment A:** Beneficiary Handbook - English

2.8.12 **Attachment B:** Beneficiary Handbook - Spanish

2.9 **Care Coordination**

2.9.1 Services provided to the consumer will be coordinated as follows:

- Between settings of care, including appropriate discharge planning for short term and long term hospital and institutional stays.
- With the services the consumer receives from any other managed care organization.
- With the services the consumer receives in FFS Medicaid.
- With the services the consumer receives from community and social support providers.
- Providers shall assist Santa Barbara County residents in filling out any applicable applications for Welfare, Medi-Cal, and/or any other social services needed or requested.

2.9.2 Provider will work closely with County Care Coordinators and other County Providers to ensure consumers remain engaged, are re-engaged or are transitioned to another level of care efficiently and successfully.
3 SANTA BARBARA COUNTY ODS-DMC CONTINUUM OF CARE AND BENEFICIARY SERVICES

3.1 Overview

3.1.1 The Department provides a continuum of substance use disorder (SUD) treatment services primarily through contracts with local community-based organizations as contract SUD treatment providers (hereafter “Providers”). It is the policy of the Department to comply with or adhere to all requirements as outlined in the Department of Health Care Services (DHCS) approved DMC-ODS waiver and hold responsibility for implementation, oversight and quality management of all programmatic components. The appropriate level of care modality is initially determined by completion of the ASAM criteria in conjunction with approved screening tools. After the initial assessment, admissions, and transitioning from modalities is based on successful completion of and referral to another level of service, until discharge. There are times that beneficiaries may need a higher level of care as a result of continued substance use or are in need of increased support. Beneficiaries will continue to be assessed and if needed, assisted by staff in transitioning to the level of care necessary to increase potential beneficiary success.

3.1.2 Reference: Policy #7.006 “Drug Medi-Cal Organized Delivery System (DMC-ODS) Continuum of Care”

3.2 Early Intervention Services

3.2.1 Early Intervention services explore and address any problems or risk factors that appear to be related to use of alcohol and/or other drugs. Treatment goals help the individual to recognize the harmful consequences of high-risk use or behavior. Such individuals may not appear to meet the diagnosis for a substance use or addictive disorder, but require early intervention for education and further assessment.

3.2.2 While no Early Intervention services will be funded through the DMC-ODS waiver, the services are an integral part of the continuum of care. Early Intervention services may include, but are not limited to:

- The application of Screening, Brief Intervention, and Referral to Treatment (SBIRT) to screen adults and adolescents for alcohol use disorders; and
- Driving Under the Influence (DUI) Programs as mandated by the court.

3.3 Outpatient Services

3.3.1 Outpatient Services are provided by a LPHA or certified AOD counselor in a DMC-certified, County-contracted facility.

3.3.2 If Outpatient Services are provided in the community, the provider must be linked to a physical site that is a DMC-certified, County-contracted facility.

3.3.3 Based on treatment recommendations, type of service, and preferences of the client, services can be provided in-person, by telephone or via telehealth.

3.3.4 Outpatient Services are sub-categorized according to the frequency and programmatic structure:

3.3.5 Outpatient (ASAM Level 1.0): outpatient counseling services provided to beneficiaries, up to nine (9) hours a week for adults and less than six (6) hours a week for adolescents, when determined to be medically necessary and in accordance with an individualized treatment plan.
3.3.6 **Intensive Outpatient (ASAM Level 2.1):** structured programming services provided to beneficiaries, a minimum of nine (9) hours with a maximum of 19 hours a week for adults and a minimum of six (6) hours with a maximum of 19 hours a week for adolescents, when determined to be medically necessary and in accordance with an individualized treatment plan.

3.3.7 **Opioid (Narcotic) Treatment Program Services (NTP):** opioid medication assisted treatment services for beneficiaries addicted to opiates, when determined to be medically necessary and in accordance with an individualized treatment plan and the regulatory requirements in Title 9, Chapter 4. Opioid (Narcotic) Treatment Programs are required to offer and prescribe medication to patients, covered under the DMC-ODS formulary including:

- Methadone
- Buprenorphine;
- Naloxone; and
- Disulfiram.

3.3.8 **Naltrexone Program Services (oral for opioid dependence):** Naltrexone (pill form) is a covered benefit for the Standard Drug Medi-Cal Program. Naltrexone MAT is restricted to the treatment of alcohol dependence and prevention of relapse in opioid dependent patients, with a limit of 100 tablets and 3 refills in 75 days. Naltrexone pill or tablet is a covered DMC benefit, not naltrexone injectable.

3.3.9 Naltrexone program services can be offered in opioid treatment programs (OTP) or other residential or outpatient service providers. A naltrexone medication assisted treatment (MAT) program must be certified by the State of California Department of Healthcare Services (DHCS) for Drug Medi-Cal (DMC) to be paid as a covered DMC benefit.

3.3.10 Naltrexone MAT program will include a combination of the following services:

- Physical examination, including any necessary medical tests, by certified medical personnel to determine medical indication of naltrexone;
- Client consent;
- Diagnosis of moderate to severe alcohol use disorder and opioid use disorder;
- Daily administration of naltrexone under the supervision of authorized medical personnel; and
- Behavioral treatment and psychosocial support in combination with medication within existing DMC Outpatient or Intensive Outpatient Treatment service regimen.

3.3.11 **Attachment C:** Outpatient Services P&P

3.3.12 **Reference:** Title 9, Chapter 4.

3.4 **Residential Services**

3.4.1 Residential Treatment Services is a 24/7 non-medical, short-term residential program that provides rehabilitation services to beneficiaries with a substance use disorder diagnosis when determined by a Medical Director or LPHA as medically necessary and in accordance with the individual treatment plan.
Residential Treatment Services are provided to non-perinatal and perinatal beneficiaries. Providers and residents work collaboratively to define barriers, set priorities, establish individualized goals, create treatment plans, and solve problems. Goals may include but are not limited to reducing the harm of alcohol and other drug use, obtaining and sustaining abstinence, preparing for relapse triggers, improving personal health and social functioning, and engaging in continuing care.

Residential Treatment Services may only be provided in a DHCS licensed and certified residential facility that also has been designated by DHCS to meet ASAM Criteria.

There is no bed capacity limit for facilities. Residential Treatment Services can be provided in facilities of any size.

Lengths of stay must not exceed 90 days for adult beneficiaries. The average length of stay is 45 days.

Beneficiaries are allowed two (2) non-continuous 90-day placements in a one-year period (365 days).

If medically necessary, providers may apply for a one-time extension of up to 30 days – beyond the maximum length of stay of 90 days – for one (1) continuous length of stay in a one-year period (365 days).

Residential Treatment Service components include, but are not limited to: intake; individual and group counseling; patient education; family therapy; safeguarding medications; collateral services; crisis intervention services; treatment planning; transportation services; and discharge services.

Reference: [Policy #7.007 “DMC-ODS Residential Treatment Services”](#)
Reference: [DHCS ASAM Levels Residential Info Notice](#)
Reference: [DHCS Medically Managed Residential and WM 3.7 & 4.0 Info Notice](#)
Reference: [DHCS Residential Authorization Info Notice](#)
Reference: [DHCS Perinatal FAQ](#)
Reference: [DHCS Residential FAQ](#)
Reference: [DHCS Medically Managed Residential and WM 3.7 & 4.0 Info Notice](#)
Reference: [DHCS Additional Withdrawal Management Info Notice](#)
Reference: [DHCS Residential Authorizations (and WM) Info Notice](#)
Reference: [DHCS Withdrawal Management FAQ](#)
Reference: [DHCS MAT Rates Info Notice](#)
Reference: [DHCS MAT Rates Info Notice Attachment](#)
Reference: [DHCS MAT FAQ](#)
Reference: [Title 9, Chapter 4](#)
3.5 Withdrawal Management

3.5.1 Withdrawal Management services are provided as per the five (5) levels of Withdrawal Management in the ASAM Criteria when authorized by a Medical Director or LPHA as medically necessary. Beneficiaries are placed at Withdrawal Management facilities based on the ASAM level of care required to address the severity of the condition.

3.5.2 Each beneficiary shall reside at the facility if receiving a residential service and will be monitored during the detoxification process.

3.5.3 The components of Withdrawal Management services are:

- Intake;
- Observation and monitoring (course of withdrawal);
- Medication services (lawfully authorized medical staff); and
- Discharge services.

3.6 Case Management Services

3.6.1 Case Management (CM) services will be provided to assist beneficiaries in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services with a focus on SUD care and integrations around primary care. All CM services must link back to the stated goals and interventions described in the client’s treatment plan.

3.6.2 CM services will be provided to beneficiaries with special treatment needs in alignment with the Perinatal Practice Guidelines and the Youth Treatment Guidelines.

3.6.3 CM services may also be utilized to serve the difficult-to-engage individuals with complex need who have not been successful in previous treatment episodes, such as frequent utilizers of multiple health, criminal justice and social services systems, and older adults with co-occurring physical health and substance use issues.

3.6.4 Contracted providers offering CM services must be Drug Medi-Cal (DMC) certified.

3.6.5 A LPHA and/or a certified AOD counselor, acting within the scope of their respective practice and competency, may provide CM Services. The individual providing CM services must be linked to a DMC-certified site/facility and must be proficient in Motivational Interviewing (MI), Cognitive Behavioral Therapy (CBT; LPHAs only), and trauma-informed care.

3.6.6 CM services can be delivered to beneficiaries in the following ways:

- Face-to-face;
- By telephone;
- By telehealth (i.e. video conferencing); or
- In the community.
3.6.7 When CM services are provided in the community, the contracted provider delivering the service must be linked to a DMC-certified site/facility and all services must be provided in allowable places of service including, but not limited to:

- Schools;
- Homeless shelters;
- Offices;
- Places of employment; and
- Clinics.

3.6.8 CM services are excluded at some locations including, but not limited to, the following:

- Private residences;
- Prison/correctional facilities;
- Surgical centers;
- Military treatment facilities;
- Psychiatric residential treatment centers; and
- Comprehensive rehabilitation facilities.

3.6.9 Any questions regarding allowable and excluded places of service for CM services that are provided in the community should be directed to the Department’s Alcohol and Drug Program.

3.6.10 A LPHA or a certified AOD counselor may provide any of the CM services stated in Sections .11-.15 below within the scope of their respective practice and competency:

3.6.11 Transition to a higher or lower level of substance use disorder (SUD) care. Transfers to the next service provider will be completed through “warm hand-offs”.

3.6.12 Communication, coordination, referral and related activities. These activities help link the beneficiary with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the client plan.

3.6.13 Monitoring service delivery to ensure beneficiary access to service and the service delivery system. Monitoring and associated follow-up activities are necessary to adequately address the beneficiary’s needs, and may be done with the beneficiary, family members, service providers, or other entities or individuals and may be conducted as frequently as necessary.

3.6.14 Monitoring the beneficiary’s progress. This includes making any necessary modifications to the beneficiary’s client plan and updating service arrangements with providers. Monitoring does not include evaluation or “check-ins” with a beneficiary when all client plan goals have been met.

3.6.15 Patient advocacy, linkages to physical and mental health care, transportation and retention in primary care services. All services, including transportation for the purposes of continuous engagement, support and linkage to treatment services, must link back to the stated goals and interventions in the client’s treatment plan.

3.6.16 Attachment D: Case Management P&P

3.6.17 Reference: Drug Medi-Cal Organized Delivery System Place of Service Codes for Professional Claims
Recovery Services

3.7.1 Recovery services will be provided to assist beneficiaries in the recovery and wellness process. Recovery Services are designed to emphasize the beneficiary’s central role in managing their health, promote the use of effective self-management support strategies, and provide internal and community resources to support ongoing self-management. All recovery services should be provided in the context of an individualized client plan that includes specific goals and identifies Substance Abuse Assistance services including peer-to-peer services and relapse prevention as needed.

3.7.2 Recovery Services are provided by a LPHA, certified AOD counselor, and/or peers (Substance Abuse Assistance only; see Section 2.19 below) in a DMC-certified, County-contracted facility.

3.7.3 If Recovery Services are provided in the community, the provider must be linked to a physical site that is a DMC-certified, County-contracted facility.

3.7.4 Based on treatment recommendations, type of service, and preferences of the client, Recovery services can be delivered to beneficiaries in the following ways:
   - Face-to-face;
   - By telephone;
   - By telehealth (i.e. video conferencing); or
   - In the community.

3.7.5 When Recovery Services are provided in the community, the contracted provider delivering the service must be linked to a DMC-certified site/facility and all services must be provided in allowable places of service including, but not limited to:
   - Schools;
   - Homeless shelters;
   - Offices;
   - Places of employment; and
   - Clinics.

3.7.6 Recovery Services are excluded at some locations including, but not limited to, the following:
   - Private residences;
   - Prison/correctional facilities;
   - Surgical centers;
   - Military treatment facilities;
   - Psychiatric residential treatment centers; and
   - Comprehensive rehabilitation facilities.
3.7.7 Any questions regarding allowable and excluded places of service for Recovery Services that are provided in the community should be directed to the Department’s Alcohol and Drug Program.

3.7.8 Recovery Services may be provided to beneficiaries who have completed their course of SUD treatment and meet medical necessity for recovery services.

3.7.9 The components of Recovery Services are:

3.7.10 **Outpatient Counseling:** Individual or group counseling to stabilize the beneficiary and reassess if further care is needed.

3.7.11 **Recovery Monitoring:** Recovery coaching and monitoring in-person, by telephone or via telehealth.

3.7.12 **Substance Abuse Assistance:** Peer-to-peer services and relapse prevention.

3.7.13 **Support for Education and Job Skills:** Linkages to life skills, employment services, job training, and education services.

3.7.14 **Family Support:** Linkages to childcare, parent education, child development support services, and family/marriage education.

3.7.15 **Support Groups:** Linkages to self-help and faith-based support.

3.7.16 **Ancillary Services:** Services may include but are not limited to linkages to housing assistance, vocational services, transportation, and individual services coordination.

3.7.17 **Attachment E:** Recovery Services P&P

3.7.18 **Attachment F:** Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice NO: 17-034, July 27, 2017. International Classification of Diseases, Tenth Revision (ICD-10) Substance Use Disorder (SUD) Remission Codes for the Drug Medi-Cal Organized Delivery System (DMC ODS) for valid ICD-10 diagnosis codes.

3.7.19 **Attachment G:** Drug Medi-Cal Organized Delivery System Place of Service Codes for Professional Claims

3.7.20 **Reference:** DHCS Recovery Services FAQ

3.8 **Peer Support Services**

Substance Use Disorder (SUD) peer support services will be provided within the context of a comprehensive, individualized client plan that includes specific goals with associated interventions specific to peer support services. The amount and duration of the peer support services will be identified in the description section of the treatment plan. The scope of the peer support services will be outlined in each applicable intervention and may be described in further detail in the description notes section. Peer support services will vary based on client input, client preference, and the scope of treatment plan goals.
3.8.1 Peer support staff will be integrated into the treatment planning process in order to provide support and advocate for the client’s desires to be the focus of the treatment plan. Peer support staff will assist the client with communicating their needs and desires to the LPHA/Counselor. They may also provide information about community resources and activities to support client recovery. Additionally, peer support staff will have the opportunity to share their lived experience for the purpose of empowering the client to better understand the uniqueness of the recovery process. For example, peer support staff may share skills related specifically to health, wellness, and recovery in order to inspire hope within the client and provide practical examples. Peer support staff will assist with designing an individualized treatment plan with measurable goals and will help identify specific areas for peer-to-peer substance abuse assistance. Although peer support staff may be incorporated into treatment planning throughout all treatment modalities, this will be an essential part of the treatment planning process for Recovery Services. All Recovery Services shall indicate on the treatment plan how peer-to-peer services will be used to support relapse prevention and the overall recovery process.

3.8.2 SUD peer support staff will receive on-site supervision by the designated “Peer Support Coordinator”. Each contracted SUD provider will be required to identify a Peer Support Coordinator for each facility and program that offers Recovery Services. The Peer Support Coordinator will provide regular face-to-face meetings with all peer support staff and will ensure that they are in compliance with the following minimum requirements:

- Peer support staff meet all Personnel Policy requirements as outlined in the Minimum Quality Drug Treatment Standards for DMC;
- Peer support staff participate in all mandatory trainings;
- Peer-to-peer services are provided in alignment with SAMHSA’s Core Competencies for Peer Workers in Behavioral Health Services; and
- Completion of annual performance evaluations.

3.8.3 The County will follow a two-step process to ensure that SUD peer support staff complete training and receive a county SUD Peer Support designation. The first step in this process will mandate that all peer support staff complies with the County’s Staff Credentialing and Licensing Departmental Policy and Procedure (Policy #4.015). Peer support staff will be required to submit all necessary documentation to ensure that they are properly credentialed and verified for eligibility to participate in Medi-Cal claiming and related activities. The credentialing process includes eligibility verification using required State and Federal databases, determination of the level of qualification and scope-of-practice category, and determination of appropriate facility-program associations. Once the entire credentialing process has been completed by County staff, the peer support staff and Peer Support Coordinator will be notified. The second step in the process is completion of the Introductory to SUD Peer Support Services Training. Upon completion of the training, a signed Training Attestation form will be submitted to County staff in order for the peer support staff to receive SUD Peer Support designation.
3.8.4 The County has identified that SUD peer support staff must obtain a basic set of competencies which include Peer Workers Core Competencies and Technical Competencies in order to perform and document the peer support function. In order to ensure that peer support staff obtains necessary core competencies, the County will develop the *Introductory to SUD Peer Support Services Training* in alignment with SAMHSA’s *Core Competencies for Peer Workers in Behavioral Health Services*. Nationally recognized foundational principles and values for peers support staff will be addressed in the training as follows: recovery-oriented, person-centered, voluntary, relationship focused, trauma-informed. Additionally, the training will address core competencies with specific examples for implementation of these core competencies into all peer-to-peer services. These core competencies will serve as a guide to the delivery of services and the standard to promote best practices. SAMHSA’s *Core Competencies for Peer Workers in Behavioral Health Services* are as follows:

- Engages peers in collaborative and caring relationships
- Provides support
- Shares lived experiences of recovery
- Personalizes peer support
- Supports recovery planning
- Links to resources, services, and supports
- Provides information about skills related to health, wellness, and recovery
- Helps peers to manage crises
- Values communication
- Supports collaboration and teamwork
- Promotes leadership and advocacy
- Promotes growth and development

3.8.5 **Attachment H:** Santa Barbara County SUD DMC-ODS Peer Support Training Plan

3.8.6 **Reference:** [DHCS information notice on Peer Support](#)

3.8.7 **Reference:** [Peer Support Info Notice Guide](#)
3.9 Additional Medicated Assisted Treatment Services

3.9.1 Additional MAT services include all FDA approved medications to treat substance use disorders, except methadone, which must be prescribed and delivered in a licensed Opioid Treatment Program (OTP). These medications include, but may not be limited to, the following:

1. Buprenorphine – for opioid use disorder
2. Naltrexone injectable – for alcohol and/or opioid use disorder
3. Acomprosate – for alcohol use disorder
4. Naltrexone (pill) – for alcohol use disorder
5. Disulfiram (Antabuse) – for alcohol use disorder
6. Methadone – only available to Medi-Cal beneficiaries through a licensed opioid treatment program (OTP)

3.9.2 Naltrexone injectable, sometimes referred to as “optional MAT” with the DMC-ODS waiver is subject to funding availability.

3.9.3 Additional MAT services can be provided at an OTP or any DMC certified facility, provided that the OTP or other DMC certified agency comply with all federal and state regulations, and follow Behavioral Wellness policy, Drug Medi-Cal Organized Delivery System (DMC-ODS) Additional Medication Assisted Treatment (MAT) Services.

3.9.4 In order to complement existing MAT services provided at OTPs and provide the most options for client centered care, non-OTP providers are encouraged to provide office based opioid treatment (OBOT) treatment programs.

3.9.5 Treatment components of additional MAT under the DMC-ODS include:

- Ordering
- Prescribing
- Administering
- Monitoring

3.9.6 **Attachment I:** Drug Medi-Cal Organized Delivery System (DMC-ODS) Additional Medication Assisted Treatment (MAT) Services

3.9.7 **Reference:** DHCS MAT Info Notice

3.9.8 **Reference:** DHCS MAT FAQ

3.10 Service Descriptions Overview

3.10.1 The following are descriptions of various treatment services available to beneficiaries served within the Department system of care. These services are available to beneficiaries receiving outpatient, intensive outpatient, residential, withdrawal management and opioid treatment services. See the sections above pertaining to additional services including screening, assessment, case management and recovery support services.
3.11 Group Counseling

3.11.1 Group counseling sessions are designed to support discussion among beneficiaries, with guidance from the facilitator to support understanding and encourage participation, on psychosocial issues related to substance use. Group counseling sessions need to utilize one of the multiple Evidence Based Practices curriculums that the Department offers to beneficiaries.

A beneficiary who is seventeen years of age or younger cannot participate in group counseling with a beneficiary that is eighteen (18) years of age.

3.11.2 Group counseling sessions are available at all levels of care and are defined as face-to-face contact between up to two (2) registered or certified SUD counselors or LPHAs, and between two (2) to twelve (12) beneficiaries at the same time.

3.11.3 A separate Progress Note must be written for each beneficiary and documented in the beneficiary’s chart.

3.11.4 Group sign-in sheets must include signatures and printed names of beneficiaries and group facilitators, date, start/end times, location, and group topic.

3.11.5 The frequency of group counseling sessions in combination with other treatment services shall be based on medical necessity and individualized beneficiary needs rather than a prescribed program required for all beneficiaries.

3.12 Individual Counseling

3.12.1 Individual counseling sessions are designed to support direct communication and dialogue between the staff and beneficiary. Sessions will focus on psychosocial issues related to substance use and goals outlined in the beneficiary’s individualized treatment plan.

3.12.2 Individual counseling sessions are available at all levels of care and are defined as face-to-face or telephone contact between one (1) registered counselor, certified counselors or LPHA, and one (1) beneficiary at the same time.

3.12.3 A progress note must be written for each session and documented in the beneficiary’s chart.

3.12.4 The frequency of individual counseling sessions, in combination with other treatment services shall be based on medical necessity and individualized beneficiary needs rather than a prescribed program required for all beneficiaries.

3.12.5 Reference: DHCS Face-to-Face Info Notice

3.13 Crisis Intervention Services

3.13.1 Crisis intervention services are contact between a SUD counselor or LPHA and a beneficiary in crisis. Services shall focus on alleviating crisis problems. “Crisis” means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to the stabilization of the beneficiary’s emergency situation.

3.13.2 Collateral services sessions are available at all levels of care and are defined as face-to-face contact between one (1) SUD counselor or LPHA, one (1) beneficiary.

3.13.3 A progress note must be written for each session and documented in the beneficiary’s chart.

3.13.4 The frequency of crisis services sessions, in combination with other treatment services shall be based on medical necessity and individualized beneficiary needs.
3.14 **Family Therapy**

3.14.1 Family therapy is a form of psychotherapy that involves both beneficiary and their family members, and uses specific techniques and evidence-based approaches (e.g. family systems theory, structural therapy, etc.) to improve the psychosocial impact of substance use and the dynamics of a social/family unit.

3.14.2 Family therapy sessions are available at all levels of care and are defined as face-to-face contact between one (1) therapist level LPHA, one (1) beneficiary and family members.

3.14.3 A progress note must be written for each session and documented in the beneficiary’s chart.

3.14.4 The frequency of family therapy sessions, in combination with other treatment services shall be based on medical necessity and individualized beneficiary needs, rather than a prescribed program required for all beneficiaries.

3.15 **Collateral Services**

3.15.1 Collateral services are sessions between significant persons in the life of the beneficiary (e.g., personal, not official or professional relationship with beneficiary) and SUD counselors or LPHAs. The sessions are used to obtained useful information regarding the beneficiary to support his or her recovery.

3.15.2 The focus of collateral services is on better addressing the treatment needs of the beneficiary.

3.15.3 Collateral services sessions are available at all levels of care and are defined as face-to-face contact between one (1) SUD counselor or LPHA, one (1) beneficiary and significant persons in the beneficiary’s life. The beneficiary does not need to be present for a collateral service.

3.15.4 A progress note must be written for each session and documented in the beneficiary’s chart.

3.15.5 The frequency of collateral services sessions, in combination with other treatment services shall be based on medical necessity and individualized beneficiary needs rather than a prescribed program required for all beneficiaries.

3.16 **Evidenced Based Practices (EBP)**

3.16.1 Providers will implement at least two of the following EBPs based on the timeline established in the county implementation plan. Provider should use a minimum of two EBPs for each modality as follows:

- Motivational Interviewing: A beneficiary-centered, empathic, but directive counseling strategy designed to explore and reduce a person’s ambivalence toward treatment. This approach frequently includes other problem solving or solution-focused strategies that build on beneficiaries’ past successes.

- Cognitive-Behavioral Therapy: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.

3.16.2 In addition to the two required EBP’s listed above, Providers may incorporate additional EBP’s as follows:
- Relapse Prevention: A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment.

- Trauma-Informed Treatment: Services shall take into account an understanding of trauma, and place priority on trauma survivors’ safety, choice and control.

- Psycho-Education: Psycho-educational groups are designed to educate beneficiaries about substance abuse, and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to beneficiaries’ lives. Psycho-educational groups should instill self-awareness, suggest options for growth through change, and identify community resources that can assist beneficiaries in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

3.17  **Drug Testing Process**

3.17.1 Drug testing should be viewed and used as a therapeutic tool. A punitive approach to drug testing generally does not facilitate a productive relationship with beneficiaries and should be avoided. Consequences to drug testing should also be communicated in a therapeutic manner.

3.17.2 Alcohol and drug testing is the examination of biological specimens (e.g., urine, blood, hair) to detect the presence of specific drugs and determine prior drug use. Drug testing is best utilized when administered randomly as opposed to being scheduled, and the method of drug testing (e.g., urine, saliva) should ideally vary as well.

3.17.3 If body fluids testing (urinalysis) is performed, the beneficiary’s emission of the urine must be collected and observed by an employee with the same gender to protect against the falsification and/or contamination of the urine sample.

3.17.4 Drug testing is a useful tool to monitor engagement and provide an objective measure of treatment efficacy and progress to inform treatment decisions.

3.17.5 The frequency of alcohol and drug testing should be based on the beneficiary’s progress in treatment, and the frequency of testing should be higher during the initial phases of treatment when continued alcohol and/or drug use has been identified as happening higher in frequency.

3.17.6 Alcohol and drug testing is allowable at all levels of care.

3.17.7 Documentation must be completed for all alcohol and drug tests in beneficiary’s chart.

3.17.8 Positive Drug Tests: Decisions about effective responses to positive drug tests and relapses should take into account:

- The chronic nature of addiction;
- That relapse is a manifestation of the condition for which people are seeking SUD treatment; and
- That medications or other factors may at times lead to false or inappropriately positive drug test results.
4  CHARTING AND DOCUMENTATION

Documentation refers to anything in the beneficiary’s EHR that describes the care provided to that beneficiary and the reasoning for any services delivered. All progress notes are to be observational and narrative in content as they tell the story of the beneficiary that is being served.

Documentation is a critical component of quality care delivery and serves multiple purposes including but not limited to helping to ensure comprehensive and quality care, ensures an efficient way to organize and communicate with other providers, protects against risk and minimizes liability, complies with legal, regulatory and institutional requirements and helps to facilitate quality improvement and application of utilization management.

4.1  Beneficiary Record

4.1.1 The Provider shall establish, maintain, and update as necessary, an individual beneficiary record for each beneficiary admitted to treatment and receiving services.

4.1.2 Each beneficiary’s individual record shall include documentation of personal information.

4.1.3 Documentation of personal information shall include all of the following:

- Information specifying the beneficiary’s identifier (i.e., name, number).
- Date of beneficiary’s birth, the beneficiary’s sex, race and/or ethnic background, the beneficiary’s address and telephone number, the beneficiary’s next of kin or emergency contact.

4.1.4 Documentation of treatment episode information shall include documentation of all activities, services, sessions and assessments, including but not limited to all of the following:

- Intake and admission data, including, if applicable, a physical examination;
- ASAM comprehensive assessment
- ASAM level of care placements;
- Treatment plans;
- Progress notes;
- Continuing services justifications;
- Laboratory test orders and results;
- Referrals;
- Individual counseling notes;
- Discharge plan;
- Discharge summary;
- County authorizations for residential services; and
- Any other information relating to the treatment services rendered to the beneficiary.
4.2 Treatment Plan

4.2.1 The initial treatment plan serves as a guide and must be individualized and based on the information obtained during the intake and assessment process. The initial treatment plan must be completed within:

- 30 days of admission for Outpatient /IOT.
- 28 days of admission for OTP/NTP.
- 10 days of admission for Residential.

4.2.2 For each beneficiary admitted to treatment services, the LPHA or counselor shall prepare an individualized written initial treatment plan based upon the information obtained in the intake and assessment process.

4.2.3 The LPHA or counselor shall attempt to engage the beneficiary to meaningfully participate in the preparation of the initial or updated treatment plan. The initial and subsequent treatment plans shall include:

- A statement of problems identified through the ASAM, other assessment tool(s) or intake documentation;
- Goals to be reached which address each problem;
- Action steps that will be taken by the Provider and/or beneficiary to accomplish identified goals;
- Target dates for accomplishment of actions steps and goals;
- A description of services, including the type of counseling, to be provided and the frequency thereof;
- Assignment of a primary counselor;
- The beneficiary’s DSM-5 diagnosis language as documented by the Medical Director or LPHA;
- If a beneficiary has not had a physical examination within the 12-months prior to the beneficiary’s admission to treatment date, a goal that the beneficiary have a physical examination should be present on the treatment plan;
- If documentation of a beneficiary’s physical examination, which was performed during the prior twelve months, indicates a beneficiary has a significant medical illness, a goal that the beneficiary obtains appropriate treatment for the illness shall be included on the treatment plan; and
- Individualization based on engaging the beneficiary in the treatment planning process.

4.2.4 The Provider shall ensure that the LPHA or counselor types or legibly prints their name, signs and dates the initial treatment plan within thirty (30) calendar days of the admission to treatment date.

4.2.5 The beneficiary shall review, approve, type or legibly print their name, sign and date the initial treatment plan within thirty (30) calendar days of the admission to treatment date.

4.2.6 If the beneficiary refuses to sign the treatment plan, the provider shall document the reason for refusal and the provider’s strategy to engage the beneficiary to participate in treatment in a progress note.
4.2.7 If a counselor completes the initial treatment plan, the Medical Director or LPHA shall review it to determine whether services are medically necessary and appropriate for the beneficiary. If the Medical Director or LPHA determines the services in the initial treatment plan are medically necessary, the Medical Director or LPHA shall type or legibly print their name, sign and date the treatment plan within fifteen (15) days of the counselor’s signature.

4.2.8 The LPHA or counselor shall complete, type or legibly print their name, sign and date updated treatment plans no later than ninety (90) calendar days after signing the initial treatment plan, and no later than every ninety (90) calendar days thereafter or when there is a change in treatment modality or significant event, whichever comes first.

4.2.9 The beneficiary shall review, approve, type or legibly print their name and, sign and date the updated treatment plan. If the beneficiary refuses to sign the updated treatment plan, the Provider shall document the reason for refusal and any strategies used to engage the beneficiary to participate in treatment.

4.2.10 After the counselor and beneficiary complete the updated treatment plan, the Medical Director or LPHA shall review each plan to determine whether continuing services are medically necessary and appropriate for the beneficiary. If the Medical Director or LPHA determines the services in the updated treatment plan are medically necessary, he or she shall type or legibly print their name, sign and date the updated treatment plan, within fifteen (15) calendar days of the counselor’s signature.

4.3 Progress Notes

4.3.1 Progress notes and individual narrative summaries shall contain the following:

- The topic of the session or purpose of the service;
- A description of the beneficiary’s progress on the treatment plan problems, goals, action steps, objectives, and/or referrals;
- Information on the beneficiary’s attendance shall be documented including the date, start/end times of each individual and group counseling session or treatment service;
- Documentation shall identify if services were provided in-person, by telephone, or by telehealth; and
- If services were provided in the community, documentation shall identify the location and how the provider ensured confidentiality was upheld.

Progress note for all Outpatient Services shall be documented for each individual and group counseling session and the counselor or LPHA shall record a progress note for each beneficiary in the session. The LPHA/counselor must type or legibly print their name, sign and date (to include electronic signatures) within seven (7) calendar days of the provided service date.

4.3.2 Progress notes for Case Management Services shall be documented by the LPHA or counselor who provided the treatment service as follows:

- Beneficiary’s name;
- The purpose of the service;
- A description of how the service relates to the beneficiary’s treatment plan problems, goals, action steps, objectives, and/or referrals;
• Contain the date, start and end times of each service.
• Identify if services were provided in-person, by telephone, or by telehealth; and
• If services were provided in the community, the note shall identify the location and how the provider ensured confidentiality was upheld.

4.3.3 Progress notes for Recovery Services requires a minimum of one progress note for each beneficiary participating in structured activities including individual and group counseling sessions. The LPHA or counselor must type or legibly print their name, sign and date (to include electronic signatures) within seven (7) calendar days of the provided service.

4.3.4 Progress notes for Residential Services requires a minimum of one progress note daily for each beneficiary. The LPHA or counselor must type or legibly print their name, sign and date (to include electronic signatures) within seven (7) calendar days of the provided service. In order for residential treatment to be reimbursed on a daily basis, the service provided must include a required service activity on the date of billing. The components of residential treatment are as follows:
  • Intake;
  • Individual Counseling;
  • Group Counseling;
  • Patient Education;
  • Family Therapy;
  • Collateral Services;
  • Treatment Planning;
  • Transportation Services: Provision of or arrangement for transportation to and from medically necessary treatment; and
  • Discharge Services.

4.3.5 For physician consultation services, additional MAT, and withdrawal management, the Medical Director or LPHA working within their scope of practice which provided the treatment service shall ensure documentation is present in a progress note in the beneficiary’s file.

4.3.6 Reference: DHCS Information Notice 18-001 Drug Medi-Cal Organized Deliver System Residential Reimbursement

4.4 Continuing Services

4.4.1 For case management, intensive outpatient treatment, Naltrexone treatment, and outpatient services, each beneficiary, no sooner than five (5) months and no later than six (6) months after the beneficiary’s admission to treatment date or the date of completion of the most recent justification for continuing services, the LPHA or counselor shall review the beneficiary’s progress and eligibility to continue to receive treatment services, and recommend whether the beneficiary should or should not continue to receive treatment services at the same level of care.
4.4.2 For each beneficiary, no sooner than five (5) months and no later than six (6) months after the beneficiary’s admission to treatment date or the date of completion of the most recent justification for continuing service, the Medical Director or LPHA shall determine medical necessity for continued services for the beneficiary. The determination of medical necessity shall be documented by the Medical Director or LPHA in the beneficiary’s individual record and shall include documentation that all of the following have been considered:

- The beneficiary’s personal, medical and substance use history;
- Documentation of the beneficiary’s most recent physical examination;
- The beneficiary’s progress notes and treatment plan goals;
- The LPHA’s or counselor’s recommendation pursuant to the first bullet point above;
- The beneficiary’s prognosis; and

The Medical Director or LPHA shall type or legibly print their name, sign and date the continuing services information when completed.

4.4.3 If the Medical Director or LPHA determines that continuing treatment services for the beneficiary is not medically necessary, the Provider shall discharge the beneficiary from treatment and arrange for the beneficiary to an appropriate level of treatment services. For more information on re-assessment see Section 2.5.

4.4.4 For OTP/NTP, annually the Medical Director or LPHA shall reevaluate and document in the beneficiary record the facts justifying the decision to continue treatment. The justification shall include:

- A summary of the progress or lack of progress on each goal identified on the most recent treatment plan; and
- A statement that failure to continue treatment would lead to a return to opiate addiction.

4.5 Discharge and Transition

4.5.1 Discharge or transition planning is available at all levels of care and is the process of preparing the beneficiary for referral into another level of care. This ensures beneficiary continuum of care, post-treatment return, reentry into the community, and/or other linkages necessary for greater success with long term recovery.

4.5.2 Discharge planning is openly discussed between staff and beneficiary at the onset of treatment services to ensure sufficient time to plan for the beneficiary’s transition to additional levels of care if determined medically necessary.

4.5.3 A discharge plan is a planned discharge that takes place while the beneficiary is still in treatment and must be completed within thirty (30) days prior to the final face-to-face service.

4.5.4 If a beneficiary is transferred to a higher or lower level of care based on the ASAM criteria within the same DMC certified program, they are not required to complete a discharge plan of discharge summary unless there has been more than a thirty (30) calendar day lapse in treatment services.

4.5.5 During the LPHA’s or counselor’s last face-to-face treatment with the beneficiary, the LPHA or counselor and the beneficiary shall type or legibly print their names, sign and date the discharge plan. A copy of the discharge plan shall be provided to the beneficiary and documented in the beneficiary record.
4.5.6 A discharge plan must, at minimum, include a list of triggers, specific coping skills to address each trigger, and a support plan. The Discharge Planning Document in ADP-Clinician’s Gateway should be used for this purpose.

4.5.7 A discharge summary is to be completed for all beneficiaries regardless of level of care or successful/unsuccesful completion.

4.5.8 For a beneficiary with whom a provider has lost contact or who does not attend treatment for more than thirty (30) days, Providers must discharge the beneficiary and complete a discharge summary within thirty (30) calendar days of the date of the Provider’s last face-to-face treatment contact with the beneficiary.

4.5.9 The discharge summary must include: 1) the duration of the beneficiary’s treatment, as determined by dates of admission to and discharge from treatment. 2) the reason for discharge. 3) a narrative summary of the treatment episode. and 4) the beneficiary’s prognosis.

4.6 **Sign-in Sheet Requirements**

4.6.1 A sign-in sheet is required for every group counseling session.

4.6.2 The sign-in sheet must include the typed or legibly printed name and signature of the LPHA(s) and/or counselor(s) conducting the counseling session. By signing the sign-in sheet, the LPHA(s) and/or counselor(s) attest that the sign-in sheet is accurate and complete.

4.6.3 The sign-in sheet must include date, topic, and start and end time of the counseling session.

4.6.4 The sign-in sheet must include a typed or legibly printed list of the participants’ names and the signature of each participant that attended the counseling session. The participants shall sign the sign-in sheet at the start of or during the counseling session.

4.6.5 **Attachment J:** DMC-ODS Sign-in Sheet
5 QUALITY ASSURANCE AND MONITORING

Quality assurance and monitoring will adhere to the larger framework established by the Department, and DHCS AOD, DMC-ODS, and EQRO oversight. The following documentation contains guidelines to follow within each of these overseeing bodies and requirements.

5.1 Adverse Incidents

5.1.1 In the event an adverse incident occurs involving beneficiaries, Providers will report incidents through the established process found in County Client Problem Resolution Process Policy.

5.1.2 Reference: Policy #4.020 Client Problem Resolution Process

5.2 Cultural Competency and Access

5.2.1 The Providers shall promote the delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation of gender identity.

5.2.2 Providers are responsible to make available culturally competent services. Providers shall ensure that their policies, procedures, and practices are consistent with the principles outlined and are embedded in the organizational structure, as well as being upheld in day-to-day operations.

5.2.3 The Providers shall provide physical access, reasonable accommodations, and accessible equipment for Medicaid beneficiaries with physical or mental health challenges.

5.2.4 To ensure equal access to quality care by diverse populations, each Provider shall adopt the federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards and comply with 42 CFR 438.206(c)(2).

5.2.5 The Providers shall make interpretation services available free of charge to each beneficiary. This includes oral interpretation and the use of auxiliary aids such as TTY/TDY. Oral interpretation requirements apply to all non-English languages, not just those that the County identifies as prevalent.

5.2.6 Services, programs, and written materials that are offered in English must also be made available in Spanish, if beneficiaries identify Spanish as their preferred language.

5.2.7 Reference: Policy #2.007 Cultural and Linguistic Competency

5.3 HIPAA and 42 CFR Part (2) Compliance

5.3.1 HIPAA and 42 CFR Part (2) training is mandatory annually for all providers. Resources to complete this mandatory training are available on Relias.

5.3.2 County policies pertaining to Protected Health Information (PHI), Personally Identifiable Information (PII) and Personal Information (PI) are available for review and to comply with.

5.3.3 Reference: Policy #11.100 Reporting Breaches and Security Incidents Involving PHI, PII and PI

5.4 Personnel Specifications

5.4.1 The following requirements shall apply to all Providers and Provider staff.
5.4.2 Providers shall comply with the Department’s Staff Credentialing and Licensing Policy and Procedure in order to ensure that all individuals permitted access to the electronic medical records system are (1) properly credentialed, (2) verified for eligibility to participate in Medi-Cal, Medicaid and/or Medicare claiming and related activities, and (3) maintain current, valid and verifiable professional status for his/her job classification.

5.4.3 Before Provider staff may access the Department’s medical records or provide services to a beneficiary, the supervisor of the relevant Provider facility/program ensures the completion and submission of all required documents as listed in the Staff Credentialing and Licensing Policy and Procedure.

5.4.4 The professional staff shall be licensed, registered, certified or recognized under California scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Licensed Practitioners of the Healing Arts (LPHA) include:

- Physician,
- Nurse Practitioners,
- Physician Assistants,
- Registered Nurses,
- Registered Pharmacists,
- Licensed Clinical Psychologists,
- Licensed Clinical Social Worker,
- Licensed Professional Clinical Counselor,
- Licensed Marriage and Family Therapists, and
- License Eligible Practitioners working under the supervision of Licensed Clinicians.

5.4.5 Professional staff (LPHAs) shall receive a minimum of (18) hours of continuing education related to addiction medicine each year.

5.4.6 Registered and certified AOD counselors shall adhere to all requirements in Title 9, Chapter 8.

5.4.7 Professional and non-professional staff (including but not limited to SUD Peer Support Staff) are required to have appropriate experience and any necessary training at the time of hiring. Documentation of trainings, certifications and licensure shall be contained in personnel files.

5.4.8 Providers will ensure personnel are competent, trained and qualified to provide any services necessary.

5.4.9 Non-professional staff shall receive appropriate onsite orientation and training prior to performing assigned duties. A professional and/or administrative staff shall supervise non-professional staff.

5.4.10 Providers will maintain records of current certification and NPI registration for all staff providing direct AOD services.

5.4.11 Providers shall maintain proof of participation in all County and State mandated training.

5.4.12 Providers shall employ and utilize staff who are culturally and ethnically representative of the population being served.
5.4.13 Providers shall not unlawfully discriminate against any person in employment as defined under the laws of the United States and the State of California. Refer to the Resources Section for applicable laws.

5.4.14 Providers will ensure all primary staff members are paid personnel. Volunteers may be used on a limited basis.

5.4.15 Providers will ensure beneficiaries of the program are not substituted for paid personnel.

5.4.16 Providers will ensure a sufficient number of staff members are certified in Cardiopulmonary Resuscitation (CPR) and basic First Aid to provide coverage in residential facilities at all times.

5.4.17 Personnel files shall be maintained on all employees and volunteers/interns and shall contain the following:

- Application for employment and/or resume;
- Signed employment confirmation statement/duty statement;
- Job description;
- Performance evaluations;
- Health records/status as required by Provider, AOD certification or Title 9;
- Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries);
- Training documentation relative to substance use disorders and treatment;
- Current registration, certification, intern status, or licensure;
- Proof of continuing education required by licensing or certifying agency and program; and
- Provider’s Code of Conduct and for registered, certified, and licensed staff, a copy of the certifying/licensing body’s code of conduct as well.

5.4.18 Job descriptions shall be developed, revised as needed and approved by the Provider’s governing body. The job descriptions shall include:

- Position title and classification,
- Duties and responsibilities,
- Lines of supervision, and
- Education, training, work experience, and other qualifications for the position.

5.4.19 Code of conduct for employees and volunteers/interns shall be established which addresses the following:

- Use of drugs and/or alcohol;
- Prohibition of social/business relationship with beneficiary’s or their family members for personal gain;
- Prohibition of sexual conduct with beneficiaries;
- Conflict of interest;
- Providing services beyond scope;
• Discrimination against beneficiary’s or staff;
• Verbally, physically, or sexually harassing, threatening, or abusing beneficiaries, family members or other staff;
• Protection beneficiary confidentiality;
• The elements found in the code of conduct(s) for the certifying organization(s) the program’s counselors are certified under; and
• Cooperate with complaint investigations.

5.4.20 If a Provider utilizes the services of volunteers and or interns, procedures shall be implemented which addresses:

• Recruitment;
• Screening;
• Selection;
• Training and orientation;
• Duties and assignments;
• Scope of practice;
• Supervision;
• Evaluation; and
• Protection of beneficiary confidentiality.

5.4.21 Reference: Policy # 4.015 Staff Credentialing and Licensing Policy and Procedure

5.4.22 Reference: Title 9, Chapter 8

5.4.23 Attachment K: DHCS Minimum Quality Drug Treatment Standards for DMC

5.5 Substance Use Disorder Medical Director

5.5.1 Written roles and responsibilities and a code of conduct for the Medical Director shall be clearly documented, signed and dated by a Provider representative and the physician.

5.5.2 The substance use disorder Medical Director’s responsibilities shall, at a minimum, include all of the following in accordance with Title 22, Section 51341.1 (b) 28:

• Ensure that medical care provided by physicians and physician extenders meets the applicable standard of care;
• Ensure that physicians do not delegate their duties to non-physician personnel;
• Develop and implement medical policies and standards for the provider;
• Ensure that physicians, registered nurse practitioners, and physician assistants follow the provider’s medical policies and standards;
• Ensure that the medical decisions made by physicians are not influenced by fiscal considerations;
• Ensure that provider’s physicians and LPHAs are adequately trained to diagnose substance use disorders for beneficiaries and determine the medical necessity of treatment for beneficiaries; and
• Ensure that physicians are adequately trained to perform other physician duties, as outlined.

5.5.3 The substance use disorder Medical Director may delegate his/her responsibilities to a physician consistent with the Provider’s medical policies and standards. However, the substance use disorder Medical Director shall remain responsible for ensuring all delegated duties are properly performed.

5.5.4 Resource: Title 22, Section 51341.1 (b) 28

5.6 State Monitoring

5.6.1 Providers are monitored by the Department of Health Care Services (DHCS) for compliance with Alcohol and/or Other Drug Program Certification Standards, Drug Medi-Cal compliance and by the Post-Service Post-Payment (PSPP) unit.

5.6.2 The Providers will make available, for the purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computers and other electronic systems relating to its beneficiaries.

5.6.3 DHCS, CMS, the HHS Inspector General, the Comptroller General, or their designees’ right to audit the Provider will exist through ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.

5.7 County Monitoring

5.7.1 Providers are monitored by the Department for compliance with administrative programmatic, clinical and fiscal requirements. The Department monitors all Providers at a level of frequency that ensures program accountability and compliance with best practices, contract requirements, and applicable federal, state and local laws. In doing so, the Department shall provide a level of support, including training and technical assistance, to ensure that each contracted provider has the ability to comply with contractual obligations. Unless otherwise noted, all treatment services will comply with or adhere to Title 22 rules and regulations. County monitoring activities include, but are not limited to, review of reporting documents, site visits, analysis of services provided, and chart reviews and are outlined in detail below.

5.7.2 Administrative Site Visits. Administrative site visits include a review of the general administration of the SUD provider’s organization, including review of staff files, board minutes, and fiscal and organizational policies and procedures.

• All SUD providers must establish policies and procedures addressing client wait times and timely access to appointments, including a resolution process for when problems or complaints arise.

• An administrative site review will take place at least once every year per California State Department of Health Care Services (DHCS) requirements as outlined in the State/County Contract. New providers or providers who need more support (as determined by Department staff) may require more frequent site visits.
During each site visit, a standardized Administrative Site Monitoring Tool (Attachment L) is used. Providers will be emailed/given the tool and notified of the site visit a minimum of one (1) week prior to the visit.

A standardized written report summarizing the findings and any recommendations will be sent to the SUD provider within 30 days of the visit and may be distributed to other county offices that share a contracting relationship with the same provider.

Programmatic/Documentation Site Visits. Programmatic/documentation site visits include a review of the agreed upon performance measures and progress to date, programmatic standards, client charts and clinical data, service delivery, and fiscal review of contracted services and compliance.

During each site visit, a standardized Programmatic/Documentation Site Monitoring Tool (Attachment M) is used. Providers will be emailed/given the tool and notified of the site visit one (1) week prior to the visit.

A standardized written report summarizing the findings and any recommendations will be sent to the SUD provider within 30 days of the visit and may be distributed to other county offices that share a contracting relationship with the same provider.

Clinical Documentation Monitoring. A minimum of 5% of SUD provider charts per month will be selected randomly for clinical documentation monitoring. The selection may or may not be coordinated with administrative or programmatic site visits.

Clinical documentation monitoring will adhere to the ADP Clinical Documentation Manual.

Written feedback will be provided directly to counselors and supervisors and will be used to identify areas for additional technical assistance.

Clinical Site Visit (Group and Individual Sessions). Department staff will monitor direct group and individual clinical services as part of the overall contract monitoring practice. The purpose of clinical monitoring is to ensure that group and individual service regulations are followed and elevate clinical practice for best client care. Actual observation of group and individual sessions is fundamental to the accurate assessment of program compliance and will inform training and technical assistance needs.

Department staff will employ a Clinical Monitoring Review Form to assess, improve and support counselor skills. This form will be completed in collaboration with the direct service or counselor staff to provide feedback and to inform training and technical assistance needs.

Care will be taken by Department staff to ensure that all confidentiality laws and guidelines are observed and that group and individual observation will not disrupt client engagement. Department staff should arrive at least 30 minutes before the group or individual session starts, meet with the program manager and group or individual counselor and explain the purpose of the observation.

On the rare occasion where a client has a reaction to Department presence in the group or individual session, Department staff will leave after the first 10 minutes. Otherwise, if staff plans on auditing the group or individual session, he/she will attend a minimum of 30 minutes.
5.7.6 Fiscal Monitoring. The Department conducts continuous fiscal desk monitoring to ensure compliance with contracted billing/invoicing procedures and federal, state, or local laws, rules and regulations.

5.7.7 Fiscal desk monitoring includes, but is not limited to: invoice and actual expenditure tracking, invoice and contract review, and cost report analysis.

5.7.8 All SUD providers will be monitored fiscally on a weekly or biweekly basis. State and Federal audits will also be included in fiscal monitoring. A fiscal site visit will be conducted when necessary or due to special circumstances.

5.7.9 All scheduled and unannounced site visits will be documented using standardized reports including cover letters, monitoring tools, and follow-up documentation. All monitoring will include text and data elements that are absolutely necessary for accurate and thorough monitoring of established county, federal and state requirements.

5.7.10 Based on the site visit findings, a Corrective Action Plan (CAP) may be required of the SUD provider. To determine the necessity of a CAP, findings from the site visit requiring corrective action are to be documented by a standardized written report. Any corrective action involving financial disallowances will be reviewed by Department fiscal staff and program staff.

A standardized letter indicating that a CAP is required will be sent to the SUD provider within 30 days from exit interview, along with standardized documentation of the areas in need of corrective action. The SUD provider will have 30 days from the date of the letter to respond with the CAP.

Once submitted by the SUD provider, Department staff will review the CAP. A follow-up visit may be scheduled within 90 days to verify compliance and implementation of the plan. The SUD provider will be sent verification of receipt of the CAP and notice to schedule a follow-up visit as appropriate.

If a CAP has not been received within 15 days after the due date, Department staff will contact the SUD provider’s Executive Director and request corrective measures be taken. If there is no response 30 days after due date, a certified letter may be sent to the Executive Director with a copy to the chair/president of the Board of Directors of the agency.

5.7.11 Contract monitoring may involve Corrective Action Plans (CAPs) that include the recoupment or disallowance of funds paid to the SUD provider.

5.7.12 Reference: Policy # 7.005 Substance Use Disorder (SUD) Provider Monitoring and Documentation Review

5.8 Beneficiary Rights

5.8.1 Providers will adhere to Beneficiary Rights as outlined by 42 CFR 438.100.

5.8.2 Beneficiaries have the right to be treated with respect and with due consideration for his or her dignity and privacy.

5.8.3 Beneficiaries have the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the beneficiary’s condition and ability to understand. (The information requirements for services that are not covered under the Agreement because of moral or religious objections are set forth in 42 CFR §438.10(g)(2)(ii)(A) and (B).)

5.8.4 Beneficiaries have the right to participate in decisions regarding his or her health care, including the right to refuse treatment.
5.8.5 Beneficiaries have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.

5.8.6 Beneficiaries have the right if the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request, and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and 164.526.

5.8.7 Each beneficiary is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Provider treats the beneficiary.

5.8.8 **Reference:** DHCS Beneficiary Protections in the DMC-ODS Pilot FAQ

5.9 **Beneficiary Satisfaction**

5.9.1 Treatment Perception Surveys will be conducted for all beneficiaries in Provider facilities/programs. Quality Care Management (QCM) will send surveys to all facilities and manage data collection. The Department’s Research and Evaluation department will analyze and submit all data to UCLA.

5.9.2 Pursuant to 42 CFR 438.3(i), Providers will allow each beneficiary to choose his or her health professional to the extent possible and appropriate.

5.9.3 **Reference:** DHCS Treatment Perceptions Survey Info Notice

5.10 **Provider Beneficiary Communications**

5.10.1 The Providers may advise or advocate on behalf of the beneficiary who is their beneficiary regarding:

- The beneficiary’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
- Any information the beneficiary needs to decide among all relevant treatment options;
- The risks, benefits, and consequences of treatment or non-treatment;
- The beneficiary’s right to participate in decisions regarding his or health care, including the right to refuse treatment; and
- To express preferences about future treatment decisions.

5.11 **Provider Grievance and Appeals**

5.11.1 Service denials and appeals may occur through the course of Providers billing for services. Services may be denied for various reasons. Steps for County processing and Provider feedback and appeals are available per the Notices of Action (NOA) Policy.

5.11.2 It is the policy of the Department and its Providers to provide Medi-Cal beneficiaries with a Notice of Action (NOA) in accordance with all relevant state and federal laws and regulations. NOAs will be issued in a timely manner and the beneficiary advised of his/her right to request a second opinion, file a verbal or written action appeal, file a verbal or written expedited action appeal, and/or request a State Fair Hearing in response to a NOA.

5.11.3 **Reference:** Policy #4.010 Notices of Action

5.11.4 **Reference:** DMC-ODS State Hearing Rights
5.12 Quality Improvement Plan

5.12.1 Quality Improvement and Continuous Quality Improvement are central tenants of how we work within the Santa Barbara County Department of Behavioral Wellness. It is a core business strategy and informs and influences all we do. This can be seen throughout the organizational structure of the department. Examples include the ongoing System Change efforts led directly by the Director, as well as the organization of the Office of Quality Care and Strategy Management (OQSM). The OQSM oversees the Quality Improvement Program and works to support continuous quality improvement throughout System Change efforts.

5.12.2 The Quality Care Management (QCM) Division monitors services that are provided by the Santa Barbara County Mental Health Plan (MHP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS) which includes services provided within the Department of Behavioral Wellness as well as by contract providers. Monitoring takes place to insure that the State contract, and State and Federal regulations are met. QCM develops implementation processes to continually monitor the quality of care that Behavioral Wellness beneficiaries receive. QCM accomplishes this in many ways including through regular audits, annual quality improvement work plans, annual quality improvement goals, annual work plan evaluations, performance improvement projects, collaboration with providers, and developing MHP and DMC-ODS related trainings and resources. Additionally, QCM maintains knowledge of current federal and state rules and regulations that guide our day to day operations.

5.12.3 Attachment N: QCM Division Description

5.12.4 Attachment O: QIC Workplan

5.12.5 Reference: DHCS Quality Management FAQ

5.13 Mandatory Trainings

5.13.1 The Santa Barbara County Department of Behavioral Wellness is committed to providing high-quality, evidence-based trainings to care providers. The Department requires the completion of certain trainings to ensure compliance with all relevant laws, regulations, contracts, and guidelines; this includes compliance with the requirements of the DMC-ODS waiver.

All staff of the Santa Barbara County Mental Health Plan (MHP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS)—that is, any employee or contractor on payroll, or any volunteer under the supervision of the MHP or DMC-ODS—are held to certain mandatory training requirements by the Department’s Mandatory Trainings policy. Many of these requirements also extend to the staff of Community-Based Organization (CBO) contracted partners.

As part of the Department’s Mandatory Trainings policy, monitoring of staff training completion is performed regularly by MHP and DMC-ODS staff, with detailed reports produced for regular review. The Department produces procedures for addressing noncompliance with the required trainings: these responsibilities extend to MHP staff, DMC-ODS staff, and the staff of CBOs.
6 ADMINISTRATIVE OVERSIGHT

6.1 Billing

6.1.1 Contractor will comply with all requirements necessary for reimbursement in accordance with the regulations applicable to the funding sources identified in the Provider County Contractor, and other applicable Federal, State and local laws, rules, manuals, policies, guidelines and directives.

6.1.2 Provider shall be compensated on a cost reimbursement basis, subject to the limitations described in the Provider County Contract for provision of the Units of Service (UOS) established in the Exhibit B-1- ADP based on satisfactory performance of the Alcohol and Drug Program services described in the Exhibit A(s).

6.1.3 The services provided by Provider’s Program described in the Exhibit A(s) that are covered by the Drug Medi-Cal Program will be reimbursed by County as specified in Exhibit B-1-ADP. Pursuant to Title 9 California Code of Regulations (CCR) 9533(a) (2), Provider shall accept proof of eligibility for Drug Medi-Cal as payment in full for treatment services rendered, and shall not collect any other fees from Drug Medi-Cal clients, except where a share of cost, defined in Title 22 CCR section 50090, is authorized under Title 22 CCR sections 50651 et seq. Provider shall not charge fees to beneficiaries for access to Drug Medi-Cal substance abuse services or for admission to a Drug Medi-Cal treatment slot.

6.1.4 Provider shall use the funds provided by County exclusively for the purposes of performing the services described in Exhibit A(s) to this Agreement. Expenses shall comply with the requirements established in the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (45 CFR Part 75), and all other applicable regulations. Violation of this provision or use of County funds for purposes other than those described in the Exhibit A(s) shall constitute a material breach of this Agreement.

6.1.5 Provider shall use County’s MIS system to enter claims for all Drug Medi-Cal (DMC) services. Provider shall document progress note in the client’s file. All progress notes shall adhere to Drug Medi-Cal guidelines. These notes will serve as documentation for billable Drug Medi-Cal units of service. If Provider and County have an agreement on file to upload services through a designated batch upload process, this upload process shall be completed within 10 calendar days of the end of the month in which the service was provided. If Provider enters services directly into the ADP Electronic Health Record, claims shall be submitted to the County MIS Unit within 72 hours of service delivery.

In the event that the MIS system is offline, County will notify providers within 24 hours for reporting purposes.

6.1.6 Provider shall maintain internal financial controls which adequately ensure proper recording, classification, and allocation of expenses, and billing and collection procedures. Provider’s procedures shall specifically provide for the identification of delinquent accounts and methods for pursuing such accounts.

6.1.7 MIS data, invoice or report(s) not submitted by Provider to County within the time limits described in this Agreement or if any such information is incomplete, incorrect, or is not completed in accordance with the requirements of this Agreement, then payment shall be withheld until County is in receipt of complete and correct data and such data has been reviewed and approved by Director or designee. Director or designee shall review such submitted service data within 60 calendar days of receipt.
6.1.8 Director or designee may deny payment for services when documentation of clinical work does not meet minimum State and County written standards.

6.1.9 Unless otherwise determined by State or federal regulations, all original (or initial) claims for eligible individual persons under this Agreement must be received by County within 7 days from the end of the month in which services were provided to avoid possible payment reduction or denial for late billing. Late claims may be submitted up to one year after the month in which services were rendered with documentation of good cause. The existence of good cause shall be determined by the State as provided in Title 22 CCR Sections 51008 and 51008.5.

6.1.10 For all other services, claims must be received by County within 10 days from the end of the month in which services were provided to avoid possible denial of reimbursement for late billing.

6.1.11 No Payment for Services Provided Following Expiration/ Termination of Agreement. Provider shall have no claim against County for payment of any funds or reimbursement, of any kind whatsoever, for any service provided by Provider after the expiration or other termination of this Agreement. Should Provider receive any such payment, it shall immediately notify County and shall immediately repay all such funds to County. Payment by County for services rendered after expiration/termination of this Agreement shall not constitute a waiver of County's right to recover such payment from Provider. This provision shall survive the expiration or other termination of this Agreement.

6.1.12 Provider shall certify that all UOS entered by Provider into the County’s MIS System or otherwise reported to County for any payor sources covered by this Agreement are true and accurate to the best of Provider’s knowledge.

6.1.13 Any overpayments of contractual amounts must be returned via direct payment within 30 days to the County. County may withhold amounts from future payments due to Provider under this Agreement or any subsequent agreement if Provider fails to make direct payment within required timeframe.

6.1.14 Each year of the Agreement, the Provider shall submit to County a copy of their audited annual financial statement, including management comments. This report shall be submitted within thirty (30) days after the report is received by Provider.


6.1.16 Attachment P: ShareCare Supplemental Training for ADP Providers

6.2 Facility Certification Requirements

6.2.1 The Department requires Contracted SUD Providers to obtain both AOD and DMC certifications from DHCS. It is the responsibility of the Contracted Provider to provide updated certifications to the Department and at no time should certifications lapse.

6.2.2 Renewable AOD certifications will designate the modalities approved at the location under the Department contract. Residential providers will also have identified ASAM levels of service, Withdrawal Management, and/or Incidental Medical Services (IMS) approvals.

6.2.3 DMC certifications and DHCS supplemental certification letters shall contain, at a minimum, a four-(4) digit DMC number, an NPI number, a California Outcomes Measurement System (CalOMS) number, Effective date, Service Location address, modalities and special populations identified.

6.2.4 Both AOD and DMC certifications shall be posted in a public space.
6.2.5 Providers shall notify the County immediately upon notification from DHCS that its license, registration, certification or approval to operate an SUD program or a covered service is revoked, suspended, modified, or not renewed by DHCS.

6.2.6 All DMC certified Providers shall be subject to continuing certification requirements at least once every five (5) years.

6.2.7 DHCS may allow the Providers to continue delivering covered services to beneficiaries at a site subject to on-site review by DHCS as part of the recertification process prior to the date of the on-site review, provided the site is operational, the certification remains valid, and has all required fire clearances.

6.2.8 DHCS shall conduct unannounced certification and recertification on-site visits at clinics pursuant to W&I Code, Section 14043.7.

6.2.9 DHCS Resource: AOD Facility Licensing

6.2.10 DHCS Resource: DMC Provider Enrollment Certification

6.3 Contracting with Behavioral Wellness

6.3.1 Providers are selected through a competitive bidding process pursuant to policies set forth by the County of Santa Barbara Purchasing and Fleet Department. Proposals are reviewed, evaluated and scored. Quality of proposal response, modalities of service, location and need are a few factors considered. Selected providers are required to maintain an AOD and DMC certification as described in section 4.2.

6.3.2 Additional information is requested at the onset of initial contract and subsequent contract renewals.

6.3.3 Reference: Policy 12.000 Competitive Procurement of Contract Services

6.4 Provider Adding/Change Notifications

6.4.1 County Administration and AOD and DMC Certified Providers are responsible for maintaining accurate records with DHCS. Administration will update any State Analyst and report through DHCSMPF@dhcs.ca.gov to update the Master Provider File (MPF) when changes occur with Contracted Providers. Providers will assist County with adhering to these requirements.

6.4.2 Providers will notify the County when the Provider applies for any new or additional services by location.

6.4.3 Providers will notify the County if there is any change in status to its AOD or DMC certification status by the State.

6.4.4 Providers shall notify the County after any change in ownership or executive management.

6.4.5 Providers shall notify the County if there is any change in Medical Director or their DMC approved status.
6.5 **State Reporting Compliance**

6.5.1 All certified facilities are required to adhere to mandated reporting by DHCS. “Any Provider that receives any public funding for SUD treatment services and all Opioid Treatment Program (OTP) Providers must report CalOMS Treatment data for all of their beneficiaries receiving treatment, whether those individual beneficiary services are funded by public funds or not.

6.5.2 **CalOMS Data reporting.** Providers will collect beneficiary data for CalOMS Treatment data reporting at admission and at discharge from the treatment program and when transferring between levels of care.

6.5.3 **CalOMS Annual Update reporting.** All Providers are required to adhere to CalOMS guidelines pertaining to proactively extending beneficiaries who will be in a treatment episode for twelve (12) months or longer. Data will be collected annually as an annual update for beneficiaries in treatment for over twelve (12) months” (CalOMS Treatment Data Dictionary, 2014). Annual update information may be collected and entered into ShareCare as early as 60 days prior to the individual’s admission date anniversary. However, annual update data must be collected and entered into ShareCare no later than twelve months from the program participant’s admission anniversary date.

6.5.4 **CalOMS Discharge reporting.** All Providers are required to adhere to CalOMS guidelines pertaining to discharging beneficiaries who have not participated in a service within thirty (30) days. Providers must review monthly Open Caseload reports and CalOMS Open Admission reports and complete CalOMS discharge data as required by the CalOMS guidelines.

6.5.5 **DHCS Resource:** [CalOMS Collection Guide](#)

6.5.6 **DHCS Resource:** [CalOMS Data Dictionary](#)

6.5.7 **DATAR Reporting and Compliance.** Additionally, “Treatment Providers that receive state or federal funding through the State or the County, as well as all licensed Opioid Treatment Programs (OTP), must send DATAR information to DHCS each month” (Department of Healthcare Services). The Drug and Alcohol Treatment Access Report (DATAR) tracks capacity and waitlists for each location. It is a State requirement for all facilities to submit statistics monthly. Each facility must log in to DATAR website and submit a DATAR capacity report to the State by the tenth (10) of every month. An email reminder is sent to all providers prior to the 10th of the month. If DATAR is not completed by the specified deadline, Contract Providers will appear on the DHCS County Non-Compliance Report. Any Provider appearing on this report will be notified via email. Providers are required to submit late DATAR submissions within one (1) day of any non-compliance email. Contact the County Alcohol and Drug Program at BWELL ADP Team [bwelladpteam@sbcwell.org](mailto:bwelladpteam@sbcwell.org) for DATAR log-in and user ID assistance.

6.5.8 **DHCS Resource:** [DATAR Log-in](#)

6.5.9 **Attachment Q:** DATAR State Instruction

6.5.10 The Department facilitates monthly ADP User Group Meetings in order to provide technical assistance for Providers to comply with state reporting requirements. Providers are expected to participate regularly in monthly ADP User Group Meetings. Meetings schedules are available through the Department’s Alcohol and Drug Program at BWELL ADP Team [bwelladpteam@sbcwell.org](mailto:bwelladpteam@sbcwell.org).
6.6 County Reporting Compliance

6.6.1 All Contracted Providers are required to adhere to mandated reporting as required by the County. Required County reporting is outlined below and in Provider contracts.

6.6.2 **Staffing Reports.** Providers shall submit quarterly staffing reports to the Department. These reports shall be on a form acceptable to, or provided by the Department. Staffing Reports shall report actual staff hours worked by position and shall include the employees' names, licensure status, bilingual and bicultural capabilities, budgeted monthly salary, actual salary, date of hire, and, if applicable, the termination date. The reports shall be received by the Department no later than twenty-five (25) calendar days following the end of the quarter being reported.

6.6.3 **Programmatic Reports.** Providers shall submit quarterly programmatic reports to the Department, which shall be received by the Department no later than twenty-five (25) calendar days following the end of the quarter being reported. Programmatic reports shall include the following:

6.6.4 Providers shall state whether it is or is not progressing satisfactorily in achieving all the terms of this Agreement and if not, shall specify what steps will be taken to achieve satisfactory progress;

6.6.5 Providers shall include a narrative description of progress in implementing the provisions of this Agreement, any pertinent facts or interim findings, staff changes, status of Licenses and/or Certifications, changes in population served and reasons for any such changes;

6.6.6 The number of active cases and number of clients admitted/discharged,

6.6.7 The Measures described in the Provider Contracts Attachment E, Program Goals, Outcomes Measures, or as otherwise collaboratively developed by the Provider and Behavioral Wellness. Amendments to Exhibit E do not require a formal amendment. In addition, Provider may include any other data that demonstrate the effectiveness of programs.

6.6.8 **Annual Mandatory Training Report.** Providers shall submit evidence of completion of the Mandatory Trainings identified as required on an annual basis to the County Systems Training Coordinator and/or ADP Program Staff. Training materials, competency tests and sign-in sheets as applicable shall be submitted for each training no later than June 15th of each year.

6.6.9 **Cost Reports.** Providers must comply with the submission of Cost Report requirements. Within four weeks after the release of the cost report template by the Department of Health Care Services (DHCS), Provider shall provide County with an accurate and complete Annual Cost Report with a statement of expenses and revenue for the applicable prior fiscal year. The Annual Cost Report shall be prepared by Provider in accordance with all applicable federal, State and County requirements and generally accepted accounting principles. Provider shall allocate direct and indirect costs to and between programs, cost centers, services, and funding sources in accordance with such requirements and consistent with prudent business practice. All revenues received by Provider shall be reported in its annual Cost Report, and shall be used to offset gross cost. Provider shall maintain source documentation to support the claimed costs, revenues and allocations which shall be available at any time to Director or Designee upon reasonable notice.

6.6.10 **Additional Reports.** Providers shall maintain records and make statistical reports as required by the Department and the State Department of Health Care Services (DHCS) or applicable agency, on forms provided by either agency. Upon the Department’s request, Providers shall make additional reports as required by the Department concerning Provider’s activities as they affect the services hereunder. The Department will be specific as to the nature of information requested and allow thirty (30) days for Providers to respond.
6.6.11 **Attachment R: Mandatory Trainings P&P**

6.7 **Administrative Training and Information Updates**

6.7.1 Administrative training for the Department’s EHR (ADP Clinician’s Gateway), billing system (ShareCare) and CalOMS data entry will be immediately scheduled after contract execution.

6.7.2 Periodic, ongoing trainings for ADP Clinician’s Gateway, ShareCare, and CalOMS data entry will be provided by the County throughout the year for new users and as needed. All new users are required to complete in-person systems trainings in addition to reviewing printed/web-based materials.

6.7.3 Monthly ADP User Group Meetings are scheduled to provide technical assistance for Providers on County systems including ADP Clinician’s Gateway and ShareCare. Providers are expected to participate regularly in monthly ADP User Group Meetings. Meetings schedules are available through the Department’s Alcohol and Drug Program at BWELL ADP Team bwelladpteam@sbcwell.org and may also be found on Relias.

6.7.4 Monthly CBO Collaborative Meetings are scheduled to provide Department updates including the Director’s Update, new policies and procedures, and any additional updates that may impact contracted Providers. Providers are expected to participate in monthly CBO Collaborative Meetings. Meetings are scheduled for the first Wednesday of every month. Meeting schedules are available through the Department’s Alcohol and Drug Program at BWELL ADP Team bwelladpteam@sbcwell.org.

6.7.5 **County Resource:** Relias

6.8 **Terminating a Contract with Behavioral Wellness**

6.8.1 The Department may by written notice to Provider, terminate the Provider Contract in whole or in part at any time, whether for the Department’s convenience, for non-appropriation of funds, or because of the failure of Provider to fulfill the obligations herein.

6.8.2 Should Department fail to pay Provider all or any part of the payment set forth in in the Provider Contract- EXHIBIT B, Provider may, at Provider’s option terminate this Agreement if such failure is not remedied by Department within thirty (30) days of written notice to Department of such late payment.
RESOURCES

7.1 Laws and Regulations

7.1.1 This Practices and Procedures document, along with other federal, state and local regulations, govern the delivery of SUD treatment services in Santa Barbara County. Below is an extensive listing of laws and regulations that are to be followed. For a comprehensive and detailed listing, please refer to the DHCS and Santa Barbara County Agreement:

7.2 Federal

7.2.1 42 Code of Federal Regulation (CFR) Part 2 of Substance Use Disorder Beneficiary Records

7.2.2 42 CFR Part 428 Managed Care

7.2.3 Health Insurance Portability and Accountability Act (HIPAA)

7.2.4 Title VI of the Civil Rights Act of 1964, Section 2000d, as amended, prohibiting discrimination based on race, color, or national origin in federally funded programs.

7.2.5 Title IX of the Education Amendments of 1972 (Regarding education programs and activities).

7.2.6 Title VIII of the Civil Rights Act of 1968 (42 USC 3601 et seq.) prohibiting discrimination on the basis of race, color, religion, sex, handicap, familial status or national origin in the sale or rental of housing.

7.2.7 The Age Discrimination Act of 1975 (45 CFR Part 90), as amended (42 USC Sections 6601-6107), which prohibits discrimination on the basis of age.

7.2.8 Age Discrimination in Employment Act (29 CFR Part 1625).

7.2.9 Title I of the Americans with Disabilities Act (29 CFR Part 1630).

7.2.10 Americans with Disabilities Act (28 CFR Part 35) prohibiting discrimination against the disabled by public entities.

7.2.11 Title III of the Americans with Disabilities Act (28 CFR Part 36) regarding access.

7.2.12 The Rehabilitation Act of 1973, as amended (29 USC Section 794), prohibiting discrimination on the basis of individuals with disabilities.

7.2.13 Executive Order 11246 (42 USC 2000(e) et seq. and 41 CFR Part 60) regarding nondiscrimination in employment under federal contracts and construction contracts greater than $10,000 funded by federal financial assistance.

7.2.14 Executive Order 13166 (67 FR 41455) to improve access to federal services for those with limited English proficiency.

7.2.15 The Drug Abuse Office and Treatment Act of 1972, as amended, relating to nondiscrimination on the basis of drug abuse.

7.2.16 The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism.

7.2.17 The Americans with Disabilities Act of 1990 as amended. 500.18 Section 1557 of the Beneficiary Protection and Affordable Care Act.
7.2.18 Record keeping requirements for providers are to retain, as applicable, the following information:

beneficiary grievance and appeal records in 42 CFR §438.416, and the data, information, and

documentation specified in 42 CFR §§438.604, 438.606, 438.608, and 438.610 for a period of no less

than 10 years.

7.3 State

7.3.1 California Code of Regulations (CCR) Title 9 Counselor Certification

7.3.2 Title 9, Division 4, Chapter 8, commencing with Section 10800.

7.3.3 CCR Title 22 Drug Medi-Cal

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cde19f6a3bdc7bd7startIndex%3d1%26Nav%3dREGULATION_PUBLICVIEW%26

contextData%3d%26s.Default%29&rank=1&list=REGULATION_PUBLICVIEW

&transitionType=SearchItem&contextData=%28sc.Search%29&t_T1=22&t_T2=5

1341.1&t_S1=CA+ADC+s

7.3.4 Sobky v. Smoley (Document 2A), 855 F. Supp. 1123 (E.D. Cal 1994),

7.3.5 Fair Employment and Housing Act (Government Code Section 12900 et seq.) and the applicable

regulations promulgated thereunder (California Administrative Code, Title 2, Section 7285.0 et seq.).

7.3.6 California non-discrimination act. Title 2, Division 3, Article 9.5 of the Government Code,

commencing with Section 11135.

7.4 Agency - DHCS

7.4.1 Drug Medi-Cal Special Terms and Conditions (Note: Refer to pages 89-122 and 335-363 for the DMC-

ODS system. (Updated June 1, 2017))

7.4.2 Department of Health Care Services (DHCS) Perinatal Practice Guidelines

7.4.3 DHCS Youth Treatment Guidelines, 2002

7.4.4 DHCS Alcohol and/or Other Drug Program Certification Standards, 2017

7.5 Licensed and Certified Programs

Providers shall be licensed, registered, AOD licensed and DMC certified and approved in accordance

with applicable laws and regulations. Providers shall comply with the following regulations and

guidelines:

7.5.1 Title 21, CFR Part 1300, et seq.. Title 42, CFR, Part 8

7.5.2 Title 22, Sections 51490.1(a)

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8DF544?originationContext=Search+Result&listSource=Search&viewType=Full

Text&navigationPath=Search/v3/search/results/navigation/i0ad50000001576
cde19f6a3bdc7bd7startIndex%3d1%26Nav%3dREGULATION_PUBLICVIEW%26

contextData%3d%26s.Default%29&rank=1&list=REGULATION_PUBLICVIEW

&transitionType=SearchItem&contextData=%28sc.Search%29&t_T1=22&t_T2=5

13490.1&t_S1=CA+ADC+s
7.5.3 Title 9, Division 4, Chapter 4, Subchapter 1, Sections 50000, et seq. References and
7.5.4 Title 22, Division 3, Chapter 3, Sections 55000 et. seq.

7.6 Terminology

7.6.1 Abuse: means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

7.6.2 Adolescents: means beneficiaries between the ages of twelve and under the age of twenty-one.

7.6.3 Administrative Costs: means the Provider’s direct costs, as recorded in the Provider’s financial records and supported by source documentation, to administer the program or an activity to provide service to the DMC program. Administrative costs do not include the cost do not include the cost of treatment or other direct services to the beneficiary. Administrative costs may include, but are not limited to, the cost of training, programmatic and financial audit reviews, and activities related to billing. Administrative costs may include Provider’s overhead per approved indirect cost rate proposal pursuant to OMB OmniCircular and the State Controller’s Office Handbook of Cost Plan Procedures.

7.6.4 Appeal: is the request for review of an adverse benefit determination.

7.6.5 Authorization: is the approval process for DMC-ODS Services prior to providing Detoxification or Residential services.

7.6.6 Available Capacity: means the total number of units of service (bed days, hours, slots, etc.) that a Provider actually makes available.

7.6.7 Beneficiary: means a person who. a) has been determined eligible for Medi-Cal. b) is not institutionalized. c) has a substance-related disorder per the current “Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria. and d) meets the admission criteria to receive DMC covered services.

7.6.8 Beneficiary Handbook: is the state developed model enrollee handbook.

7.6.9 Calendar Week: means the seven day period from Sunday through Saturday.

7.6.10 Case Management: means a service to assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.

7.6.11 Certified Provider: means a substance use disorder clinic location that has received certification to be reimbursed as a DMC clinic by the state to provide services as described in Title 22, California Code of Regulations, Section 51341.1.

7.6.12 Collateral Services: means sessions with therapists or counselors and significant persons in the life of a beneficiary, focused on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary’s treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the beneficiary.

7.6.13 Complaint: means requesting to have a problem solved or have a decision changed because you are not satisfied. A complaint is sometimes called a grievance or an appeal.
7.6.14 Corrective Action Plan (CAP): means the written plan of action document which the Provider develops and submits to County and/or DHCS to address or correct a deficiency or process that is non-compliant with contract, laws, regulations, or standards.

7.6.15 County: means the county in which the provider physically provides covered substance use treatment services.

7.6.16 Crisis Intervention: means a contact between a therapist or counselor and a beneficiary in crisis. Services shall focus on alleviating crisis problems. Crisis means an actual relapse or an unforeseen event or circumstance, which present to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to stabilization of the beneficiary’s emergency situation.

7.6.17 Delivery System: DMC-Organized Delivery System is a Medi-Cal benefit in counties that choose to opt into and implement the Pilot program. DMC-ODS shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in a county that opts into the Pilot program. Upon approval of an implementation plan, the state shall contract with the county to provide DMC-ODS services. The county shall, in turn contract with DMC certified providers or provide county-operated services to provide all services outlined in the DMC-ODS. Counties may also contract with a managed care plan to provide services. Participating counties with the approval from the state may develop regional delivery systems for one or more of the required modalities or request flexibility in delivery system design or comparability of services. Counties may act jointly in order to deliver these services.

7.6.18 Discharge Services: means the process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services.

7.6.19 DMC-ODS Services: means those DMC services authorized by Title XIX or Title XXI of the Social Security Act. Title 22 Section 51341.1. W&I Code, Section 14124.24. and California’s Medicaid State Plan, including the DMC ODS 1115 Demonstration Waiver special terms and conditions.

7.6.20 Drug Medi-Cal Program: means the state system wherein beneficiaries receive covered services from DMC-certified substance use disorder treatment providers.

7.6.21 Drug Medi-Cal Termination of Certification: means the provider is no longer certified to participate in the Drug Medi-Cal program upon the state’s issuance of a Drug Medi-Cal certification termination notice.

7.6.22 Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT): means the federally mandated Medicaid benefit that entitles full-scope Medi-Cal covered beneficiaries less than 21 years of age to receive any Medicaid service necessary to correct or ameliorate a defect, mental illness, or other condition, such as a substance-related disorder, that is discovered during a health screening.

7.6.23 Education and Job Skills: means linkages to life skills, employment services, job training, and education services.

7.6.24 Emergency Medical Condition: means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, for a pregnant woman, the health of the woman of her unborn child) in serious jeopardy.
• Serious impairment to bodily functions.
• Serious dysfunction of any bodily organ or part.

7.6.25 Emergency Services: mans covered inpatient and outpatient services that are as follows:
  • Furnished by a provider that is qualified to furnish these services under this Title.
  • Needed to evaluate or stabilize an emergency medical condition.

7.6.26 Excluded Services: means services that are not covered under the DMC-ODS Waiver.

7.6.27 Face-to-Face: means a service occurring in person.

7.6.28 Family Support: means linkages to childcare, parent education, child development support services, and family and marriage education. Family support is only available under Recovery services.

7.6.29 Family Therapy: means including a beneficiary’s family members and loved ones in the treatment process, and education about factors that are important to the beneficiary’s recovery as well as their own recovery can be conveyed. Family members may provide social support to beneficiaries, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.

7.6.30 Fair Hearing: means the state hearing provided to beneficiaries upon denial of appeal pursuant to 22 CCR 50951 and 50953 and 9 CCR 1810.216.6 Fair hearings shall comply with 42 CFR 431.220(a)(5), 438.408(f), 438.414, and 438.10(g)(1).

7.6.31 Final Settlement: means permanent settlement of the Provider’s actual allowable costs or expenditures as determined at the time of audit, which shall be completed within three years of the date the year-end cost settlement report was accepted for interim settlement by the state. If the audit is not completed within three years, the interim settlement shall be considered as the final settlement.

7.6.32 Fraud: means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or state law.

7.6.33 Grievance: means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee’s rights regardless of whether remedial action is requested. Grievance includes an enrollee’s right to dispute an extension of time proposed by the County to make an authorization decision.

7.6.34 Grievance and Appeal System: means the processes the County implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.

7.6.35 Group Counseling: means contacts in which one or more therapists or counselors treat two or more beneficiaries at the same time with a maximum of 12 in the group, focusing on the needs of the individuals served. A beneficiary that is 17 years of age or younger shall not participate in-group counseling with any participants who are 18 years of age or older. However, a beneficiary who is 17 years of age or younger may participate in group counseling with participants who are 18 years of age or older when the counseling is at a provider’s certified school site.
Hospitalization: means that a beneficiary needs a supervised recovery period in a facility that provides hospital inpatient care.

Individual Counseling: means contact between a beneficiary and a therapist or counselor. Services provided in-person, by telephone or by telehealth qualify as Medi-Cal reimbursable units of service, and are reimbursed without distinction.

Intake: means the process of determining a beneficiary meets the medical necessity criteria and a beneficiary is admitted into a substance use disorder treatment program. Intake includes the evaluation or analysis of the cause or nature of mental, emotional, psychological, behavioral, and substance use disorders. and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing (e.g. body specimen screening) necessary for substance use disorder treatment and evaluation.

Intensive Outpatient Treatment: means (ASAM Level 2.1) structured programming services consisting primarily of counseling and education about addiction-related problems a minimum of nine (9) hours with a maximum of 19 hours per week for adults, and a minimum of six (6) hours with a maximum of 19 hours per week for adolescents. Services may be provided in any appropriate setting in the community. Services may be provided in-person, by telephone or by telehealth.

Licensed Practitioners of the Healing Arts (LPHA) includes: Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Work (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

Medical Necessity and Medical Necessary Services: means those SUD treatment services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of a disease, illness or injury consistent with and 42 CFR 438.210(a)(4) or, in the case of EPSDT, services that meet the criteria specified in Title 22, Sections 51303 and 51340.1.

Medical Necessity Criteria: means adult beneficiaries must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, and must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria. Youth under 21 may be assessed to be at risk for developing a substance use disorder, and if applicable, must meet the ASAM adolescent treatment criteria. Beneficiaries under age 21 are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, beneficiaries under age 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health.

Medical Psychotherapy: means a type of counseling service that has the same meaning as defined in 9 CCR § 10345.

Medication Services: means the prescription or administration of medication related to substance use disorder treatment services, or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services.

Opioid (Narcotic) Treatment Program: means an outpatient clinic licensed by the state to provide narcotic replacement therapy directed at stabilization and rehabilitation of persons who are opiate-addicted and have a substance use diagnosis.
7.6.46 Naltrexone Treatment Services: means an outpatient treatment service directed at serving detoxified opiate addicts by using the drug Naltrexone, which blocks the euphoric effects of opiates and helps prevent relapse to opiate addiction.

7.6.47 Network: means the group of entities that have contracted with the County to provide services under the DMC-ODS Waiver.

7.6.48 Network Provider: means any provider, group of providers, or entity that has a network provider agreement with the County and receives Medicaid funding directly or indirectly to order, refer or render covered services.

7.6.49 Non-Perinatal Residential Program: services are provided in DHCS licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria. These residential services are provided to the non-perinatal population and do not require the enhanced services found in the perinatal residential programs.

7.6.50 Notice of Adverse Benefit Determination: means a formal communication of any action and consistent with 42 CFR 438.404 and 438.10.

7.6.51 Observation: means the process of monitoring the beneficiary’s course of withdrawal. It is to be conducted as frequently as deemed appropriate for the beneficiary and the level of care the beneficiary is receiving. This may include but is not limited to observation of the beneficiary’s health status.

7.6.52 Outpatient Services: means (ASAM Level 1.0) outpatient service directed at stabilizing and rehabilitating persons up to nine hours of service per week for adults, and less than six hours per week for adolescents.

7.6.53 Overpayment: means any payment to a network provider by County to which the network provider is not entitled to under Title XIX of the Act or any payment to County by State to which the County is not entitled to under Title XIX of the Act.

7.6.54 Beneficiary Education: means providing research based education on addiction, treatment, recovery and associated health risks.

7.6.55 Participating Provider: means a provider that is engaged in the continuum of services under this Agreement.

7.6.56 Perinatal DMC Services: means covered services as well as mother/child habilitative and rehabilitative services, services access (i.e., provision or arrangement of transportation to and from medically necessary treatment), education to reduce harmful effects of alcohol and drugs on the mother and fetus or infant, and coordination of ancillary services (Title 22, Section 51341.1(c)(4).

7.6.57 Physician: as it pertains to the supervision, collaboration, and oversight requirements. A doctor of medicine or osteopathy legally authorized to practice medicine or surgery in the State in which the function is performed.

7.6.58 Physician Services: means services provided by an individual licensed under state law to practice medicine.

7.6.59 Postpartum: as defined for DMC purposes, means the 60-day period beginning on the last day of pregnancy, regardless of whether other conditions of eligibility are met. Eligibility for perinatal services shall end on the last day of the calendar month in which the 60th day occurs.
7.6.60 Postservice Postpayment (PSPP) Utilization Review: means the review for program compliance and medical necessity conducted by the state after service was rendered and paid. DHCS may recover prior payments of Federal and State funds if such a review determines that the services did not comply with applicable statutes, regulations, or terms under the DMC-ODS Waiver.

7.6.61 Preauthorization: means approval by County that a covered service is medically necessary.

7.6.62 Prescription Drugs: means simple substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are:

- Prescribed by a physician or other licensed practitioner of the healing arts within the scope of this professional practice as defined and limited by Federal and State law.
- Dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act. and
- Dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist’s or practitioner’s records.

7.6.63 Primary Care: means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

7.6.64 Primary Care Physician (PCP): means a Physician responsible for supervising, coordinating, and providing initial and Primary Care to beneficiaries and serves as the medical home for members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist.

7.6.65 Primary Care Provider: means a person responsible for supervising, coordinating, and providing initial and Primary Care to beneficiaries, for initiating referrals, and for maintaining the continuity of beneficiary care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.

7.6.66 Projected Units of Service: means the number of reimbursable DMC units of service, based on historical data and current capacity, the Provider expects to provide on an annual basis.

7.6.67 Provider: means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the state in which it delivers the services.

7.6.68 Re-Certification: means the process by which the DMC certified clinic is required to submit an application and specified documentation, as determined by DHCS, to remain eligible to participate in and be reimbursed through the DMC program. Re-certification shall occur no less than every five years from the date of previous DMC certification or re-certification.

7.6.69 Recovery Monitoring: means recovery coaching, monitoring via telephone and internet. Recovery monitoring is only available in Recovery services.

7.6.70 Recovery Services: are available after the beneficiary has completed a course of treatment. Recovery services emphasize the beneficiary’s central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to beneficiaries.
7.6.71 Rehabilitation Services: includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under state law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible function level.

7.6.72 Relapse: means a single instance of a beneficiary’s substance use or a beneficiary’s return to a pattern of substance use.

7.6.73 Relapse Trigger: means an event, circumstance, place or person that puts a beneficiary at risk of relapse.

7.6.74 Residential Treatment Services: means a non-institutional, 24-hour non-medical, short-term residential program of any size that provides rehabilitation services to beneficiaries. Each beneficiary shall live on the premises and shall be supported in their efforts to restore, maintain, and apply interpersonal and independent living skills, and access community support systems. Programs shall provide a range of activities and services. Residential treatment shall include 24-hour structure with available trained personnel, seven days a week, including a minimum of five (5) hours of clinical service a week to prepare beneficiary for outpatient treatment.

7.6.75 Safeguarding Medications: means facilities will store all resident medication and facility staff members may assist with resident’s self-administration of medication.

7.6.76 Service Authorization Request: means a beneficiary’s request for the provision of a service.

7.6.77 Short-Term Resident: means any beneficiary receiving residential services pursuant to DMC-ODS, regardless of the length of stay, are a “short-term resident” of the residential facility in which they are receiving the services.

7.6.78 State: means the Department of Health Care Services or DHCS.

7.6.79 Subcontract: means an agreement between the County and its subcontractors (Providers). A subcontractor shall not delegate its obligation to provide covered services or otherwise subcontract for the provision of direct beneficiary/beneficiary services.

7.6.80 Subcontractor (Provider): means an individual or entity that is DMC certified and has entered into an agreement with the County to be a provider of covered services. It may also mean a vendor who has entered into a procurement agreement with the County to provide any of the administrative functions related to fulfilling the County’s DMC-ODS Waiver obligations.

7.6.81 Substance Abuse Assistance: means peer-to-peer services and relapse prevention. Substance abuse assistance is only available in Recovery Services.

7.6.82 Substance Use Disorder Diagnosis: are those set forth in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, published by the American Psychiatric Association.

7.6.83 Support Groups: means linkages to self-help and support, spiritual and faith based support.

7.6.84 Support Plan: means a list of individuals and/or organizations that can provide support and assistance to a beneficiary to maintain sobriety.

7.6.85 Telehealth between Provider and Beneficiary: means office or outpatient visits via interactive audio and video telecommunication systems.

7.6.86 Telehealth between Providers: means communication between two providers for purposes of consultation, performed via interactive audio and video telecommunications systems.
Temporary Suspension: means the provider is temporarily suspended from participating in the DMC program as authorized by W&I Code, Section 14043.36(a). The provider cannot bill for DMC services from the effective date of the temporary suspension.

Threshold Language: means a language that has been identified as the primary language, indicated on the Medi-Cal Eligibility System (MEDS), of 3000 beneficiaries or five percent of the beneficiary population whichever is lower, in an identified geographic area. Santa Barbara County’s threshold language is Spanish.

Transportation Services: means provision of or arrangement for transportation to and from medically necessary treatment.

Unit of Service: For case management, intensive outpatient treatment, outpatient services, Naltrexone treatment services, and recovery services contact with a beneficiary in 15-minute increments on a calendar day.

- For additional medication assisted treatment, physician services that includes ordering, prescribing, administering, and monitoring of all medications for substance use disorders per visit or in 15-minute increments.
- For narcotic treatment program services, a calendar month of treatment services provided pursuant to this section and Chapter 4 commencing with 9 CCR § 10000.
- For physician consultation services, consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists in 15-minute increments.
- For residential services, providing 24-hour daily service, per beneficiary, per bed rate.
- For withdrawal management per beneficiary per visit/daily unit of service.

Urgent Care: means a condition perceived by a beneficiary as serious, but not life threatening. A condition that disrupts normal activities of daily necessary, treatment within 24-72 hours.

Utilization: means the total actual units of service used by beneficiaries and participants.

Withdrawal Management: means detoxification services provided in either an ambulatory or non-ambulatory setting consistent with the ASAM level of care criteria to DMC ODS beneficiaries.
COUNTY OF SANTA BARBARA
DRUG MEDI-CAL ORGANIZED
DELIVERY SYSTEM (DMC-ODS)

BENEFICIARY HANDBOOK

Santa Barbara County
Department of Behavioral Wellness
Alcohol and Drug Program
http://www.countyofsb.org/behavioral-wellness/
English
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-868-1649, TTY: 711.

ATTENTION: Auxiliary aids and services, including but not limited to large print documents and alternative formats, are available to you free of charge upon request. Call 1-888-868-1649, TTY: 711.

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-868-1649, TTY: 711.

Tiếng Việt (Vietnamese)

Tagalog (Tagalog/Filipino)

한국어 (Korean)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-868-1649, TTY: 711。

Հայերեն (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսու մեք եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լ եզվական աջ ակց ու թյ ան ծ առայ ու թյ ու ններ:
Զանգահարեք 1-888-868-1649, TTY: 711:

Русский (Russian)

فارسی (Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسه‌های لا تزبانی بصورت رایگان ارای شما فراهم می‌باشد. با تکمیل 1-888-868-1649, TTY: 711.

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-868-1649, TTY: 711 まで、お電話にてご連絡ください。
**Hmoob (Hmong)**

**ਪੰਜਾਬੀ (Punjabi)**
ਪੰਜਾਬੀ ਵਿਚ ਵੇਲੇ ਹਨ, ਉਸਾਂ ਦੇ ਭਾਸ਼ਾ ਦੀ ਸਹਾਇਤਾ ਸੇਵਾ ਉਪਲਬਧ ਹੈ। 1-888-868-1649, TTY: 711. ਉੱਤਰ ਵਪਾਰ ਵਾਲੇ।

**العربية (Arabic)**

**हिंदी (Hindi)**
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-868-1649 (TTY: 711) पर कॉल करें।

**ภาษาไทย (Thai)**
เรียน:
ប្រយ័ត្ន៖ ររសើនជាអ្នកនិយាយភាសាខ្មែរ, រវាជំនួយមនុសា�企业提供服务时，可能会有不同方言。为客户提供服务，1-888-868-1649
(TTY: 711)។

ພາສາລາວ (Lao)
ໂປດຊາບ: ດ້າວ ຕ່າAGENT ທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ປ່ອຍ 1-888-868-1649 (TTY: 711).
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GENERAL INFORMATION

Emergency Services

Emergency services are covered 24 hours a day and 7 days a week. If you think you are having a health related emergency, call 911 or go to the nearest emergency room for help.

Emergency Services are services provided for an unexpected medical condition, including a psychiatric emergency medical condition.

An emergency medical condition is present when you have symptoms that cause severe pain or a serious illness or an injury, which a prudent layperson (a careful or cautious non-medical person) believes, could reasonably expect without medical care could:

- Put your health in serious danger, or
- If you are pregnant, put your health or the health of your unborn child in serious danger,
- Cause serious harm to the way your body works, or
- Cause serious damage to any body organ or part.

You have the right to use any hospital in the case of emergency. Emergency services never require authorization.

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Who Do I Contact If I’m Having Suicidal Thoughts?
If you or someone you know is in crisis, please call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255).

For local residents seeking assistance in a crisis and to access local mental health programs, please call 1-888-868-1649.

**Why Is It Important To Read This Handbook?**

We welcome you to Santa Barbara County Substance Use Disorder (SUD) treatment services and to the Drug Medi-Cal Organized Delivery System (DMC-ODS). We provide a full range of alcohol and other drug (AOD) treatment options for people who live in Santa Barbara County. If you feel you or someone close to you needs help reducing alcohol and or other drug related harm, and are eligible for Medi-Cal/Drug Medi-Cal, please read this handbook carefully. It contains important information.

It is important that you understand how the Drug Medi-Cal Organized Delivery System (DMC-ODS) plan works so you can get the care you need. This handbook explains your benefits and how to get care. It will also answer many of your questions.

You will learn:
- How to receive substance use disorder (SUD) treatment services through your county DMC-ODS plan
- What benefits you have access to
- What to do if you have a question or problem
- Your rights and responsibilities as a member of your county DMC-ODS plan

If you don’t read this handbook now, you should keep this handbook so you can read it later. Use this handbook as an addition to the member handbook that you received when you enrolled in your current Medi-Cal benefit. That could be with a Medi-Cal managed care plan or with the regular Medi-Cal “Fee for Service” program.

**As A Member Of Your County DMC-ODS Plan, Your County Plan Is Responsible For...**

- Figuring out if you are eligible for DMC-ODS services from the county or its provider network.
- Coordinating your care.
- Providing a toll-free phone number that is answered 24 hours a day and 7 days a week that can tell you about how to get services from the county plan. You can also contact the county plan at this number to request availability of after-hours care.
- Having enough providers to make sure that you can get the SUD treatment services covered by the county plan if you need them.
- Informing and educating you about services available from your county plan.
- Providing you services in your language or by an interpreter (if necessary) free of charge and letting you know that these interpreter services are available.
• Providing you with written information about what is available to you in other languages or forms. We provide information and treatment services in Spanish and English, as well as culturally and linguistically adapted supports, including services for the visually and hearing impaired and for beneficiaries with limited reading ability, that respond effectively to the diverse needs of all individuals.

• Providing you with notice of any significant change in the information specified in this handbook at least 30 days before the intended effective date of the change. A change would be considered significant when there is an increase or decrease in the amount or type of services that are available, or if there is an increase or decrease in the number of network providers, or if there is any other change that would impact the benefits you receive through the County Plan.

• Informing you if any contracted provider refuses to perform or otherwise support any covered service due to moral, ethical, or religious objections and informing you of alternative providers that do offer the covered service.

If you or someone close to you may need help to cope with alcohol and or other drug use, please call our toll free twenty-four hour 24/7 Access Line @ (888) 868-1649 for a screening and referral.

Information For Members Who Need Materials In A Different Language

Information is In SUD Provider lobbies, available in Spanish and English, and at http://www.countyofsb.org/behavioral-wellness/qcmconsumer.sbc
For additional languages, contact (805) 681-5220.

Information For Members Who Have Trouble Reading

Information is In SUD Provider lobbies, available in Spanish and English, and at http://www.countyofsb.org/behavioral-wellness/qcmconsumer.sbc

Information For Members Who Are Hearing Impaired

Information is In SUD Provider lobbies, available in Spanish and English, and at http://www.countyofsb.org/behavioral-wellness/qcmconsumer.sbc

Information For Members Who Are Vision Impaired

Information is In SUD Provider lobbies, available in Spanish and English, and at http://www.countyofsb.org/behavioral-wellness/qcmconsumer.sbc

Notice Of Privacy Practices

Information is in SUD Provider lobbies, and at: http://www.countyofsb.org/behavioral-wellness/hipaa-privacy.sbc
Who Do I Contact If I Feel That I Was Discriminated Against?

Discrimination is against the law. The State of California and DMC-ODS comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. DMC-ODS:

- Provides free aids and services to people with disabilities, such as:
  - Qualified sign language interpreters
  - Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified oral interpreters
  - Information in threshold languages

If you need these services, contact your County Plan.

If you believe that the State of California or DMC-ODS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Patients’ Rights Office
Attention: Kay Kizer-Waldo
300 N. San Antonio Rd
Santa Barbara, CA 93101
Phone- 1-805-681-4735, 1-805-934-6548
Fax- 1-805-681-5262
Email- kjeffer@co.santa-barbara.ca.us

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Kay Kizer Waldo, Patients’ Rights Advocate, is available to help you.

You can also file a civil rights complaint electronically with the U.S. Department of Health and Human Services, Office for Civil Rights through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf. You can file a civil rights complaint by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Phone- 1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at [https://www.hhs.gov/ocr/complaints/index.html](https://www.hhs.gov/ocr/complaints/index.html).

**SERVICES**

**What Are DMC-ODS Services?**

DMC-ODS services are health care services for people who have at least one SUD that the regular doctor cannot treat.

DMC-ODS services include:
- Outpatient Services
- Intensive Outpatient Treatment
- Partial Hospitalization (only available in some counties)
- Residential Treatment (subject to prior authorization by the county)
- Withdrawal Management
- Opioid Treatment
- Medication Assisted Treatment (varies by county)
- Recovery Services
- Case Management

If you would like to learn more about each DMC-ODS service that may be available to you, see the descriptions below:

- **Outpatient Services**
  - Counseling services are provided to members up to nine hours a week for adults and less than six hours a week for adolescents when determined to be medically necessary and in accordance with an individualized client plan. Services can be provided by a licensed professional or a certified counselor in any appropriate setting in the community.
  - Outpatient Services includes intake and assessment, treatment planning, individual counseling, group counseling, family therapy, collateral services, member education, medication services, crisis intervention services, and discharge planning.
  - When medically necessary, case management and recovery services are also available.
  - The length of treatment is determined on an individual a case by case basis and takes into consideration the severity of the challenges and the supports required to benefit from treatment.

- **Intensive Outpatient Treatment**
  - Intensive Outpatient Treatment services are provided to members (a minimum of nine hours with a maximum of 19 hours a week for adults and a minimum of six hours with a maximum of 19 hours a week for adolescents) when determined
to be medically necessary and in accordance with an individualized client plan. Services consist primarily of counseling and education about addiction-related problems. Services can be provided by a certified counselor in any appropriate setting in the community.

- Intensive Outpatient Treatment Services include the same components as Outpatient Services. The increased number of hours of service are the main difference.
- When medically necessary, case management and recovery services are also available.
- The length of treatment is determined on a case by case basis and takes into consideration the severity of the challenges and the supports required to benefit from treatment.

- **Partial Hospitalization** (only available in some counties)
  - Partial Hospitalization services feature 20 or more hours of clinically intensive programming per week, as specified in the member’s treatment plan. Partial hospitalization programs typically have direct access to psychiatric, medical, and laboratory services, and are to meet the identified needs which warrant daily monitoring or management but which can be appropriately addressed in a structured outpatient setting.
  - Partial Hospitalization services are similar to Intensive Outpatient Services, with an increase in number of hours and additional access to medical services being the main differences.
  - Partial Hospitalization services are not currently available in Santa Barbara County.

- **Residential Treatment** (subject to authorization by the county)
  - Residential Treatment is a non-institutional, 24-hour non-medical, short-term residential program that provides rehabilitation services to members with a SUD diagnosis when determined as medically necessary and in accordance with an individualized treatment plan. Each member shall live on the premises and shall be supported in their efforts to restore, maintain and apply interpersonal and independent living skills and access community support systems. Providers and residents work collaboratively to define barriers, set priorities, establish goals, create treatment plans, and solve SUD related problems. Goals include sustaining abstinence, preparing for relapse triggers, improving personal health and social functioning, and engaging in continuing care.
  - Residential services require prior authorization by the county plan. Each authorization for residential services can be for a maximum of 90 days for adults and 30 days for youth. Only two authorizations for residential services are allowed in a one-year-period. It is possible to have one 30-day extension per year based on medical necessity. Pregnant women can receive residential services through the last day of the month that the 60th day after delivery
Early Periodic Screening, Diagnosis, and Treatment (EPSDT) eligible members (under the age of 21) will not have the authorization limits described above as long as medical necessity establishes the need for ongoing residential services.

- Residential Services includes intake and assessment, treatment planning, individual counseling, group counseling, family therapy, collateral services, member education, medication services, safeguarding medications (facilities will store all resident medication and facility staff members may assist with resident’s self-administration of medication), crisis intervention services, transportation (provision of or arrangement for transportation to and from medically necessary treatment) and discharge planning.

- When medically necessary, case management and recovery services are also available.

- The length of residential treatment is no longer than ninety (90) days, taking into consideration the severity of the challenges and the supports required to benefit from treatment.

- Depending on medical necessity, residential treatment may be followed with a referral to outpatient treatment where indicated and if client is amenable.

- **Withdrawal Management**
  - Withdrawal Management services are provided when determined as medically necessary and in accordance with an individualized client plan. Each member shall reside at the facility if receiving a residential service and will be monitored during the detoxification process. Medically necessary habilitative and rehabilitative services are provided in accordance with an individualized client plan prescribed by a licensed physician, or licensed prescriber and approved and authorized according to the State of California requirements.
  - Withdrawal Management Services include intake and assessment, observation (to evaluate health status and response to any prescribed medication), medication services, and discharge planning.
  - Most Withdrawal management services last from five (5) to seven (7) days, after which clients are placed into a treatment level that best suits their needs.

- **Opioid Treatment**
  - Opioid (Narcotic) Treatment Program (OTP/NTP) services are provided in NTP licensed facilities. Medically necessary services are provided in accordance with an individualized client plan determined by a licensed physician or licensed prescriber, and approved and authorized according to the State of California requirements. OTPs/NTPs are required to offer and prescribe medications to members covered under the DMC-ODS formulary including Methadone, Buprenorphine, Naloxone, and Disulfiram.
• A member must receive, at a minimum, 50 minutes of counseling sessions with a therapist or counselor for up to 200 minutes per calendar month, although additional services may be provided based on medical necessity.
• Opioid Treatment Services include the same components as Outpatient Treatment Services, with the inclusion of medical psychotherapy consisting of a face-to-face discussion conducted by a physician on a one-on-one basis with the member.
• Depending on the severity of the opioid use disorder, the length of treatment can last months to years, and is heavily focused on relapse prevention.

- **Medication Assisted Treatment** (varies by county)
  - Medication Assisted Treatment (MAT) Services are available outside of the OTP clinic. MAT is the use of prescription medications, in combination with counseling and behavioral therapies, to provide a whole-person approach to the treatment of SUD. Providing this level of service is optional for participating counties.
  - MAT services includes the ordering, prescribing, administering, and monitoring of all medications for SUD. Opioid and alcohol dependence, in particular, have well established medication options. Physicians and other prescribers may offer medications to members covered under the DMC-ODS formulary including Buprenorphine, Naloxone, Disulfiram, Vivitrol, Acamprosate, or any FDA approved medication for the treatment of SUD.
  - MAT services can be provided to clients who may not engage or succeed in treatment and recovery services without medication(s). The length of MAT is determined on an individual case by case basis and takes into consideration the severity of client challenges and the supports required to benefit from treatment.

- **Recovery Services**
  - Recovery Services are important to the member’s recovery and wellness. The treatment community becomes a therapeutic agent through which members are empowered and prepared to manage their health and health care. Therefore, treatment must emphasize the member’s central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to members.
  - Recovery Services include individual and group counseling; recovery monitoring/substance abuse assistance (recovery coaching, relapse prevention, and peer-to-peer services); and case management (linkages to educational, vocational, family supports, community-based supports, housing, transportation, and other services based on need).
  - Recovery services are often provided by trained peers or those whose life experiences can be helpful to another client’s recovery.
• Recovery services are not needed for clients who can successfully engage in recovery without them. These services must be medically necessary and will typically last from three (3) to six (6) months.

• **Case Management**
  - Case Management Services assist a member to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. These services focus on coordination of SUD care, integration around primary care especially for members with a chronic SUD, and interaction with the criminal justice system, if needed.
  - Case Management Services include a comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of case management services; transitions to higher or lower levels of SUD care; development and periodic revision of a client plan that includes service activities; communication, coordination, referral and related activities; monitoring service delivery to ensure member access to service and the service delivery system; monitoring the member’s progress; and, member advocacy, linkages to physical and mental health care, transportation and retention in primary care services.
  - Case management shall be consistent with and shall not violate confidentiality of any member as set forth in Federal and California law.
  - It is anticipated that most clients will not need CM services, as they can engage and benefit from treatment and recovery without these services. CM is usually provided to clients who are adolescents, pregnant and parenting, have co-occurring mental and or physical health issues, and or whose complex needs require more than standard treatment and recovery services.

**Early Periodic Screening, Diagnosis, and Treatment (EPSDT)**

If you are under 21 years of age, you may receive additional medically necessary services under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). EPSDT services include screening, vision, dental, hearing and all other medically necessary mandatory and optional services listed in federal law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered for adults. The requirement for medical necessity and cost effectiveness are the only limitations or exclusions that are applicable to EPSDT services.

For a more complete description of the EPSDT services that are available and to have your questions answered, please call the County of Santa Barbara Be Well Member Services 1-888 868-1649.

**HOW TO GET DMC-ODS SERVICES**
How Do I Get DMC-ODS Services?

If you think you need substance use disorder (SUD) treatment services, you can get services by asking the county plan for them yourself. You can call your county toll-free phone number listed in the front section of this handbook. You may also be referred to your county plan for SUD treatment services in other ways. Your county plan is required to accept referrals for SUD treatment services from doctors and other primary care providers who think you may need these services and from your Medi-Cal managed care health plan, if you are a member. Usually the provider or the Medi-Cal managed care health plan will need your permission or the permission of the parent or caregiver of a child to make the referral, unless there is an emergency. Other people and organizations may also make referrals to the county, including schools; county welfare or social services departments; conservators, guardians or family members; and law enforcement agencies.

The covered services are available through the County of Santa Barbara Behavioral Wellness Department provider network. If any contracted provider raises an objection to performing or otherwise supporting any covered service, County of Santa Barbara Alcohol and Drug Program (ADP) will arrange for another provider to perform the service. The County of Santa Barbara Behavioral wellness Department will respond with timely referrals and coordination in the event that a covered service is not available from a provider because of religious, ethical or moral objections to the covered service.

Clients will be placed into a specific level of care that best matches their needs per ASAM Criteria. As client needs fluctuate, the level of care or intensity of treatment will change. The County of Santa Barbara has specific policies and procedures to transition clients from one level of care to another as needs change. Care will be taken to ensure that the transition or movement from one level of care to another is seamless and client centered.

Where Can I Get DMC-ODS Services?

The County of Santa Barbara Behavioral Wellness Department is participating in the DMC-ODS pilot program. Since you are a resident of Santa Barbara County, you can get DMC-ODS services in the county where you live through the DMC-ODS county plan. Your county plan has SUD treatment providers available to treat conditions that are covered by the plan. Other counties that provide Drug Medi-Cal services that are not participating in the DMC-ODS pilot will be able to provide regular DMC services to you if needed. If you are under 21 years of age, you are also eligible for EPSDT services in any other county across the state.

After Hours Care
Substance use / alcohol and other drug services can be accessed in English or Spanish after hours by calling our 24/7 ACCESS LINE Toll-Free @ 888-868-1649.

How Do I Know When I Need Help?
Many people have difficult times in life and may experience SUD problems. The most important thing to remember when asking yourself if you need professional help is to trust yourself. If you are eligible for Medi-Cal, and you think you may need professional help, you should request an assessment from your county plan to find out for sure since you currently reside in a DMC-ODS participating county.

**How Do I Know When A Child or Teenager Needs Help?**

You may contact your participating county DMC-ODS plan for an assessment for your child or teenager if you think he or she is showing any of the signs of a SUD. If your child or teenager qualifies for Medi-Cal and the county assessment indicates that drug and alcohol treatment services covered by the participating county are needed, the county will arrange for your child or teenager to receive the services.

**HOW TO GET MENTAL HEALTH SERVICES**

**Where Can I Get Specialty Mental Health Services?**

You can get specialty mental health services in the county where you live. Each county has specialty mental health services for children, youth, adults, and older adults. If you are under 21 years of age, you are eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT), which may include additional coverage and benefits.

Your MHP will determine if you need specialty mental health services. If you do need specialty mental health services, the MHP will refer you to a mental health provider. For more information, please call 1-888-868-1649.

**MEDICAL NECESSITY**

**What Is Medical Necessity And Why Is It So Important?**

One of the conditions necessary for receiving SUD treatment services through your county’s DMC-ODS plan is something called ‘medical necessity.’ This means a doctor or other licensed professional will talk with you to decide if there is a medical need for services, and if you can be helped by services if you receive them.

The term medical necessity is important because it will help decide if you are eligible for DMC-ODS services, and what kind of DMC-ODS services are appropriate. Deciding medical necessity is a very important part of the process of getting DMC-ODS services.
What Are The ‘Medical Necessity’ Criteria For Coverage Of Substance Use Disorder Treatment Services?

As part of deciding if you need SUD treatment services, the county DMC-ODS plan will work with you and your provider to decide if the services are a medical necessity, as explained above. This section explains how your participating county will make that decision.

In order to receive services through the DMC-ODS, you must meet the following criteria:

- You must be enrolled in Medi-Cal.
- You must reside in a county that is participating in the DMC-ODS.
- You must have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for a Substance-Related and Addictive Disorder with certain exceptions for the youth under 21, be assessed as ‘at-risk’ for developing a SUD.
- You must meet the American Society of Addiction Medicine (ASAM) definition of medical necessity for services based on the ASAM Criteria (ASAM Criteria are national treatment standards for addictive and substance-related conditions).

You don’t need to know if you have a diagnosis to ask for help. Your county DMC-ODS plan will help you get this information and will determine medical necessity with an assessment.

SELECTING A PROVIDER

How Do I Find A Provider For The Substance Use Disorder Treatment Services I Need?

The county plan may put some limits on your choice of providers. Your county DMC-ODS plan must give you a chance to choose between at least two providers when you first start services, unless the county plan has a good reason why it can’t provide a choice, for example, there is only one provider who can deliver the service you need. Your county plan must also allow you to change providers. When you ask to change providers, the county must allow you to choose between at least two providers, unless there is a good reason not to do so.

Sometimes county contract providers leave the county network on their own or at the request of the county plan. When this happens, the county plan must make a good faith effort to give written notice of termination of a county contracted provider within 15 days after receipt or issuance of the termination notice, to each person who was receiving SUD treatment services from the provider.

Once I Find a Provider, Can the County Plan Tell the Provider What Services I Get?

You, your provider, and the county plan are all involved in deciding what services you need to receive through the county by following the medical necessity criteria and the list of covered services. Sometimes the county will leave the decision to you and the provider. Other times, the county plan may require your provider to ask the county plan to review the reasons the
provider thinks you need a service before the service is provided. The county plan must use a qualified professional to do the review. This review process is called a plan payment authorization process.

The county plan’s authorization process must follow specific timelines. For a standard authorization, the plan must make a decision on your provider’s request within 14 calendar days. If you or your provider request or if the county plan thinks it is in your interest to get more information from your provider, the timeline can be extended for up to another 14 calendar days. An example of when an extension might be in your interest is when the county thinks it might be able to approve your provider’s request for authorization if the county plan had additional information from your provider and would have to deny the request without the information. If the county plan extends the timeline, the county will send you a written notice about the extension.

If the county doesn’t make a decision within the timeline required for a standard or an expedited authorization request, the county plan must send you a Notice of Adverse Benefit Determination telling you that the services are denied and that you may file an appeal or ask for a State Fair Hearing.

You may ask the county plan for more information about its authorization process. Check the front section of this handbook to see how to request the information.

If you don’t agree with the county plan’s decision on an authorization process, you may file an appeal with the county or ask for a State Fair Hearing.

**Which Providers Does My DMC-ODS Plan Use?**

If you are new to the county plan, a complete list of providers in your county plan can be found at the end of this handbook and contains information about where providers are located, the SUD treatment services they provide, and other information to help you access care, including information about the cultural and language services that are available from the providers. If you have questions about providers, call your county toll-free phone number located in the front section of this handbook.

**NOTICE OF ADVERSE BENEFIT DETERMINATION**

**What is a Notice of Adverse Benefit Determination?**

A Notice of Adverse Benefit Determination, sometimes called a NOABD, is a form that your county DMC-ODS plan uses to tell you when the plan makes a decision about whether or not you will get Medi-Cal SUD treatment services. A Notice of Adverse Benefit Determination is also used to tell you if your grievance, appeal, or expedited appeal was not resolved in time, or if you didn’t get services within the county plan’s timeline standards for providing services.
When Will I Get A Notice Of Adverse Benefit Determination?

You will get a Notice of Adverse Benefit Determination:

• If your county plan or one of the county plan providers decides that you do not qualify to receive any Medi-Cal SUD treatment services because you do not meet the medical necessity criteria.
• If your provider thinks you need a SUD service and asks the county plan for approval, but the county plan does not agree and denies your provider’s request, or changes the type or frequency of service. Most of the time you will receive a Notice of Adverse Benefit Determination before you receive the service, but sometimes the Notice of Adverse Benefit Determination will come after you already received the service, or while you are receiving the service. If you get a Notice of Adverse Benefit Determination after you have already received the service you do not have to pay for the service.
• If your provider has asked the county plan for approval, but the county plan needs more information to make a decision and doesn’t complete the approval process on time.
• If your county plan does not provide services to you based on the timelines the county plan has set up. Call your county plan to find out if the county plan has set up timeline standards.
• If you file a grievance with the county plan and the county plan does not get back to you with a written decision on your grievance within 90 days. If you file an appeal with the county plan and the county plan does not get back to you with a written decision on your appeal within 30 days or, if you filed an expedited appeal, and did not receive a response within three working days.

Will I Always Get A Notice of Adverse Benefit Determination When I Don’t Get The Services I Want?

There are some cases where you may not receive a Notice of Adverse Benefit Determination. You may still file an appeal with the county plan or if you have completed the appeal process, you can request a state fair hearing when these things happen. Information on how to file an appeal or request a fair hearing is included in this handbook. Information should also be available in your provider’s office.

What Will The Notice of Adverse Benefit Determination Tell Me?

The Notice of Adverse Benefit Determination will tell you:

• What your county plan did that affects you and your ability to get services.
• The effective date of the decision and the reason the plan made its decision.
• The state or federal rules the county was following when it made the decision.
• What your rights are if you do not agree with what the plan did.
• How to file an appeal with the plan.
• How to request a State Fair Hearing.
• How to request an expedited appeal or an expedited fair hearing.
• How to get help filing an appeal or requesting a State Fair Hearing.
• How long you have to file an appeal or request a State Fair Hearing.
• If you are eligible to continue to receive services while you wait for an Appeal or State Fair Hearing decision.
• When you have to file your Appeal or State Fair Hearing request if you want the services to continue.

**What Should I Do When I Get A Notice Of Adverse Benefit Determination?**

When you get a Notice of Adverse Benefit Determination you should read all the information on the form carefully. If you don’t understand the form, your county plan can help you. You may also ask another person to help you.

You can request a continuation of the service that has been discontinued when you submit an appeal or a request for State Fair Hearing. You must request the continuation of services no later than 10 days after receiving a Notice of Adverse Benefit Determination or before the effective date of the change.

**PROBLEM RESOLUTION PROCESSES**

**What If I Don’t Get the Services I Want From My County DMC-ODS Plan?**

Your county plan has a way for you to work out a problem about any issue related to the SUD treatment services you are receiving. This is called the problem resolution process and it could involve the following processes.

1. The Grievance Process – an expression of unhappiness about anything regarding your SUD treatment services.
2. The Appeal Process – review of a decision (denial or changes to services) that was made about your SUD treatment services by the county plan or your provider.
3. The State Fair Hearing Process – review to make sure you receive the SUD treatment services which you are entitled to under the Medi-Cal program.

Filing a grievance or appeal or a State Fair Hearing will not count against you and will not impact the services you are receiving. When your grievance or appeal is complete, your county plan will notify you and others involved of the final outcome. When your State Fair Hearing is complete, the State Hearing Office will notify you and others involved of the final outcome.

Learn more about each problem resolution process below.

**Can I Get Help To File An Appeal, Grievance Or State Fair Hearing?**
Your county plan will have people available to explain these processes to you and to help you report a problem either as a grievance, an appeal, or as a request for State Fair Hearing. They may also help you decide if you qualify for what’s called an ‘expedited’ process, which means it will be reviewed more quickly because your health or stability are at risk. You may also authorize another person to act on your behalf, including your SUD treatment provider.

If you would like help, call our 24/7 ACCESS LINE Toll-Free: 1- 888-868-1649. Screening and referral services can be provided in English and Spanish.

**What If I Need Help To Solve A Problem With My County DMC-ODS Plan But Don’t Want File A Grievance Or Appeal?**

You can get help from the State if you are having trouble finding the right people at the county to help you find your way through the system.

You may get free legal help at your local legal aid office or other groups. You can ask about your hearing rights or free legal aid from the Public Inquiry and Response Unit:

Call toll free: 1-800-952-5253
If you are deaf and use TDD, call: 1-800-952-8349

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**THE GRIEVANCE PROCESS**

**What Is A Grievance?**

A grievance is an expression of unhappiness about anything regarding your SUD treatment services that are not one of the problems covered by the appeal and State Fair Hearing processes.

The grievance process will:
- Involve simple, and easily understood procedures that allow you to present your grievance orally or in writing.
- Not count against you or your provider in any way.
- Allow you to authorize another person to act on your behalf, including a provider. If you authorize another person to act on your behalf, the county plan might ask you to sign a form authorizing the plan to release information to that person.
- Ensure that the individuals making the decisions are qualified to do so and not involved in any previous levels of review or decision-making.
- Identify the roles and responsibilities of you, your county plan and your provider.
- Provide resolution for the grievance in the required timeframes.

**When Can I File A Grievance?**
You can file a grievance with the county plan if you are unhappy with the SUD treatment services you are receiving from the county plan or have another concern regarding the county plan.

**How Can I File A Grievance?**

You may call your county plan’s toll-free phone number to get help with a grievance. The county will provide self-addressed envelopes at all the providers’ sites for you to mail in your grievance. Grievances can be filed orally or in writing. Oral grievances do not have to be followed up in writing.

**How Do I Know If The County Plan Received My Grievance?**

Your county plan will let you know that it received your grievance by sending you a written confirmation.

**When Will My Grievance Be Decided?**

The county plan must make a decision about your grievance within 90 calendar days from the date you filed your grievance. Timeframes may be extended by up to 14 calendar days if you request an extension, or if the county plan believes that there is a need for additional information and that the delay is for your benefit. An example of when a delay might be for your benefit is when the county believes it might be able to resolve your grievance if the county plan had a little more time to get information from you or other people involved.

**How Do I Know If The County Plan Has Made a Decision About My Grievance?**

When a decision has been made regarding your grievance, the county plan will notify you or your representative in writing of the decision. If your county plan fails to notify you or any affected parties of the grievance decision on time, then the county plan will provide you with a Notice of Adverse Benefit Determination advising you of your right to request a State Fair Hearing. Your county plan will provide you with a Notice of Adverse Benefit Determination on the date the timeframe expires.

**Is There A Deadline To File To A Grievance?**

You may file a grievance at any time.

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**THE APPEAL PROCESS (Standard and Expedited)**

Your county plan is responsible for allowing you to request a review of a decision that was made about your SUD treatment services by the plan or your providers. There are two ways you can request a review. One way is using the standard appeals process. The second way is by
using the expedited appeals process. These two forms of appeals are similar; however, there are specific requirements to qualify for an expedited appeal. The specific requirements are explained below.

What Is A Standard Appeal?

A standard appeal is a request for review of a problem you have with the plan or your provider that involves a denial or changes to services you think you need. If you request a standard appeal, the county plan may take up to 30 days to review it. If you think waiting 30 days will put your health at risk, you should ask for an ‘expedited appeal.’

The standard appeals process will:

- Allow you to file an appeal in person, on the phone, or in writing. If you submit your appeal in person or on the phone, you must follow it up with a signed written appeal. You can get help to write the appeal. If you do not follow-up with a signed written appeal, your appeal will not be resolved. However, the date that you submitted the oral appeal is the filing date.
- Ensure filing an appeal will not count against you or your provider in any way.
- Allow you to authorize another person to act on your behalf, including a provider. If you authorize another person to act on your behalf, the plan might ask you to sign a form authorizing the plan to release information to that person.
- Have your benefits continued upon request for an appeal within the required timeframe, which is 10 days from the date your Notice of Adverse Benefit Determination was mailed or personally given to you. You do not have to pay for continued services while the appeal is pending. If you do request continuation of the benefit, and the final decision of the appeal confirms the decision to reduce or discontinue the service you are receiving, you may be required to pay the cost of services furnished while the appeal was pending;
- Ensure that the individuals making the decisions are qualified to do so and not involved in any previous level of review or decision-making.
- Allow you or your representative to examine your case file, including your medical record, and any other documents or records considered during the appeal process, before and during the appeal process.
- Allow you to have a reasonable opportunity to present evidence and allegations of fact or law, in person or in writing.
- Allow you, your representative, or the legal representative of a deceased member’s estate to be included as parties to the appeal.
- Let you know your appeal is being reviewed by sending you written confirmation.
- Inform you of your right to request a State Fair Hearing, following the completion of the appeal process.

When Can I File An Appeal?

You can file an appeal with your county DMC-ODS Plan:
- If your county or one of the county contracted providers decides that you do not qualify to receive any Medi-Cal SUD treatment services because you do not meet the medical necessity criteria.
- If your provider thinks you need a SUD treatment service and asks the county for approval, but the county does not agree and denies your provider’s request, or changes the type or frequency of service.
- If your provider has asked the county plan for approval, but the county needs more information to make a decision and doesn’t complete the approval process on time.
- If your county plan doesn’t provide services to you based on the timelines the county plan has set up.
- If you don’t think the county plan is providing services soon enough to meet your needs.
- If your grievance, appeal or expedited appeal wasn’t resolved in time.
- If you and your provider do not agree on the SUD services you need.

**How Can I File An Appeal?**

You may call your County Plan’s toll-free phone number (1-888-868-1649) to get help with filing an appeal. The plan will provide self-addressed envelopes at all provider sites for you to mail in your appeal.

**How Do I Know If My Appeal Has Been Decided?**

Your county DMC-ODS plan will notify you or your representative in writing about their decision for your appeal. The notification will have the following information:

- The results of the appeal resolution process.
- The date the appeal decision was made.
- If the appeal is not resolved wholly in your favor, the notice will also contain information regarding your right to a State Fair Hearing and the procedure for filing a State Fair Hearing.

**Is There A Deadline To File An Appeal?**

You must file an appeal within 60 days of the date of the action you’re appealing when you get a Notice of Adverse Benefit Determination. Keep in mind that you will not always get a Notice of Adverse Benefit Determination. There are no deadlines for filing an appeal when you do not get a Notice of Adverse Benefit Determination; so you may file this type of appeal at any time.

**When Will A Decision Be Made About My Appeal?**

The county plan must decide on your appeal within 30 calendar days from when the county plan receives your request for the appeal. Timeframes may be extended by up to 14 calendar days if you request an extension, or if the county plan believes that there is a need for additional information and that the delay is for your benefit. An example of when a delay is for
your benefit is when the county believes it might be able to approve your appeal if the county plan had a little more time to get information from you or your provider.

**What If I Can’t Wait 30 Days For My Appeal Decision?**

The appeal process may be faster if it qualifies for the expedited appeals process.

**What Is An Expedited Appeal?**

An expedited appeal is a faster way to decide an appeal. The expedited appeals process follows a similar process to the standard appeals process. However,

- Your appeal must meet certain requirements.
- The expedited appeals process also follows different deadlines than the standard appeals.
- You can make a verbal request for an expedited appeal. You do not have to put your expedited appeal request in writing.

**When Can I File an Expedited Appeal?**

If you think that waiting up to 30 days for a standard appeal decision will jeopardize your life, health or ability to attain, maintain or regain maximum function, you may request an expedited resolution of an appeal. If the county plan agrees that your appeal meets the requirements for an expedited appeal, your county will resolve your expedited appeal within 72 hours after the county plan receives the appeal. Timeframes may be extended by up to 14 calendar days if you request an extension, or if the county plan shows that there is a need for additional information and that the delay is in your interest. If your county plan extends the timeframes, the plan will give you a written explanation as to why the timeframes were extended.

If the county plan decides that your appeal does not qualify for an expedited appeal, the county plan must make reasonable efforts to give you prompt oral notice and will notify you in writing within 2 calendar days giving you the reason for the decision. Your appeal will then follow the standard appeal timeframes outlined earlier in this section. If you disagree with the county’s decision that your appeal doesn’t meet the expedited appeal criteria, you may file a grievance.

Once your county plan resolves your expedited appeal, the plan will notify you and all affected parties orally and in writing.

**THE STATE FAIR HEARING PROCESS**

**What is a State Fair Hearing?**
A State Fair Hearing is an independent review conducted by the California Department of Social Services to ensure you receive the SUD treatment services to which you are entitled under the Medi-Cal program.

**What Are My State Fair Hearing Rights?**

You have the right to:

- Have a hearing before the California Department of Social Services (also called a State Fair Hearing).
- Be told about how to ask for a State Fair Hearing.
- Be told about the rules that govern representation at the State Fair Hearing.
- Have your benefits continued upon your request during the State Fair Hearing process if you ask for a State Fair Hearing within the required timeframes.

**When Can I File For A State Fair Hearing?**

You can file for a State Fair Hearing:

- If you have completed the county plan’s appeal process.
- If your county or one of the county contracted providers decides that you do not qualify to receive any Medi-Cal SUD treatment services because you do not meet the medical necessity criteria.
- If your provider thinks you need a SUD treatment service and asks the county plan for approval, but the county plan does not agree and denies your provider’s request, or changes the type or frequency of service.
- If your provider has asked the county plan for approval, but the county needs more information to make a decision and doesn’t complete the approval process on time.
- If your county plan doesn’t provide services to you based on the timelines the county has set up.
- If you don’t think the county plan is providing services soon enough to meet your needs.
- If your grievance, appeal or expedited appeal wasn’t resolved in time.
- If you and your provider do not agree on the SUD treatment services you need.

**How Do I Request A State Fair Hearing?**

You can request a State Fair Hearing directly from the California Department of Social Services. You can ask for a State Fair Hearing by writing to:

*State Hearings Division*
*California Department of Social Services*
*744 P Street, Mail Station 9-17-37*
*Sacramento, California 95814*

You can also call 1-800-952-8349 or for TDD 1-800-952-8349.
**Is There a Deadline for Filing For A State Fair Hearing?**

You only have 120 days to ask for a State Fair Hearing. The 120 days start either the day after the county plan personally gave you its appeal decision notice, or the day after the postmark date of the county appeal decision notice.

If you didn’t receive a Notice of Adverse Benefit Determination, you may file for a State Fair Hearing at any time.

**Can I Continue Services While I’m Waiting For A State Fair Hearing Decision?**

Yes, if you are currently receiving treatment and you want to continue your treatment while you appeal, you must ask for a State Fair Hearing within 10 days from the date the appeal decision notice was postmarked or delivered to you OR before the date your County Plan says services will be stopped or reduced. When you ask for a State Fair Hearing, you must say that you want to keep receiving your treatment. Additionally, you will not have to pay for services received while the State Fair Hearing is pending.

If you do request continuation of the benefit, and the final decision of the State Fair Hearing confirms the decision to reduce or discontinue the service you are receiving, you may be required to pay the cost of services furnished while the state fair hearing was pending.

**What Do I Need To Do if I Want to Continue Services While I’m Waiting For A State Fair Hearing Decision?**

If you want services to continue during the State Fair Hearing process, you must request a State Fair Hearing within 120 days from the date of the county notice of resolution.

**What If I Can’t Wait 90 Days For My State Fair Hearing Decision?**

You may ask for an expedited (quicker) State Fair Hearing if you think the normal 90-calendar day time frame will cause serious problems with your health, including problems with your ability to gain, maintain, or regain important life functions. The Department of Social Services, State Hearings Division, will review your request for an expedited State Fair Hearing and decide if it qualifies. If your expedited hearing request is approved, a hearing will be held and a hearing decision will be issued within 3 working days of the date your request is received by the State Hearings Division.

**IMPORTANT INFORMATION ABOUT THE STATE OF CALIFORNIA MEDI-CAL PROGRAM**

**Who Can Get Medi-Cal?**
You may qualify for Medi-Cal if you are in one of these groups:

- 65 years old, or older
- Under 21 years of age
- An adult, between 21 and 65 based on income eligibility
- Blind or disabled
- Pregnant
- Certain refugees, or Cuban/Haitian immigrants
- Receiving care in a nursing home

You must be living in California to qualify for Medi-Cal. Call or visit your local county social services office to ask for a Medi-Cal application, or get one on the Internet at http://www.dhcs.ca.gov/services/medi-cal/pages/MediCalApplications.aspx

**Do I Have To Pay For Medi-Cal?**

You may have to pay for Medi-Cal depending on the amount of money you get or earn each month.

- If your income is less than Medi-Cal limits for your family size, you will not have to pay for Medi-Cal services.
- If your income is more than Medi-Cal limits for your family size, you will have to pay some money for your medical or SUD treatment services. The amount that you pay is called your ‘share of cost.’ Once you have paid your ‘share of cost,’ Medi-Cal will pay the rest of your covered medical bills for that month. In the months that you don't have medical expenses, you don’t have to pay anything.
- You may have to pay a ‘co-payment’ for any treatment under Medi-Cal. This means you pay an out of pocket amount each time you get a medical or SUD treatment service or a prescribed drug (medicine) and a co-payment if you go to a hospital emergency room for your regular services.

Your provider will tell you if you need to make a co-payment.

**Does Medi-Cal Cover Transportation?**

If you have trouble getting to your medical appointments or drug and alcohol treatment appointments, the Medi-Cal program can help you find transportation.

- For children, the county Child Health and Disability Prevention (CHDP) program can help.
- CHDP Address:
  - 345 Camino Del Remedio, Santa Barbara, CA 93110
  - Phone: (805) 681-5130
  - Fax: (805) 681-4958
• You can also get information online by visiting: http://www.dhcs.ca.gov/services/chdp/Pages/CountyOffices.aspx
• For adults and children, your county social services office can help. You can call:
  • Santa Maria DSS:  (805) 346-7135
  • Lompoc DSS:  (805) 737-7080
  • Santa Barbara DSS:  (805) 681-4401
• Or you can get information online by visiting www.dhcs.ca.gov/Services/medical/pages/applyformedi-cal.aspx
• Transportation services are available for all service needs, including those that are not included in the DMC-ODS program.

MEMBER RIGHTS AND RESPONSIBILITIES

What Are My Rights As A Recipient of DMC-ODS Services?

As a person eligible for Medi-Cal and residing in a DMC-ODS pilot program county, you have a right to receive medically necessary SUD treatment services from the county plan. You have the right to:

• Be treated with respect, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information.
• Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member’s condition and ability to understand.
• Participate in decisions regarding your SUD care, including the right to refuse treatment.
• Receive timely access to care, including services available 24 hours a day, 7 days a week, when medically necessary to treat an emergency condition or an urgent or crisis condition.
• Receive the information in this handbook about the SUD treatment services covered by the county DMC-ODS plan, other obligations of the county plan and your rights as described here.
• Have your confidential health information protected.
• Request and receive a copy of your medical records, and request that they be amended or corrected as specified in 45 CFR §164.524 and 164.526.
• Receive written materials in alternative formats (including Braille, large size print, and audio format) upon request and in a timely fashion appropriate for the format being requested.
• Receive oral interpretation services for your preferred language.
• Receive SUD treatment services from a county plan that follows the requirements of its contract with the State in the areas of availability of services, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.
• Access Minor Consent Services, if you are a minor.
• Access medically necessary services out-of-network in a timely manner, if the plan doesn’t have an employee or contract provider who can deliver the services. “Out-of-network provider” means a provider who is not on the county plan’s list of providers. The county must make sure you don’t pay anything extra for seeing an out-of-network provider. You can contact the 24/7 ACCESS LINE (888) 868-1649 for information on how to receive services from an out-of-network provider.
• Request a second opinion from a qualified health care professional within the county network, or one outside the network, at no additional cost to you.
• File grievances, either verbally or in writing, about the organization or the care received.
• Request an appeal, either verbally or in writing, upon receipt of a notice of adverse benefit determination.
• Request a State Medi-Cal fair hearing, including information on the circumstances under which an expedited fair hearing is possible.
• Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
• Be free to exercise these rights without adversely affecting how you are treated by the county plan, providers, or the State.

**What Are My Responsibilities As A Recipient of DMC-ODS Services?**

As a recipient of DMC-ODS service, it is your responsibility to:

• Carefully read the member informing materials that you have received from the county plan. These materials will help you understand which services are available and how to get treatment if you need it.
• Attend your treatment as scheduled. You will have the best result if you follow your treatment plan. If you do need to miss an appointment, call your provider at least 24 hours in advance and reschedule for another day and time.
• Always carry your Medi-Cal (county plan) ID card and a photo ID when you attend treatment.
• Let your provider know if you need an interpreter before your appointment.
• Tell your provider all your medical concerns in order for your plan to be accurate. The more complete information that you share about your needs, the more successful your treatment will be.
• Make sure to ask your provider any questions that you have. It is very important you completely understand your treatment plan and any other information that you receive during treatment.
• Follow the treatment plan you and your provider have agreed upon.
• Be willing to build a strong working relationship with the provider that is treating you.
• Contact the county plan if you have any questions about your services or if you have any problems with your provider that you are unable to resolve.
• Tell your provider and the county plan if you have any changes to your personal information. This includes address, phone number, and any other medical information that can affect your ability to participate in treatment.
• Treat the staff who provide your treatment with respect and courtesy.
• If you suspect fraud or wrongdoing, report it. Please call the Compliance Helpline: (805) 884-6855 or online at: http://www.countyofsb.org/behavioral-wellness/compliance.sbc

The Beneficiary Handbook will be available in SUD Provider lobbies and online at: http://www.countyofsb.org/behavioral-wellness/compliance.sbc
### SANTA BARBARA REGION

For initial treatment authorizations, contact the Access Line: 1-888-868-1649

<table>
<thead>
<tr>
<th>Agency</th>
<th>Address</th>
<th>Ph./Fax</th>
<th>Contact</th>
<th>Email</th>
<th>Website</th>
<th>Services Type</th>
<th>Specialty</th>
<th>Accepting new clients</th>
<th>Cultural Capabilities</th>
<th>Other Linguistic Capabilities</th>
<th>ADA Accommodations</th>
<th>Cultural Competence Training</th>
<th>Medical Director</th>
<th>NPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aegis Treatment Centers</td>
<td>4129 State Street, Suite B</td>
<td>805-964-4795 / 805-683-3027</td>
<td>John Gabbert, Clinic Manager</td>
<td><a href="mailto:jgabbert@aegistreatmentcenters.com">jgabbert@aegistreatmentcenters.com</a></td>
<td><a href="http://www.aegistreatmentcenters.com">www.aegistreatmentcenters.com</a></td>
<td>Opioid Treatment Program (OTP)</td>
<td>Adult Services, Medicated Assisted Treatment</td>
<td>Yes</td>
<td>Hispanic Issues, TAY</td>
<td>Spanish</td>
<td>Wheelchair access</td>
<td>Yes</td>
<td>1649376351</td>
<td></td>
</tr>
<tr>
<td>Aegis Treatment Centers</td>
<td>4129 State Street, Suite B</td>
<td>805-964-4795 / 805-683-3027</td>
<td>John Gabbert, Clinic Manager</td>
<td><a href="mailto:jgabbert@aegistreatmentcenters.com">jgabbert@aegistreatmentcenters.com</a></td>
<td><a href="http://www.aegistreatmentcenters.com">www.aegistreatmentcenters.com</a></td>
<td>Outpatient Services (Level 1.0); Intensive Outpatient Services (Level 2.1)</td>
<td>Adult Services, Perinatal Services, Medication Assisted Treatment</td>
<td>Yes</td>
<td>Hispanic Issues, VETS</td>
<td>Spanish</td>
<td>Wheelchair access</td>
<td>Yes</td>
<td>1649376351</td>
<td></td>
</tr>
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</table>

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<table>
<thead>
<tr>
<th>Agency: CADA- Council on Alcoholism and Drug Abuse - DUI and PC1000 Programs</th>
<th>Agency: Family Service Agency (FSA)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Address:</strong> 232 E. Canon Perdido St. Santa Barbara, CA 93101</td>
<td><strong>Address:</strong> 123 W. Gutierrez St. Santa Barbara, CA 93101</td>
</tr>
<tr>
<td><strong>Ph./Fax:</strong> (805) 963-1433 / (805) 963-4099</td>
<td><strong>Ph./Fax:</strong> (805) 965-1001</td>
</tr>
<tr>
<td><strong>Contact:</strong> Ramon Velazquez, Program Director</td>
<td><strong>Contact:</strong> Ashleigh Irving, Program Manager</td>
</tr>
<tr>
<td><strong>Email:</strong> <a href="mailto:rvelazquez@cadasb.org">rvelazquez@cadasb.org</a></td>
<td><strong>Email:</strong> <a href="mailto:ashleigh@fsacares.org">ashleigh@fsacares.org</a></td>
</tr>
<tr>
<td><strong>Website:</strong> <a href="http://www.cadasb.org">www.cadasb.org</a></td>
<td><strong>Website:</strong> <a href="http://www.fsacares.org">www.fsacares.org</a></td>
</tr>
<tr>
<td><strong>Service Type:</strong> DUI Multiple Offender Program; PC1000 (Drug Diversion)</td>
<td><strong>Service Type:</strong> Primary Prevention; Early Intervention (Level 0.5)</td>
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<tr>
<td><strong>Specialty:</strong> Adult Services</td>
<td><strong>Specialty:</strong> Strengthening Families Program</td>
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<td><strong>Accepting new clients:</strong> Yes</td>
<td><strong>Accepting new clients:</strong> Yes</td>
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<tr>
<td><strong>Cultural Capabilities:</strong> Hispanic Issues</td>
<td><strong>Cultural Capabilities:</strong> Hispanic Issues</td>
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<td><strong>ADA Accommodations:</strong> Wheelchair access</td>
<td><strong>ADA Accommodations:</strong> Wheelchair access</td>
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<tr>
<td><strong>Cultural Competence Training:</strong> Yes</td>
<td><strong>Cultural Competence Training:</strong> Yes</td>
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<tr>
<td><strong>Clinical Director:</strong> Nancy Gottlieb, LMFT #18340</td>
<td><strong>Clinical Director:</strong> Nancy Ranck, LMFT #29688</td>
</tr>
<tr>
<td><strong>NPI:</strong> 1386796761</td>
<td><strong>NPI:</strong> 1003985276</td>
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<table>
<thead>
<tr>
<th>Agency: Future Leaders of America (FLA)</th>
<th>Agency: Pacific Pride Foundation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Address:</strong> 1528 Chapala St. #308, Santa Barbara, CA 93101</td>
<td><strong>Address:</strong> 608 Anacapa St. Suite A-11 Santa Barbara, CA 93101</td>
</tr>
<tr>
<td><strong>Ph./Fax:</strong> (805) 642-6208</td>
<td><strong>Ph./Fax:</strong> (805) 963-3636 / (805) 963-9086</td>
</tr>
<tr>
<td><strong>Contact:</strong> Eder Gaona-Macedo, Executive Director</td>
<td><strong>Contact:</strong> Ken Osepayan, Program Manager</td>
</tr>
<tr>
<td><strong>Email:</strong> <a href="mailto:eder@futureleadersnow.org">eder@futureleadersnow.org</a></td>
<td><strong>Email:</strong> <a href="mailto:ken@pacificpridefoundation.org">ken@pacificpridefoundation.org</a></td>
</tr>
<tr>
<td><strong>Website:</strong> <a href="http://www.futureleadersnow.org">www.futureleadersnow.org</a></td>
<td><strong>Website:</strong> <a href="http://www.pacificpridefoundation.org">www.pacificpridefoundation.org</a></td>
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<tr>
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<td><strong>Service Type:</strong> Primary Prevention</td>
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<td><strong>Specialty:</strong> Adolescent Services, Prevention Coalition</td>
<td><strong>Specialty:</strong> Naloxone Training and Distribution</td>
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<td><strong>Cultural Capabilities:</strong> Hispanic Issues, LGBTQ</td>
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<td><strong>Other Linguistic Capabilities:</strong> Spanish</td>
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### SANTA BARBARA REGION

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<th>Email</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sanctuary Centers of Santa Barbara</strong></td>
<td>1136 De La Vina St. &amp; 222 W. Valerio St. Santa Barbara, CA 93101</td>
<td>(805) 569-2785</td>
<td>Christina Grabowsky, Program Manager</td>
<td><a href="mailto:crabowsky@spcsb.org">crabowsky@spcsb.org</a></td>
<td><a href="http://www.sanctuarycenters.org">www.sanctuarycenters.org</a></td>
</tr>
<tr>
<td><strong>Zona Seca</strong></td>
<td>26 Figueroa St.</td>
<td>(805) 963-8961 / 963-8964</td>
<td>Diana Banales, Program Manager</td>
<td><a href="mailto:dbanales@zonaseca.com">dbanales@zonaseca.com</a></td>
<td><a href="http://www.zonaseca.com">www.zonaseca.com</a></td>
</tr>
</tbody>
</table>

**Service Type:**
- Outpatient Services (Level 1.0) and Intensive Outpatient Services (Level 2.1)

**Specialty:**
- Adult Services, Co-Occurring Disorders

**Accepting new clients:**
- Yes

**Cultural Capabilities:**
- Hispanic Issues, TAY

**Other Linguistic Capabilities:**
- Spanish

**ADA Accommodations:**
- Wheelchair access

**Cultural Competence Training:**
- Yes

**Medical Director:**
- George Bifano, MD #3983

**NPI:**
- 1083604920

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**Cultural Capabilities** may include competence in the following areas: Hispanic Issues, Asian Issues, African American Issues, Veterans (VETS) Issues, Transition Age Youth (TAY) Issues, Older Adult Issues, and LGBTQ Issues.

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### LOMPOC REGION

For initial treatment authorizations, contact the Access Line: 1-888-868-1649

| **Agency** | Central Coast Headway  
| **Address** | 115 E. College St., #16  
| **Ph./Fax** | (805) 737-0015 / (805) 737-7154  
| **Contact** | Clemencia Figueroa, Program Manager  
| **Email** | smcch@utect.net  
| **Website** | N/A  
| **Service Type** | DUI First Offender and DUI Multiple Offender Programs  
| **Specialty** | Adult Services  
| **Accepting new clients** | Yes  
| **Cultural Capabilities** | Hispanic Issues  
| **Other Linguistic Capabilities** | Spanish  
| **ADA Accommodations** | Wheelchair access  
| **Cultural Competence Training** | Yes  

| **Agency** | Coast Valley Substance Abuse Treatment Center (CVSATC)  
| **Address** | 133 N. F St.  
| **Ph./Fax** | (805) 735-7525 / (805) 737-0524  
| **Contact** | Luis Gonzalez, Site Supervisor  
| **Email** | luis@coastvalleysatc.com  
| **Website** | www.coastvalleysatc.com  
| **Service Type** | Outpatient Services (Levels 1.0); Intensive Outpatient Services (Level 2.1); PC1000  
| **Specialty** | Adolescent Services, Adult Services  
| **Accepting new clients** | Yes  
| **Cultural Capabilities** | Hispanic Issues, TAY, VETS  
| **Other Linguistic Capabilities** | Spanish  
| **ADA Accommodations** | Wheelchair access  
| **Cultural Competence Training** | Yes  
| **Medical Director** | Silvia Corral, MD #48874  
| **NPI** | 1043327356  

| **Agency** | Family Service Agency (FSA)  
| **Address** | Dorothy Jackson Family Resource Center  
| **Ph./Fax** | (805) 965-1001  
| **Contact** | Ashleigh Erving, Program Manager  
| **Email** | ashleigh@fascares.org  
| **Website** | www.fascares.org  
| **Service Type** | Primary Prevention; Early Intervention (Level 0.5)  
| **Specialty** | Strengthening Families Program  
| **Accepting new clients** | Yes  
| **Cultural Capabilities** | Hispanic Issues  
| **Other Linguistic Capabilities** | Spanish  
| **ADA Accommodations** | Wheelchair access  
| **Cultural Competence Training** | Yes  
| **Clinical Director** | Nancy Ranck, LMFT #29688  
| **NPI** | 1003985276  

| **Agency** | Good Samaritan Shelter – Another Road Detox  
| **Address** | 113 S. M Street  
| **Ph./Fax** | (805) 736-0357 X207 / (866) 543-5841  
| **Contact** | Turtle Klein, Program Manager  
| **Email** | tklein@goodsamaritanshelter.org  
| **Website** | www.goodsamaritanshelter.org  
| **Service Type** | Residential Treatment (Level 3.1); Withdrawal Management (Level 3.2)  
| **Specialty** | Adult Services  
| **Accepting new clients** | Yes  
| **Cultural Capabilities** | TAY  
| **Other Linguistic Capabilities** | N/A  
| **ADA Accommodations** | Wheelchair access  
| **Cultural Competence Training** | Yes  
| **Medical Director** | Josephine Preciado, MD #75900  
| **NPI** | 1013948256  

**Cultural Capabilities** may include competence in the following areas: Hispanic Issues, Asian Issues, African American Issues, Veterans (VETS) Issues, Transition Age Youth (TAY) Issues, Older Adult Issues, and LGBTQ Issues.

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### LOMPOC REGION

**Agency:** Good Samaritan Shelter – Lompoc Recovery Center  
**Address:** 104 S. C St.  
Lompoc, CA 93436  
**Ph./Fax:** (805) 741-7853 / (805) 357-5372  
**Contact:** Donna Flores, Program Manager  
**Email:** dflores@goodsamaritanshelter.org  
**Website:** [www.goodsamaritanshelter.org](http://www.goodsamaritanshelter.org)  
**Service Type:** Outpatient Services (Level 1.0); Intensive Outpatient Services (Level 2.1)  
**Specialty:** Adult Services  
**Accepting new clients:** Yes  
**Cultural Capabilities:** Hispanic Issues  
**Other Linguistic Capabilities:** Spanish  
**ADA Accommodations:** Wheelchair access  
**Cultural Competence Training:** Yes  
**Medical Director:** Josephine Preciado, MD #75900  
**NPI:** 1013948256

**Agency:** Good Samaritan Shelter – Turning Point  
**Address:** 604 W. Ocean Ave.  
Lompoc, CA 93436  
**Ph./Fax:** (805) 736-0357 X201 / (805) 969-9350  
**Contact:** Linda Brown, Program Manager  
**Email:** lbrown@goodsamaritanshelter.org  
**Website:** [www.goodsamaritanshelter.org](http://www.goodsamaritanshelter.org)  
**Service Type:** Outpatient Services (Level 1.0); Intensive Outpatient Services (Level 2.1)  
**Specialty:** Adult Services, Perinatal Services  
**Accepting new clients:** Yes  
**Cultural Capabilities:** Hispanic Issues  
**Other Linguistic Capabilities:** N/A  
**ADA Accommodations:** Wheelchair access  
**Cultural Competence Training:** Yes  
**Medical Director:** Josephine Preciado, MD #75900  
**NPI:** 1013948256

**Agency:** People Helping People  
**Address:** PO Box 1478  
Santa Ynez, CA 93464  
**Ph./Fax:** (805) 686-0295 / (805) 686-2856  
**Contact:** Mary Conway, Program Manager  
**Email:** mary@syvphp.org  
**Website:** [www.syvphp.org](http://www.syvphp.org)  
**Service Type:** Primary Prevention  
**Specialty:** Adolescent Services, Prevention Coalition  
**Accepting new clients:** Yes  
**Cultural Capabilities:** Hispanic Issues, TAY  
**Other Linguistic Capabilities:** Spanish  
**ADA Accommodations:** Wheelchair access  
**Cultural Competence Training:** Yes

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ALCOHOL AND DRUG PROGRAM
PROVIDER DIRECTORY
FISCAL YEAR 2018-2019

SANTA MARIA REGION
For initial treatment authorizations, contact the Access Line: 1-888-868-1649

**Agency:** Aegis Treatment Centers  
**Address:** 115 E. Fesler St.  
Santa Maria, CA 93454  
**Ph./Fax:** (805) 922-6597 / (805) 922-5978  
**Contact:** Jeffrey Curtis, Clinic Manager  
**Email:** jeffrey.curtis@aegistreatmentcenters.com  
**Website:** www.aegistreatmentcenters.com  
**Service Type:** Opioid Treatment Program  
**Specialty:** Adult Services, Medication Assisted Treatment  
**Accepting new clients:** Yes  
**Cultural Capabilities:** Hispanic Issues, TAY  
**Other Linguistic Capabilities:** Spanish  
**ADA Accommodations:** Wheelchair access  
**Cultural Competence Training:** Yes  
**Medical Director:** Kristopher Howalt, MD #62030  
**NPI:** 1962511162

**Agency:** CADA – Santa Maria  
**Address:** 526 E. Chapel St.  
Santa Maria, CA 93454  
**Ph./Fax:** (805) 925-8860  
**Contact:** Britt Stanley, Director of Operations  
**Email:** bstanley@cadasb.org  
**Website:** www.cadasb.org  
**Service Type:** Primary Prevention, Early Intervention (Level 0.5); Outpatient Services (Level 1.0); Intensive Outpatient Services (Level 2.1)  
**Specialty:** Adolescent Services  
**Accepting new clients:** Yes  
**Cultural Capabilities:** TAY  
**Other Linguistic Capabilities:** N/A  
**ADA Accommodations:** Wheelchair access  
**Cultural Competence Training:** Yes  
**Medical Director:** Jane McClenahan, MD #57808  
**NPI:** 1679599377

**Agency:** Central Coast Headway  
**Address:** 318 W. Carmen Lane  
Santa Maria, CA 93454  
**Ph./Fax:** (805) 922-2106; 922-2751  
**Contact:** Clemencia Figueroa, Program Manager  
**Email:** smcch@utect.net  
**Website:** N/A  
**Service Type:** DUI First Offender and DUI Multiple Offender Programs  
**Specialty:** Adult Services  
**Accepting new clients:** Yes  
**Cultural Capabilities:** Hispanic Issues  
**Other Linguistic Capabilities:** Spanish  
**ADA Accommodations:** Wheelchair access  
**Cultural Competence Training:** Yes

**Agency:** Coast Valley Substance Abuse Treatment Center (CVSATC)  
**Address:** 1414 S. Miller St. #11  
Santa Maria, CA 93454  
**Ph./Fax:** (805) 739-1512 / (805) 739-2855  
**Contact:** Deshon Chavez, Site Supervisor  
**Email:** deshon@coastvalleysatc.com  
**Website:** www.coastvalleysatc.com  
**Service Type:** Outpatient Services (Level 1.0); Intensive Outpatient Services (Level 2.1); PC 1000  
**Specialty:** Adult Services, Adolescent Services, Medication Assisted Treatment  
**Accepting new clients:** Yes  
**Cultural Capabilities:** Hispanic Issues, TAY, VETS  
**Other Linguistic Capabilities:** Spanish  
**ADA Accommodations:** Wheelchair access  
**Cultural Competence Training:** Yes  
**Medical Director:** Jennifer Kissinger, MD #55862  
**NPI:** 1982758884

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TRANSITION OF CARE REQUEST

When can I request to keep my previous, and now out-of-network, provider?

- After joining the County Plan, you may request to keep your out-of-network provider if:
  - Moving to a new provider would result in a serious detriment to your health or would increase your risk of hospitalization or institutionalization; and
  - You were receiving treatment from the out-of-network provider prior to the date of your transition to the County Plan.

How do I request to keep my out-of-network provider?

- You, your authorized representatives, or your current provider, may submit a request in writing to the County Plan. You can also contact member services at 1-888-868-1649 for information on how to request services from an out-of-network provider.
- The County Plan will send written acknowledgement of receipt of your request and begin to process your request within three (3) working days.

What if I continued to see my out-of-network provider after transitioning to the County Plan?

- You may request a retroactive transition of care request within thirty (30) calendar days of receiving services from an out-of-network provider.

Why would the County Plan deny my transition of care request?

- The County Plan may deny your request to retain your previous, and now out-of-network, provider, if:
  - The County Plan has documented quality of care issues with the provider

What happens if my transition of care request is denied?

- If the County Plan denies your transition of care it will:
  - Notify you in writing;
  - Offer you at least one in-network alternative provider that offers the same level of services as the out-of-network provider; and
  - Inform you of your right to file a grievance if you disagree with the denial.
- If the County Plan offers you multiple in-network provider alternatives and you do not make a choice, then the County Plan will refer or assign you to an in-network provider and notify you of that referral or assignment in writing.

What happens if my transition of care request is approved?

- Within seven (7) days of approving your transition of care request the County Plan will provide you with:
  - The request approval;
  - The duration of the transition of care arrangement;
  - The process that will occur to transition your care at the end of the continuity of care period; and
Your right to choose a different provider from the County Plan’s provider network at anytime.

How quickly will my transition of care request be processed?
- The County Plan will complete its review of your transition of care request within thirty (30) calendar days from the date the County Plan received your request.

What happens at the end of my transition of care period?
- The County Plan will notify you in writing thirty (30) calendar days before the end of the transition of care period about the process that will occur to transition your care to an in-network provider at the end of your transition of care period.
Attachment B
SISTEMA ORGANIZADO DE MEDI-CAL PARA LA DISTRIBUCIÓN DE SERVICIOS CONTRA EL ABUSO DE SUSTANCIAS (DMC-ODS)

MANUAL PARA MIEMBROS DEL PLAN

Condado de Santa Bárbara
Departamento de Behavioral Wellness
Programa contra el abuso de alcohol y drogas
http://countyofsb.org/behavioral-wellness/
Español
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-868-1649, TTY: 711.


English
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-868-1649, TTY: 711.

ATTENTION: Auxiliary aids and services, including but not limited to large print documents and alternative formats, are available to you free of charge upon request. Call 1-888-868-1649, TTY: 711.

Tiếng Việt (Vietnamese)

Tagalog (Tagalog/Filipino)
한국어 (Korean)

프랑스어 (Chinese)

Հայ երեն (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսու մեկուկան երեն եք, ապա ձեզ անվճար կարող են տրամադրվել լ եզվական աջ ակցի և թետ առայ ու թետ ու նաներ: Զանգահարեք 1-888-868-1649, TTY: 711.

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-868-1649, TTY: 711.

فارسی (Farsi)
日本語 (Japanese)
まで、お電話にてご連絡ください。

Hmoob (Hmong)

पंजाबी (Punjabi)
विशेष निर्देश: मैं पंजाबी बोलते हैं, तो आपके लिए भाषा सहायता सेवाएं मुफ्त में उपलब्ध है। 1-888-868-1649, TTY: 711.
'उ वाल्ड वर्ड।

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اللغة، فإن خدمات المساعدة اللغوية متاحة لك بكلفة مفتوحة. اتصل برقم هاتف الصم والبكم 1-888-868-1649, TTY: 711.

हिंदी (Hindi)
ध्यान दें: यदि हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-868-1649, TTY: 711.
पर कॉल करें।

ภาษาไทย (Thai)
เรียน:
អ្នកនិយាយភាសាអ៊ីរ៍ តែមាននឹងមានវិធីសំខាន់ដូចជា ២០ សើរិនដូចពណ៌ក្រហម និងចូទូព្យាយាម ១-៨៨៨-៨៦៨-១៦៤៩, TTY: ៧១១។

ພានាគ់ (Lao)
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INFORMACIÓN GENERAL

Servicios de emergencia

Los servicios de emergencia están disponibles las 24 horas, los 7 días de la semana. En caso de emergencia relacionada con su salud, llame al 911 o vaya a la sala de emergencias más cercana para recibir ayuda.

Estos servicios se proporcionan en caso de algún problema de salud inesperado, como lo puede ser una emergencia psiquiátrica.

Un incidente médico requiere tratamiento de emergencia cuando se presentan síntomas que causan intenso dolor o una enfermedad o lesión grave, ante lo cual una persona prudente (no especialista, pero una persona cautelosa o cuidadosa) considerará que sin atención médica podría suceder lo siguiente:
- Poner su salud en grave peligro,
- En caso de embarazo, poner su salud o la del bebé en grave peligro,
- Dañar gravemente el funcionamiento de su cuerpo, o
- Dañar gravemente un órgano o una parte del cuerpo.

Usted tiene derecho a ir a cualquier hospital en caso de emergencia. Los servicios de emergencia nunca requieren autorización previa.

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¿A quién debo contactar si tengo pensamientos suicidas?

Si usted o alguien que conoce está en crisis, llame a la Línea Nacional de Prevención del Suicidio al 1-800-273-TALK (8255).

Los residentes locales que buscan asistencia en caso de crisis y acceder programas de salud mental deben llamar al 1-888-868-1649
¿Por qué es importante leer este manual?

Le damos la bienvenida al plan de servicios para tratar trastornos por uso de sustancias (SUD) y al sistema organizado de Medi-Cal para la distribución de servicios contra el abuso de sustancias (DMC-ODS por sus siglas en inglés) que brinda el condado de Santa Bárbara. Proporcionamos toda la gama de opciones de tratamiento sobre alcohol y otras drogas (AOD por sus siglas en inglés) para quienes viven en el condado de Santa Bárbara. Si usted o alguien que conoce necesita ayuda para reducir el daño relacionado con el alcohol u otra droga, y tiene derecho a Medi-Cal o “Drug Medi-Cal”, lea este manual con atención. Contiene información importante.

Es importante que usted comprenda cómo funciona el sistema organizado de Medi-Cal para la distribución de servicios contra el abuso de sustancias (DMC-ODS) para recibir la atención que necesita. Este manual explica los beneficios y cómo recibir atención. También responderá muchas de sus preguntas.

Usted aprenderá:

- Cómo obtener servicios para tratar trastornos por uso de sustancias (SUD) a través del plan DMC-ODS de su condado.
- Los beneficios a los que usted tendrá acceso.
- Qué hacer en caso de tener preguntas o problemas.
- Sus derechos y responsabilidades como miembro del plan DMC-ODS de su condado.

Si usted no lee este manual ahora, guárdelo para leerlo más tarde. Use este manual como un complemento al manual para miembros que se le entregó cuando se inscribió como beneficiario de Medi-Cal, ya sea a través de un plan de atención gestionado por Medi-Cal o con el programa regular de Medi-Cal de "pago por servicio".

Como miembro del plan DMC-ODS de su condado, ese plan es responsable por lo siguiente:

- Saber si usted tiene derecho a recibir servicios de DMC-ODS del condado o de la red de proveedores.
- Coordinar su atención médica.
- Proporcionar un número gratuito atendido las 24 horas, los 7 días de la semana, de información de los servicios del plan de su condado, y en el cual se puede solicitar disponibilidad de atención fuera del horario normal.
- Contar con suficientes proveedores para garantizar que usted reciba el tratamiento por trastorno por uso de sustancias que esté cubierto por el plan de su condado, en caso de necesitarlo.
- Informar y educar sobre los servicios disponibles del plan de su condado.
- Proporcionarle servicios en su idioma o mediante un intérprete (en caso de ser necesario) de forma gratuita, y dejarle saber que esos servicios de interpretación están disponibles.
• Proporcionarle información por escrito sobre lo que está disponible para usted en otros idiomas o métodos. Brindamos información y tratamiento en español y en inglés, así como también recursos adaptados a otras culturas e idiomas, que incluyen servicios para las personas con problemas auditivos y de visión, y para quienes tienen una habilidad limitada para leer, para responder de manera efectiva a las necesidades diversas de todas las personas.

• Notificarle todo cambio significativo en la información brindada en este manual al menos 30 días antes de la fecha efectiva del cambio. Un cambio se considera significativo cuando implica una mayor o menor cantidad o tipo de servicios disponibles, o si hay un aumento o disminución de proveedores en la red, o cualquier otra modificación que impacte en los beneficios que usted recibe a través del plan del condado.

• Informarle en caso de que algún proveedor se niegue a realizar o apoyar cualquier servicio cubierto por objeciones morales, éticas o religiosas, e informarle los proveedores que sí ofrezcan ese servicio.

Si usted u otra persona cercana necesita ayuda para lidiar con el uso de alcohol u otra droga, llame a nuestra línea de acceso gratuita disponible las 24 horas en el (888) 868-1649, para un chequeo y una recomendación a un médico.

**Información para miembros que necesitan materiales en otro idioma**

La información se encuentra en las salas de espera de los que atienden trastornos por uso de sustancias (SUD por sus siglas en inglés), disponible en español y en inglés, y en [http://www.countyofsb.org/behavioral-wellness/qcmconsumer.sbc](http://www.countyofsb.org/behavioral-wellness/qcmconsumer.sbc)

Para otros idiomas, por favor comuníquese al (805) 681-5220.

**Información para miembros con dificultad para leer**

La información se encuentra en las salas de espera de los que atienden trastornos por uso de sustancias (SUD), disponible en español y en inglés, y en [http://www.countyofsb.org/behavioral-wellness/qcmconsumer.sbc](http://www.countyofsb.org/behavioral-wellness/qcmconsumer.sbc)

**Información para miembros con deficiencia de la capacidad auditiva**

La información se encuentra en las salas de espera de los que atienden trastornos por uso de sustancias (SUD), disponible en español y en inglés, y en [http://www.countyofsb.org/behavioral-wellness/qcmconsumer.sbc](http://www.countyofsb.org/behavioral-wellness/qcmconsumer.sbc)
Información para miembros con deficiencia de la capacidad de visión

La información se encuentra en las salas de espera de los que atienden trastornos por uso de sustancias (SUD), disponible en español y en inglés, y en http://www.countyofsb.org/behavioral-wellness/qcmconsumer.sbc

Notificación sobre prácticas de privacidad

La información se encuentra en las salas de espera de los que atienden trastornos por uso de sustancias (SUD), y en: http://www.countyofsb.org/behavioral-wellness/hipaa-privacy.sbc

¿Con quién me comunico si considero que soy objeto de discriminación?

La discriminación es contra la ley. El Estado de California y el sistema organizado de Medi-Cal para la distribución de servicios contra el abuso de sustancias (DMC-ODS) cumplen con las leyes federales de derechos civiles aplicables y no discrimina por raza, color, origen nacional, ascendencia, religión, sexo, estado civil, género, identidad de género, orientación sexual, edad o discapacidad. El sistema DMC-ODS:

• Proporciona ayuda y servicios gratuitos para personas con discapacidades, como:
  o Intérpretes calificados en lengua de señas
  o Información escrita con otros métodos (braille, letra grande, audio, formatos electrónicos accesibles, entre otros)

• Proporciona servicios lingüísticos gratuitos a personas cuyo idioma principal no es el inglés, como:
  o Intérpretes orales calificados
  o Información en otros idiomas minoritarios

En caso de necesitar esos servicios, comuníquese con el plan de su condado.

Si considera que el Estado de California o el sistema DMC-ODS no le proporcionó esos servicios o lo discriminó de otra manera por raza, color, origen nacional, edad, discapacidad o sexo, puede presentar una queja formal en:

  Oficina de Derechos de los Pacientes
  Atención: Kay Kizer-Waldo
  300 N. San Antonio Rd
  Santa Barbara, CA 93101
  Tel.: 1-805-681-4735, 1-805-934-6548
  Fax: 1-805-681-5262
  Correo electrónico: kjeffer@co.santa-barbara.ca.us

Puede presentar una queja formal en persona o por carta, fax o correo electrónico. Si precisa ayuda para presentar una queja formal, Kay Kizer Waldo, la Defensora de los Derechos de los Pacientes, está disponible para ayudarle.
También puede presentar una queja por atropello de sus derechos civiles de forma electrónica ante el Departamento de Salud y Servicios Humanos de los Estados Unidos, Oficina de Derechos Civiles a través del Portal de Denuncias de dicha oficina, disponible en https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf. Puede presentar una queja por atropello de sus derechos civiles por teléfono o por correo:

U.S. Department of Health and Human Services [Departamento de Salud y Servicios Humanos de los Estados Unidos]
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
Tel.: 1-800-368-1019, 800-537-7697 (TDD)

Hay formularios para presentar una queja disponibles en https://www.hhs.gov/ocr/complaints/index.html

SERVICIOS

¿Qué servicios comprende el sistema organizado de Medi-Cal para la distribución de servicios contra el abuso de sustancias (DMC-ODS)?

Los servicios de DMC-ODS son servicios de atención médica para personas que tienen al menos un trastorno por uso de sustancias (SUD) que un médico regular no puede tratar.

Los servicios de DMC-ODS incluyen:
- Servicios ambulatorios
- Tratamiento ambulatorio intensivo
- Hospitalización parcial (únicamente disponible en algunos condados)
- Tratamiento residencial (sujeto a autorización previa por el condado)
- Manejo de la abstinencia
- Tratamiento del trastorno por consumo de opioides
- Tratamiento asistido con medicamentos (varía según el condado)
- Recuperación
- Manejo de casos

Si quiere saber más sobre cada uno de los servicios de DMC-ODS disponible para usted, lea las siguientes descripciones:

- **Servicios ambulatorios**
  - Se proporciona consejería, hasta nueve horas por semana para adultos y hasta seis horas por semana para adolescentes, cuando se determina que existe necesidad médica de acuerdo con el plan individualizado del paciente. Los servicios pueden ser prestados por un profesional autorizado o por un consejero certificado en un lugar adecuado dentro de la comunidad.
• Los servicios para pacientes ambulatorios incluyen el ingreso y la evaluación, la planificación del tratamiento, la consejería individual, la consejería de grupo, la terapia familiar, los servicios relacionados, educación para miembros, servicios de medicación, servicios de intervención en caso de crisis, y la planificación del alta.
• Cuando es médicamente necesario, también se ofrece el manejo del caso y servicios de recuperación.
• La duración del tratamiento se determina según cada caso individual y toma en consideración la gravedad de los problemas y los apoyos necesarios para que el tratamiento sea beneficioso.

**Tratamiento ambulatorio intensivo**
• Se proporciona (un mínimo de nueve horas con un máximo de 19 por semana para adultos y un mínimo de seis horas con un máximo de 19 horas por semana para adolescentes) cuando se determina una necesidad médica de acuerdo con el plan individualizado del paciente. Los servicios consisten principalmente en consejería y educación sobre problemas relacionados con la adicción. Los servicios puede proporcionarlos un consejero certificado en un lugar adecuado dentro de la comunidad.
• Incluyen los mismos componentes que los servicios ambulatorios. La principal diferencia radica en la mayor cantidad de horas de servicio.
• Cuando es médicamente necesario, también se ofrece el manejo del caso y servicios de recuperación.
• La duración del tratamiento se determina según cada caso y toma en consideración la gravedad de los problemas y los apoyos necesarios para que el tratamiento sea beneficioso.

**Hospitalización parcial** (únicamente disponible en algunos condados)
• Comprende 20 horas o más de programación clínica intensiva por semana, tal y como se especifica en el plan de tratamiento del paciente. Los programas de hospitalización parcial en general tienen acceso directo a servicios psiquiátricos, médicos y de laboratorio, y sirven para cumplir con las necesidades identificadas que ameriten un manejo o supervisión diarios, pero que se puedan tratar de manera adecuada en un ambiente estructurado para pacientes ambulatorios.
• Estos servicios son similares a los de tratamiento intensivo para pacientes ambulatorios, siendo la principal diferencia una mayor cantidad de horas y un mayor acceso a servicios médicos.
• Estos servicios no están disponibles actualmente en el condado de Santa Barbara.

**Tratamiento residencial** (sujeto a autorización previa por el condado)
• Es un programa residencial de corto plazo, no médico, disponible las 24 horas, que no involucra a una institución, y que ofrece servicios de rehabilitación para
miembros con un diagnóstico de SUD cuando se determina una necesidad médica, de acuerdo con un plan individualizado de tratamiento. Cada paciente reside en el lugar y recibe apoyo para restaurar, mantener y aplicar las habilidades de vida independiente e interpersonal, y para acceder a los sistemas comunitarios de apoyo. Los proveedores y residentes trabajan en estrecha colaboración para definir las barreras, establecer prioridades, metas, elaborar planes de tratamiento y resolver los problemas relacionados con el SUD. Las metas incluyen mantener la abstinencia, prepararse para los detonantes de recaídas, mejorar la salud personal y el funcionamiento social, y participar activamente de la atención continua.

- Los servicios residenciales requieren autorización previa del plan del condado. Cada autorización se otorga por un máximo de 90 días para adultos y 30 días para jóvenes. Únicamente dos autorizaciones se permiten en un período de un año. Es posible tener una extensión de 30 días por año con base en la necesidad médica. Las embarazadas pueden recibir servicios residenciales hasta el último día del mes en el que cumplen 60 días después del parto. Los pacientes elegibles para una evaluación periódica temprana, diagnóstico y tratamiento (EPSDT por sus siglas en inglés) (menores de 21 años) no tendrán los límites de autorización descritos antes, siempre y cuando los servicios residenciales continuos sean médicamente necesarios.

- Incluyen admisión y evaluación, planificación de tratamiento, consejería individual o en grupo, terapia familiar, servicios relacionados, servicios de educación para miembros, servicios de medicación, protección de medicamentos (los centros almacenarán todos los medicamentos de los residentes y el personal podrá asistirlos para que se los administren ellos mismos), intervención en caso de crisis, transporte (provisión de transporte o coordinación hacia y desde un tratamiento médicamente necesario), y planificación del alta.

- Cuando es médicamente necesario, también se ofrece el manejo del caso y servicios de recuperación.

- La duración del tratamiento residencial no supera los noventa (90) días, tomando en consideración la gravedad de los problemas y los apoyos necesarios para que el tratamiento sea beneficioso.

- Según la necesidad médica, el tratamiento residencial podrá ser seguido de una derivación para un tratamiento ambulatorio si el paciente está dispuesto a ello.

- **Manejo de la abstinencia**

  - Estos servicios se proporcionan cuando se determina una necesidad médica y de acuerdo con el plan individualizado del paciente. Cada paciente reside en el lugar si recibe un servicio residencial y se le supervisará durante el proceso de desintoxicación. Los servicios por necesidad médica para la habilitación y rehabilitación se proporcionan de acuerdo con el plan individualizado del paciente, recetados por un médico autorizado o alguien con capacidad para...
recetar, y aprobados y autorizados de acuerdo con los requisitos del Estado de California.

- Estos servicios incluyen admisión y evaluación, observación (para evaluar el estado de salud y la respuesta a todo medicamento recetado), servicios de medicamentos, y planificación del alta.
- La mayoría de estos servicios duran de cinco (5) a siete (7) días, luego de lo cual los pacientes pasan al nivel de tratamiento más adecuado a sus necesidades.

- **Tratamiento del trastorno por consumo de opioides**
  - En centros autorizados se ofrecen servicios de los programas de tratamiento del trastorno por consumo de opioides (narcóticos) (OTP/NTP por sus siglas en inglés). Los servicios por necesidad médica se proporcionan de acuerdo con el plan individualizado del paciente elaborado por un médico autorizado o alguien con capacidad para recetar, y se aprueban y autorizan de acuerdo con los requisitos del Estado de California. Los programas OTP/NTP están obligados a ofrecer y recetar medicamentos a los pacientes cubiertos conforme a la lista autorizada de DMC-ODS, que incluye metadona, buprenorfina, naloxona y disulfiram.
  - El miembro del plan debe recibir, al menos, 50 minutos de sesiones de consejería con un terapeuta o consejero, y hasta 200 minutos por mes calendario, aunque se pueden proporcionar servicios adicionales según la necesidad médica.
  - Los servicios incluyen los mismos componentes que los de tratamiento ambulatorio, con la adición de psicoterapia médica que consiste en conversaciones en persona realizadas con un médico, de manera individual.
  - Dependiendo de la gravedad del trastorno por uso de opioides, la duración del tratamiento llevar meses a años, y se enfoca principalmente en prevenir las recaídas

- **Tratamiento asistido con medicamentos (varía según el condado)**
  - Servicios de tratamiento asistido con medicamentos (MAT por sus siglas en inglés) disponibles fuera de la clínica del programa de tratamiento por consumo de opioides (OTP por sus siglas en inglés). Consiste en usar medicamentos que necesitan receta, en combinación con terapias conductuales y de consejería, para darle un enfoque integral y personal al tratamiento por uso de sustancias (SUD). Ofrecer este nivel de servicio es opcional para los condados participantes.
  - Los servicios de MAT incluyen ordenar, recetar, administrar y supervisor todos los medicamentos para el tratamiento por uso de sustancias (SUD). La dependencia del alcohol y de los opioides, en particular, cuentan con opciones médicas bien establecidas. Los médicos, así como otros profesionales que también expiden medicamentos con receta, podrían ofrecer medicamentos a los miembros que estén cubiertos según la lista autorizada de DMC-ODS, la que incluye buprenorfina, naloxona, disulfiram, vivitrol, acamprosato, o cualquier otro aprobado por la FDA para el tratamiento por uso de sustancias (SUD).
Los servicios de MAT se pueden brindar a pacientes que no desean recibir un tratamiento y recuperación sin medicamentos, o que estos no le resultan. La duración de estos servicios se determina según cada caso individual y toma en consideración la gravedad de los problemas y los apoyos necesarios para que el tratamiento sea beneficioso.

**Servicios de recuperación**

- Estos servicios son importantes para la recuperación y el bienestar del miembro del plan. La comunidad que interviene en el tratamiento se convierte en un agente terapéutico a través del cual se empodera y se prepara a los pacientes para que manejen sus salud y su atención médica. Por lo tanto, el tratamiento debe enfatizar el papel central de ese paciente en el manejo de su propia salud, usar estrategias de apoyo efectivas para el automanejo, y organizar los recursos comunitarios e internos para proporcionar un apoyo continuo de automanejo para esos miembros.
- Incluyen consejería grupal e individual; asistencia ante el consumo de sustancias/supervisión de la recuperación (consejería de recuperación, prevención de recaídas, y servicios entre pares); y manejo del caso (vinculación a servicios educativos, vocacionales, de apoyo familiar, de apoyo comunitario, de vivienda, de transporte, y otros según las necesidades).
- A menudo los proporcionan pares debidamente capacitados, o personas cuyas experiencias de vida pueden ser útiles para la recuperación de otros.
- Los servicios de recuperación no son necesarios para aquellos pacientes que pueden recuperarse sin ellos. Estos servicios deben ser médicamente necesarios, y en general duran de tres (3) a seis (6) meses.

**Manejo de casos**

- Los servicios de manejo de casos permiten al miembro del plan acceder a servicios necesarios médicos, educativos, sociales, prevocacionales, vocacionales y de rehabilitación, entre otros. Estos servicios se centran en la coordinación de la atención de los trastornos por uso de sustancias (SUD), la integración de la atención primaria especialmente para los miembros que tienen SUD crónico, y la interacción con el sistema de justicia penal, en caso de ser necesario.
- Incluyen una evaluación completa y una reevaluación periódica de las necesidades de la persona para determinar la necesidad de continuar brindándolos; transiciones a niveles más altos o más bajos de atención del SUD; desarrollo y revisión periódica del plan de un miembro que incluye actividades del servicio; comunicación, coordinación, recomendaciones y otras actividades relacionadas; supervisión del servicio para garantizar que el miembro accede al servicio y al sistema de servicios; supervisión del progreso del miembro; y defensa del miembro, vinculación a atención médica física y mental, transporte y retención en servicios de cuidado primarios.
El manejo de casos debe ser consistente con la legislación Federal y la de California y no infringirá la confidencialidad de ningún miembro.

Se anticipa que la mayoría de los miembros no necesitarán los servicios de manejo de casos dado que pueden realizar con éxito un tratamiento y la recuperación, sin dichos servicios. Los servicios de manejo de casos en general se proporcionan a pacientes adolescentes, embarazadas o con niños, que tienen problemas de salud mental y/o física concurrentes, y/o cuyas necesidades complejas requieren más que los servicios de tratamiento y recuperación estándares.

Evaluación temprana y periódica, diagnóstico y tratamiento (EPSDT por sus siglas en inglés)

Si usted es menor de 21 años, podría recibir servicios adicionales médicamente necesarios conforme a la evaluación temprana y periódica, diagnóstico y tratamiento (EPSDT por sus siglas en inglés). Estos servicios incluyen exámenes de detección, servicios oftalmológicos, de odontología, audición y todos los demás que sean necesarios desde el punto de vista médico, obligatorios y opcionales, conforme la sección 1396d (a) del título 42 del Código de los Estados Unidos para corregir y mejorar defectos y enfermedades y afecciones físicas y mentales identificadas en un examen de detección EPSDT, independientemente de que los servicios estén cubiertos para adultos. El requisito de necesidad médica y bajo costo son las únicas limitaciones o exclusiones que se aplican a los servicios de EPSDT.

Para obtener una descripción más completa de los servicios de EPSDT disponibles, y para plantear dudas, llame la línea de acceso al 1-888-868-1649.

CÓMO OBTENER SERVICIOS DE DMC-ODS

¿Cómo obtengo los servicios de DMC-ODS?

Si considera que necesita servicios para tratar un trastorno por uso de sustancias (SUD), puede solicitarlos usted mismo al plan del condado. Llame al número gratuito del condado que figura en la primera parte de este manual. También existen otras maneras de que le recomienden acudir al plan del condado para tratar el trastorno por uso de sustancias (SUD). El plan de su condado está obligado a aceptar recomendaciones para servicios de tratamiento de SUD de parte de médicos y otros proveedores de atención médica primaria quienes consideren que usted los necesite, y de parte del plan de salud administrado por Medi-Cal, en caso de que lo tenga. En general, el proveedor del plan de salud administrado por Medi-Cal necesitará contar con su permiso, o el de los padres u otras personas a cargo en caso de ser menor, para emitir una recomendación, salvo en caso de emergencia. Las recomendaciones para el condado también las pueden emitir otros: escuelas, departamentos de servicios sociales o de asistencia social del condado, curadores, tutores o familiares, y agencias del orden público.
Los servicios cubiertos están disponibles a través de la red de proveedores del Departamento de Behavioral Wellness del condado de Santa Barbara. En caso de que un proveedor contratado se oponga a realizar o a apoyar cualquier servicio cubierto, el programa contra el alcohol y las drogas (ADP por sus siglas en inglés) del condado de Santa Barbara hará arreglos para que otro proveedor los realice. El Departamento de Behavioral Wellness del condado de Santa Barbara responderá oportunamente con recomendaciones y coordinación en caso de que un servicio cubierto no se encuentre disponible porque el proveedor correspondiente haya presentado objeciones religiosas, éticas o morales ante dicho servicio cubierto.

El nivel de atención médica específico de cada paciente será el que corresponda con sus necesidades según los criterios de asignación elaborados por la Sociedad Americana de Medicina de la Adicción (ASAM por sus siglas en inglés). Dado que las necesidades de cada uno varían, el nivel de atención médica o la intensidad de un tratamiento será diferente. El condado de Santa Barbara cuenta con políticas y procedimientos especííficos para la transición de los pacientes de un nivel de atención médica a otro según esas variaciones de necesidades. Se prestará especial atención para que esa transición o paso de un nivel de atención médica a otro se realice sin contratiempos y esté enfocada en el paciente.

¿Dónde puedo obtener los servicios de DMC-ODS?

El Departamento de Behavioral Wellness del condado de Santa Barbara participa en el programa piloto de DMC-ODS. Como residente del condado de Santa Barbara, puede utilizar los servicios de DMC-ODS en ese condado a través del plan de DMC-ODS del condado. El plan de su condado cuenta con proveedores de tratamiento de SUD para tratar afecciones cubiertas por el plan. Otros condados que proporcionan servicios del programa “Drug Medi-Cal” (DMC) que no participan en el programa piloto de DMC-ODS podrán ofrecer servicios regulares de DMC si los necesita. Si usted tiene menos de 21 años, también tiene derecho a utilizar los servicios de EPSDT en cualquier otro condado del Estado.

Atención médica fuera del horario normal
Para acceder a servicios relacionados con uso de sustancias o alcohol y otras drogas, en inglés o en español, fuera del horario normal de servicio, llame a nuestra línea de acceso gratuita disponible las 24 horas, todos los días: 888-868-1649.

¿Cómo sé cuándo necesito ayuda?

Muchas personas pasan por momentos difíciles en la vida y presentan trastornos por uso de sustancias (SUD). Pregúntese a usted mismo si necesita ayuda profesional, y recuerde siempre que debe confiar en usted mismo. Si tiene derecho a Medi-Cal, y decide que necesita ayuda profesional, solicite una evaluación del plan de su condado para confirmarlo, ya que actualmente reside en un condado que participa en el sistema DMC-ODS.
¿Cómo sé cuando un niño o adolescente necesita ayuda?

Comuníquese con el plan DMC-ODS del condado participante y solicite una evaluación para el niño o adolescente si le parece que presenta signos de un trastorno por uso de sustancias (SUD). Si ese niño o adolescente tiene derecho a Medi-Cal, y la evaluación del condado indica que los servicios de tratamiento por drogas o alcohol son necesarios, el condado hará los arreglos para que ese niño o adolescente los obtenga.

CÓMO OBTENER SERVICIOS DE SALUD MENTAL

¿Dónde puedo obtener servicios especializados de salud mental?

Usted puede obtener servicios especializados de salud mental en el condado en el que vive. Cada condado ofrece servicios especializados de salud mental para niños, jóvenes, adultos y adultos mayores. Si usted es menor de 21 años, tiene derecho al examen de detección temprana y periódica, diagnóstico y tratamiento (EPSDT por sus siglas en inglés), que puede incluir cobertura y beneficios adicionales.

El plan de salud mental (MHP por sus siglas en inglés) que consulte determinará si usted necesita servicios especializados. En ese caso, el mismo plan le recomendará a un proveedor de servicios de salud mental. Para obtener mayor información, llame al 1-888-868-1649.

NECESIDAD MÉDICA

¿Qué es la necesidad médica y por qué es tan importante?

Una de las condiciones necesarias para recibir tratamiento para trastornos por uso de sustancias (SUD) a través del plan DMC-ODS de su condado es la llamada "necesidad médica". Significa que un médico u otro profesional habilitado hablará con usted para decidir si los servicios son necesarios desde el punto de vista médico, y si obtener esos servicios le beneficiaría.

El término necesidad médica es importante porque permitirá decidir si usted tiene derecho a los servicios de DMC-ODS, y qué tipo de servicios son apropiados. Decidir la necesidad médica es una parte muy importante del proceso para obtener los servicios de DMC-ODS.
¿Cuáles son los criterios de "necesidad médica" para cubrir servicios de tratamiento de trastornos por uso de sustancias?

El plan DMC-ODS de su condado, antes de decidir si usted necesita servicios de tratamiento de trastornos por uso de sustancias (SUD), determinará, junto con usted y su proveedor, si esos servicios son médicamente necesarios, según se explicó antes. En esta sección se explica cómo su condado participante tomará esa decisión.

Para recibir servicios a través de DMC-ODS, usted debe cumplir los siguientes criterios:

- Debe estar registrado en Medi-Cal.
- Debe residir en un condado que participe en el sistema DMC-ODS.
- Debe tener al menos un diagnóstico del Manual diagnóstico y estadístico de trastornos mentales (DSM por sus siglas en inglés) para un trastorno adictivo relacionado con sustancias, con ciertas excepciones para los menores de 21, con una evaluación de "en riesgo" de desarrollar un SUD.
- Debe satisfacer la definición que da la Sociedad Americana de Medicina de la Adicción (ASAM por sus siglas en inglés) de necesidad médica para servicios basada en los criterios formulados por dicha Sociedad (los criterios ASAM son estándares nacionales de tratamiento para afecciones adictivas y relacionadas con sustancias).

Usted no necesita saber si tiene un diagnóstico para pedir ayuda. El plan DMC-ODS de su condado le ayudará a obtener esta información y a determinar la necesidad médica mediante una evaluación.

**LA ELECCIÓN DEL PROVEEDOR**

¿Cómo encuentro un proveedor para recibir servicios de tratamiento de trastorno por uso de sustancias que necesito?

El plan de su condado podría imponer algunos límites a la elección de proveedores. Este debe brindarle la oportunidad de elegir entre al menos dos proveedores cuando usted apenas inicia los servicios, salvo que tenga una buena razón para no hacerlo, como, por ejemplo, si solo hubiera un solo proveedor para los servicios que necesita. Debe también permitirle cambiar de proveedor. Cuando usted solicita cambiar de proveedor, el condado debe permitirle elegir entre al menos dos proveedores, salvo que haya una buena razón para no hacerlo.

En algunos casos, los proveedores contratados por el condado se retiran de la red del condado por su cuenta o a solicitud del plan. Cuando esto ocurre, el plan del condado debe hacer un esfuerzo de buena fe y presentar una notificación por escrito de la rescisión del contrato de ese proveedor dentro de los 15 días de recibir o emitir la notificación de rescisión a cada persona que recibía tratamiento de SUD de parte de ese proveedor.
Una vez que encuentro a un proveedor, ¿puede el plan del condado informarme a ese proveedor los servicios que recibo?

Usted, su proveedor y el plan de su condado, todos participan de la decisión sobre qué servicios necesita usted recibir a través del condado según los criterios de necesidad médica y la lista de servicios cubiertos. En algunos casos, el condado le dejará esa decisión a usted y al proveedor. En otros casos, podrá solicitarle a su proveedor que le pida revisar las razones por que cree que usted necesita un servicio antes de proporcionarlo. El plan del condado debe emplear a un profesional habilitado para hacer la revisión. Ese proceso de revisión se llama proceso de autorización de plan de pagos.

El proceso de autorización del plan del condado debe seguir un cronograma específico. Para obtener una autorización estándar, el plan debe tomar una decisión sobre la solicitud de su proveedor dentro de los 14 días calendario. Si usted o su proveedor lo solicitan, o el plan del condado considera que es más beneficioso para usted obtener más información de su proveedor, ese plazo se puede extender hasta por otros 14 días calendario. Un ejemplo de cuándo una extensión pueda ser en su beneficio es cuando el condado considera que podría llegar a aprobar la solicitud de autorización del proveedor si contara con información adicional sobre su proveedor, y que tendría que rechazarla en caso de no contar con ella. Si el plan del condado extiende el plazo, le enviará una notificación por escrito sobre esa extensión.

Si el condado no toma una decisión dentro del plazo requerido para una solicitud de autorización regular o acelerada, deberá hacerle llegar un aviso de determinación adversa de beneficios explicando que se le niegan los servicios ante lo cual usted puede apelar o solicitar una audiencia imparcial del Estado (State Fair Hearing en inglés). Usted puede pedir al plan del condado más información sobre su proceso de autorización. Consulte la primera parte de este manual para ver cómo pedir esa información.

Si no está de acuerdo con la decisión del plan de su condado o con un proceso de autorización, puede apelar ante el condado o pedir una audiencia imparcial del Estado.

¿Qué proveedores hay en el plan de DMC-ODS que me corresponde?

Si usted es nuevo en el plan del condado, encontrará una lista completa de los proveedores al final de este manual, que incluye dónde están ubicados, los servicios relacionados con el tratamiento de trastornos por uso de sustancias (SUD) que proporcionan, y otros datos que le permitirán acceder a esa atención médica, así como información sobre los servicios culturales y lingüísticos disponibles a través de esos proveedores. Si tiene consultas, llame al número gratuito de su condado que encontrará en la primera parte de este manual.
AVISO DE DETERMINACIÓN ADVERSA DE BENEFICIOS

¿Qué es un aviso de determinación adversa de beneficios?

El aviso de determinación adversa de beneficios es un formulario que emplea el plan DMC-ODS del condado para informarle cuándo toma una decisión sobre si usted obtendrá o no los servicios de tratamiento de Medi-Cal. Ese aviso también se emplea para informarle en caso de que una queja formal, una apelación o una apelación acelerada no se hubiera resuelto en tiempo, o si usted no hubiera recibido servicios dentro de los plazos que el plan de condado tiene para proporcionarlos.

¿Cuándo recibiré un aviso de determinación adversa de beneficios?

Usted recibirá un aviso de determinación adversa de beneficios en los siguientes casos:

- Si el plan de su condado o uno de los proveedores de dicho plan decide que usted no califica para recibir ningún servicio de tratamiento SUD de Medi-Cal por no satisfacer los criterios de necesidad médica.
- Si su proveedor considera que usted necesita los servicios relacionados con SUD y pide aprobación al plan del condado, pero este no está de acuerdo y rechaza ese pedido, o modifica el tipo o la frecuencia del servicio. La mayoría de las veces usted recibirá un aviso de determinación adversa de beneficios antes de recibir el servicio, pero a veces ese aviso llegará después de que usted haya utilizado el servicio, o mientras usted lo esté utilizando. Si recibe ese aviso después de haber utilizado el servicio, no tendrá que pagar por él.
- Si su proveedor hubiera solicitado aprobación al plan del condado, pero el plan del condado necesita más información para tomar una decisión y no completa ese proceso de aprobación en tiempo.
- Si el plan de su condado no le proporciona servicios a usted dentro de los plazos que ha establecido. Llame al plan de su condado para saber cuáles son los plazos establecidos, si los hay.
- Si usted presenta una queja formal ante el plan del condado y este no le responde con una decisión por escrito dentro de los 90 días. Si usted presenta una apelación ante el plan del condado y este no le responde con una decisión por escrito dentro de los 30 días o, si usted presentó una apelación acelerada y no ha recibido respuesta dentro de los tres días hábiles.

¿Siempre recibiré un aviso de determinación adversa de beneficios cuando no reciba los servicios que yo deseo?

Existen algunos casos en los que usted no recibirá un aviso de determinación adversa de beneficios. Aun en esos casos usted podrá presentar una apelación ante el plan del condado o, habiendo completado el proceso de apelación, podrá solicitar una audiencia imparcial del Estado. En este manual se informa sobre cómo presentar una apelación o solicitar una
audiencia imparcial. Dicha información también debería estar disponible en el consultorio de su proveedor.

¿Qué me comunica el aviso de determinación adversa de beneficios?

El aviso de determinación adversa de beneficios le comunicará:

• Qué fue lo que el plan del condado hizo que le afecta a usted y le impide utilizar los servicios.
• La fecha efectiva de la decisión y la razón por la que se tomó esa decisión.
• Las normas estatales o federales que el condado cumplió al tomar la decisión.
• Qué derechos tiene usted si no está de acuerdo con la medida que tomó el plan.
• Cómo presentar una apelación ante el plan.
• Cómo solicitar una audiencia imparcial del Estado.
• Cómo solicitar una apelación acelerada o una audiencia imparcial acelerada.
• Cómo obtener ayuda para presentar una apelación o para solicitar una audiencia imparcial del Estado.
• Con cuánto tiempo cuenta usted para presentar una apelación o solicitar una audiencia imparcial del Estado.
• Si tiene derecho a continuar utilizando los servicios mientras espera una decisión sobre una apelación o una audiencia imparcial del Estado.
• Cuándo debe presentar su apelación o solicitud de audiencia imparcial del Estado si quiere continuar utilizando los servicios.

¿Qué debo hacer cuando recibo un aviso determinación adversa de beneficios?

Cuando usted recibe un aviso de determinación adversa de beneficios, debe leer con atención toda la información que contiene. Si no entiende el formulario, el plan del condado podrá ayudarle, o puede pedir ayuda a otra persona.

Puede solicitar la continuación del servicio que hubiera sido suspendido cuando presenta una apelación o solicita una audiencia imparcial del Estado. Deberá hacerlo antes de que pasen 10 días de recibir el aviso de determinación adversa de beneficios, o antes de la fecha efectiva de cambio.

PROCESOS DE RESOLUCIÓN DE PROBLEMAS

¿Qué ocurre si el plan DMC-ODS de mi condado no me brinda los servicios que yo deseo?

El plan de su condado cuenta con maneras de solucionar cualquier problema relacionado con los servicios de tratamiento de SUD que usted esté recibiendo. Se denomina proceso de resolución de problemas, y comprende los siguientes procesos:
1. El proceso a través de una queja formal: una expresión de insatisfacción sobre cualquier problema relacionado con los servicios de su tratamiento de SUD.

2. El proceso de apelación: examinar una decisión (rechazo o cambios de servicios) que el plan del condado o el proveedor hubiera tomado sobre los servicios de tratamiento de SUD.

3. El proceso de audiencia imparcial del Estado: una revisión que garantiza que usted recibe los servicios de tratamiento de SUD a los cuales tiene derecho según el programa de Medi-Cal.

Presentar una queja formal, una apelación o solicitar una audiencia imparcial del Estado, no pesará en su contra y no afectará los servicios que esté recibiendo. Una vez finalizada la queja formal o apelación, o la audiencia imparcial del Estado, el plan del condado le notificará el resultado final a usted y a las demás partes implicadas.

Siga leyendo para conocer un poco más sobre cada uno de los procesos de resolución de problemas.

¿Puedo obtener ayuda para presentar una apelación, una queja formal o solicitar una audiencia imparcial del Estado?

El plan de su condado cuenta con personal disponible para explicarle esos procesos y ayudarlo a notificar un problema, ya sea con una queja formal, una apelación, o una solicitud de audiencia imparcial del Estado. Asimismo, le pueden ayudar a tomar una decisión, si tiene derecho a lo que se llama el proceso "acelerado", es decir, que será examinado más rápidamente porque su salud o su estabilidad están en riesgo. Usted también puede autorizar a otra persona a actuar en su nombre, incluso a su proveedor de tratamiento de SUD.

Si desea contar con ayuda, llame a nuestra línea de acceso gratuita y disponible las 24 horas, todos los días, al 1-888-868-1649. Los servicios de recomendación y de exámenes de detección se brindan en inglés y en español.

¿Qué ocurre si necesito resolver un problema con el plan DMC-ODS de mi condado pero no quiero presentar una queja formal o una apelación?

Puede obtener ayuda del Estado si no logra encontrar a las personas adecuadas en el condado para ayudarle a entender cómo funciona el sistema.

Puede obtener ayuda legal gratuita en una oficina local de ayuda legal o a través de otros grupos. Puede consultar sobre sus derechos de audiencia en la Unidad Pública de Investigación y Respuesta (Public Inquiry and Response Unit):

Llame sin costo: 1-800-952-5253
Si usted es sordo y usa TDD, llame al: 1-800-952-8349
PROCESO A TRAVÉS DE UNA QUEJA FORMAL

¿Qué es una queja formal?

Una queja formal es la expresión de insatisfacción sobre cualquier problema relacionado con los servicios de tratamiento de SUD que no esté cubierto por los procesos de apelación y de audiencia imparcial del Estado.

El proceso de queja formal:
• Son procedimientos sencillos y fáciles de entender que le permiten presentar su queja formal de forma verbal o por escrito.
• No pesará en su contra ni en contra de su proveedor de ninguna forma.
• Le permitirá autorizar a otra persona a actuar en su nombre, incluso a un proveedor. Si autoriza a otra persona para actuar en su nombre, el plan del condado le solicitará que firme un formulario en el que se autoriza al plan a divulgar información a aquella persona.
• Garantiza que las personas que toman las decisiones están calificadas para hacerlo y que no han participado en ningún nivel previo de revisión o de toma de decisión.
• Identifica sus roles y su responsabilidades, así como las del plan de su condado y las de su proveedor.
• Resuelve la queja formal en los plazos establecidos.

¿Dónde puedo presentar una queja formal?

Puede presentar una queja formal ante el plan del condado si está insatisfecho con los servicios de tratamiento de SUD que recibe, o si tiene alguna otra inquietud sobre ese plan del condado.

¿Cómo presento una queja formal?

Llame al número de teléfono gratuito del plan de su condado para que le ayuden. El condado dispone de sobres con la dirección preimpresa en los lugares que atienden los proveedores para que usted pueda enviar su queja formal por correo. Las quejas formales se pueden presentar en forma verbal o por escrito. Las quejas formales verbales no necesitan un seguimiento por escrito.

¿Cómo sé que el plan del condado recibió mi queja formal?

El plan de su condado le enviará una confirmación por escrito.
¿Cuándo se decidirá sobre mi queja formal?

El plan del condado debe tomar una decisión sobre su queja formal dentro de los 90 días calendario a partir de la fecha en que la presentó. Los plazos podrán extenderse hasta por otros 14 días calendario si usted hubiera solicitado una extensión, o si el plan del condado considera que necesita más información y que esa demora es en su beneficio. Un ejemplo de demora beneficiosa para usted es en el caso que el condado considere que sería posible resolver su queja formal si contara con más tiempo para recabar la información de su parte y de las demás personas intervinientes.

¿Cómo sé si el plan del condado ha tomado una decisión sobre mi queja formal?

Cuando el plan del condado ha tomado una decisión sobre su queja formal, se la notificará por escrito a usted o a la persona que haya autorizado. En caso de que no se le notifique a tiempo a usted o a alguna de las partes afectadas, entonces le dará un aviso de determinación adversa de beneficios avisándole de su derecho a solicitar una audiencia imparcial del Estado. Ese aviso de determinación adversa de beneficios se le entregará en la fecha de vencimiento del plazo.

¿Hay una fecha límite para presentar una queja formal?

Usted puede presentar una queja formal en cualquier momento.

PROCESO DE APELACIÓN (estándar y acelerado)

El plan de su condado tiene la obligación de permitirle solicitar una revisión de una decisión tomada por el plan o sus proveedores sobre los servicios de su tratamiento de SUD. Existen dos maneras de solicitar una revisión. Una manera es mediante el proceso estándar de apelación. La segunda manera es mediante el proceso de apelación acelerado. Estas dos maneras son similares; pero para tener derecho a presentar la apelación acelerada se deben cumplir requisitos específicos, los que se explican a continuación.

¿Qué es una apelación estándar?

La apelación estándar consiste en una solicitud de revisión de un problema que usted tenga con el plan o su proveedor con respecto a servicios que usted considere que necesita y se le hayan negado o se los hayan cambiado. Si solicita una apelación estándar, el plan del condado puede tomar hasta 30 días para revisarla. Si considera que 30 días significará un riesgo para su salud, debería solicitar una "apelación acelerada". El proceso de apelación estándar:

- Le permite presentarla en persona, por teléfono o por escrito. Si la presenta en persona o por teléfono, deberá realizar un seguimiento con una apelación escrita y firmada. Puede solicitar ayuda para redactar la apelación. En caso de que no realice
ese seguimiento con una apelación por escrito y firmada, no se resolverá su apelación. Sin embargo, la fecha en que usted presente la apelación verbal se considerará como la fecha de presentación de dicha apelación.

- Le garantiza que presentar una apelación no pesará en su contra ni en contra de su proveedor de ninguna forma.
- Le permitirá autorizar a otra persona para actuar en su nombre, incluso a un proveedor. En caso de autorizar a otra persona para actuar en su nombre, el plan del condado le solicitará que firme un formulario en el que se autoriza al plan a divulgar información a aquella persona.
- Hará que sus beneficios continúen siempre y cuando haya solicitado la apelación dentro del plazo requerido, que son 10 días a partir de la fecha en que se le envió o se le entregó en persona el aviso de determinación adversa de beneficios. Usted no debe pagar por la continuación de servicios mientras la apelación esté pendiente. Si usted solicita la continuación del beneficio, y la decisión final de la apelación confirma la decisión de reducir o suspender el servicio que estaba recibiendo, es probable que deba pagar el costo de los servicios brindados mientras la apelación estaba pendiente.
- Garantiza que las personas que toman las decisiones están calificadas para hacerlo y que no han participado en ningún nivel previo de revisión o de toma de decisión.
- Le permite a usted o a la persona que usted autorice a examinar el archivo de su caso, incluido su expediente médico y cualquier otro documento o expediente considerado durante el proceso de apelación, antes y durante dicho proceso.
- Le brindará un tiempo razonable para presentar pruebas y alegaciones de hecho o de derecho, en persona o por escrito.
- Le permitirá a usted o a la persona que usted autorice, o al representante legal de la sucesión de un miembro que haya fallecido, ser parte en la apelación.
- Le enviará una confirmación por escrito para informarle que su apelación está siendo revisada.
- Le informará sobre su derecho a solicitar una audiencia imparcial del Estado, una vez concluido el proceso de apelación.

¿Cuándo presento una apelación?

Puede presentar una apelación ante el plan de DMC-ODS de su condado:

- Si el condado o uno de los proveedores contratos por el condado decide que usted no califica para recibir ningún servicio de tratamiento de SUD de Medi-Cal por no satisfacer el criterio de necesidad médica.
- Si su proveedor considera que usted necesita un servicio de tratamiento de SUD y pide aprobación al plan del condado, pero este no está de acuerdo y rechaza esa solicitud, o modifica el tipo o la frecuencia del servicio.
- Si su proveedor hubiera solicitado aprobación al plan del condado, pero el plan del condado necesita más información para tomar una decisión y no completa ese proceso de aprobación en tiempo.
• Si el plan de su condado no le proporciona servicios dentro de los plazos que ha establecido.
• Si usted considera que el plan del condado no proporciona servicios lo suficientemente rápido como para satisfacer sus necesidades.
• Si su queja formal, apelación o apelación acelerada no hubiera sido resuelta en tiempo.
• Si usted y su proveedor no están de acuerdo sobre los servicios de SUD que usted necesita.

¿Cómo presento una apelación?

En la primera parte de este manual se explica cómo presentar una apelación ante el plan de su condado. Puede llamar al número gratuito del plan de su condado para que le ayuden. El plan pondrá a disposición sobres con la dirección preimpresa en todos los lugares que atienden los proveedores para que usted pueda enviar su apelación por correo.

¿Cómo sé si se ha tomado una decisión respecto de mi apelación?

El plan de DMC-ODS de su condado le notificará por escrito a usted o a quien usted autorice sobre la decisión respecto de su apelación. En esa notificación figurará lo siguiente:
• El resultado del proceso de resolución de apelaciones.
• La fecha en que se tomó la decisión respecto de la apelación.
• Si la apelación no se resuelve por completo en su favor, se le informará su derecho a y el proceso de solicitar una audiencia imparcial del Estado.

¿Hay una fecha límite para presentar una apelación?

Debe presentar una apelación dentro de los 60 días siguientes a la fecha de la acción que apela cuando recibe un aviso de determinación adversa de beneficios. Recuerde que no siempre recibirá un aviso de determinación adversa de beneficios. No hay fechas límite para presentar una apelación cuando no recibe un aviso de determinación adversa de beneficios, por lo que puede presentar este tipo de apelación en cualquier momento.

¿Cuándo se tomará una decisión respecto de mi apelación?

El plan del condado debe decidir sobre su apelación dentro de los 30 días calendario a partir de que recibe su solicitud de apelación. Los plazos podrán extenderse hasta por otros 14 días calendario si usted hubiera solicitado una extensión, o si el plan considera que necesita más información y que esa demora es en su beneficio. Un ejemplo de demora beneficiosa para usted es en el caso que el contado considere que sería posible aprobar su apelación si contara con más tiempo para recabar la información de su parte o de su proveedor.
¿Qué ocurre si no puedo esperar 30 días para que se decida mi apelación?

El proceso de apelación podrá ser más rápido si califica para el proceso de apelación acelerada.

¿Qué es una apelación acelerada?

Una apelación acelerada es una forma más rápida de decidir sobre una apelación. El proceso acelerado es en cierta manera similar al proceso estándar. Sin embargo:

- La apelación debe cumplir ciertos requisitos.
- El proceso de apelación también cuenta con diferentes fechas límites que la apelación estándar.
- En la apelación acelerada se puede hacer una solicitud verbal. No tiene por qué poner por escrito su solicitud de apelación acelerada.

¿Cuándo presento una apelación acelerada?

Si considera que esperar 30 días para recibir la decisión sobre una apelación estándar hará peligrar su vida, su salud o su habilidad de alcanzar, mantener o recuperar su máxima funcionalidad, podrá solicitar una resolución acelerada. Si el plan del condado considera que cumple los requisitos para hacerlo, resolverá esa apelación acelerada dentro de las 72 horas luego de recibirla. Se puede extender la fecha límite hasta por otros 14 días calendario si usted hubiera solicitado una extensión, o si el plan del condado considera que necesita recabar más información y que esa demora es en su beneficio. Si el plan del condado extiende la fecha límite, le hará llegar una explicación por escrito al respecto.

Si el plan del condado decide que su apelación no califica para ser acelerada, hará todo lo posible por hacerle llegar una notificación verbal cuanto antes y le informará por escrito dentro de los 2 días calendario la razón de la decisión. Luego, su apelación seguirá los plazos de una apelación estándar descritos más arriba. Si usted no está de acuerdo con esa decisión, podrá presentar una queja formal.

En cuanto el plan resuelve su apelación acelerada, se le notificará por escrito a usted y a todas las partes afectadas.

PROCESO DE AUDIENCIA IMPARCIAL DEL ESTADO

¿Qué es la audiencia imparcial del Estado?

La audiencia imparcial del Estado es una revisión independiente que realiza el Departamento de Servicios Sociales de California para garantizar que usted reciba los servicios por tratamiento de SUD a los que usted tiene derecho según el programa de Medi-Cal.
¿Cuáles son mis derechos en una audiencia imparcial del Estado?

Tiene derecho a lo siguiente:

• Una audiencia en el Departamento de Servicios Sociales de California (también denominada “audiencia imparcial del Estado”).
• Que le expliquen cómo solicitar una audiencia imparcial del Estado.
• Que le expliquen las normas que rigen la representación en una audiencia imparcial del Estado.
• Continuar recibiendo los beneficios, si lo solicita, durante el proceso de audiencia imparcial del Estado, siempre que haya solicitado dicha audiencia dentro de los plazos establecidos.

¿Cuándo solicito una audiencia imparcial del Estado?

Usted puede solicitar una audiencia imparcial del Estado:

• Si ya ha completado el proceso de apelación del plan del condado.
• Si el condado o uno de los proveedores contratados por el condado decide que usted no califica para recibir ningún servicio de tratamiento de SUD de Medi-Cal por no satisfacer el criterio de necesidad médica.
• Si su proveedor considera que usted necesita los servicios relacionados con SUD y pide aprobación al plan del condado, pero este no está de acuerdo y rechaza esa solicitud, o modifica el tipo o la frecuencia del servicio.
• Si su proveedor hubiera solicitado aprobación al plan del condado pero este necesita más información para tomar una decisión y no completa ese proceso de aprobación en tiempo.
• Si su condado no le proporciona los servicios dentro de los plazos que el condado ha establecido.
• Si no considera que el plan le proporciona los servicios lo suficientemente rápido como para satisfacer sus necesidades.
• Si su queja formal, apelación, o apelación acelerada no hubiera sido resuelta en tiempo.
• Si usted y su proveedor no están de acuerdo sobre los servicios de SUD que usted necesita.

¿Cómo solicito una audiencia imparcial del Estado?

Puede solicitar una audiencia imparcial del Estado directamente en el Departamento de Servicios Sociales de California. Envíe su solicitud por escrito a:

State Hearings Division [División de Audiencias del Estado]
California Department of Social Services [Departamento de Servicios Sociales de California]
744 P Street, Mail Station 9-17-37
Sacramento, California 95814
También puede llamar al 1-800-952-8349 o por TDD al 1-800-952-8349.

¿Hay una fecha límite para solicitar una audiencia imparcial del Estado?

Usted solo cuenta con 120 días para solicitar una audiencia imparcial del Estado. Los 120 días se cuentan a partir del día siguiente al que el plan de su condado le entregó en persona la notificación de la decisión de la apelación, o del día siguiente a la fecha en que se le envió por correo esa notificación de la decisión de la apelación.

En caso de no haber recibido un aviso de determinación adversa de beneficios, podrá presentar una solicitud de audiencia imparcial del Estado en cualquier momento.

¿Se puede continuar utilizando los servicios mientras espero la decisión de la audiencia imparcial del Estado?

Usted puede seguir el tratamiento mientras espera la decisión de una audiencia imparcial del Estado si su proveedor considera que es necesario que usted continúe el tratamiento que ya está recibiendo y solicita al plan del condado una aprobación para que se continúen, pero el condado no lo acepta y rechaza la solicitud del proveedor, o cambia el tipo o la frecuencia del servicio solicitado por el proveedor. Usted en todos estos casos recibirá un aviso de determinación adversa de beneficios. Además, no deberá pagar los servicios que reciba mientras la audiencia imparcial del Estado esté pendiente.

Si solicita la continuación del beneficio, y la decisión final de la audiencia imparcial del Estado confirma la decisión de reducir o suspender el servicio que estaba recibiendo, se le podrá exigir que pague los servicios brindados mientras la audiencia imparcial del Estado estaba pendiente.

¿Qué necesito hacer si quiero continuar los servicios mientras espero la decisión de una audiencia imparcial del Estado?

Si desea continuar los servicios durante un proceso de audiencia imparcial del Estado, debe solicitar una audiencia imparcial del Estado dentro de los 120 días de la fecha de notificación de resolución del condado.

¿Qué ocurre si no puedo esperar 120 días para conocer la decisión de la audiencia imparcial del Estado?

Podrá solicitar una audiencia imparcial del Estado acelerada (más rápida) si considera que el plazo normal de 120 días resultará en serios problemas para su salud, como su habilidad para ganar, mantener o recuperar funciones vitales importantes. La División de Audiencias del Estado, del Departamento de Servicios Sociales, revisará su solicitud de audiencia imparcial del Estado acelerada y decidirá si puede presentarla. En caso de aprobarla, la audiencia se

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celebrará y la decisión sobre esa audiencia se emitirá dentro de los tres (3) días laborales siguientes a la fecha en que su solicitud fue recibida por la División de Audiencias del Estado.

INFORMACIÓN IMPORTANTE SOBRE EL PROGRAMA DE MEDI-CAL DEL ESTADO DE CALIFORNIA

¿Quién tiene derecho a Medi-Cal?

Usted tiene derecho a Medi-Cal si está comprendido en uno de estos grupos:

- 65 años de edad, o mayores
- Menores de 21 años de edad
- Adultos, entre 21 y 65 años, según elegibilidad por ingresos
- Ciegos o discapacitados
- Embarazadas
- Cierto refugiados, o inmigrantes cubanos/haitianos
- Recibe atención en un asilo de ancianos

Usted debe estar viviendo en California para tener derecho a Medi-Cal. Llame o vaya a la oficina local de servicios sociales de su condado y pida una solicitud para Medi-Cal, o consiga una en Internet en la dirección http://www.dhcs.ca.gov/services/medi-cal/pages/MediCalApplications.aspx

¿Debo pagar por Medi-Cal?

Es posible que deba pagar por Medi-Cal, según cuánto dinero reciba o gane cada mes.

- Si sus ingresos son menores que los límites establecidos por Medi-Cal para el tamaño de su núcleo familiar, no deberá pagar por los servicios de Medi-Cal.
- Si sus ingresos son mayores que los límites establecidos por Medi-Cal para el tamaño de su núcleo familiar, deberá pagar una parte por los servicios médicos o del tratamiento SUD. El monto que usted paga se denomina “parte del costo”. Una vez que usted ha pagado su “parte del costo”, Medi-Cal pagará el resto de su factura por servicios médicos cubiertos del mes que corresponda. En los meses en los que no tiene ningún gasto médico, no debe pagar nada.
- Podría tener que pagar un “co-pago” por cualquier tratamiento según Medi-Cal. Esto significa que pagará un monto por su cuenta cada vez que reciba un servicio médico o tratamiento SUD, o un medicamento con receta, y un co-pago si usted va a la sala de emergencias por un servicio regular.

Su proveedor le informará si necesita hacer un co-pago.
¿Cubre Medi-Cal el transporte?

Si tiene problemas para llegar a las citas médicas o a las citas para el tratamiento por drogas o alcohol, el programa Medi-Cal le puede ayudar a encontrar transporte.

- En caso de tener niños, el Programa de Salud y Prevención de Discapacidades de Niños (CHDP por sus siglas en inglés) le puede ayudar;
- Dirección del programa CHDP:
  - 345 Camino Del Remedio, Santa Barbara, CA 93110
  - Tel.: (805) 681-5130
  - Fax: (805) 681-4958
- También puede obtener información en línea en: http://www.dhcs.ca.gov/services/chdp/Pages/CountyOffices.aspx
- La oficina de servicios sociales de su condado puede ayudar a adultos y niños. Puede llamar por teléfono:
  - Santa María DSS: (805) 346-7135
  - Lompoc DSS: (805) 737-7080
  - Santa Barbara DSS: (805) 681-4401
- Hay servicios de transporte para acceder a todos los servicios, incluso aquellos no incluidos en el programa de DMC-ODS.

**DERECHOS Y OBLIGACIONES DE LOS MIEMBROS**

¿Cuáles son mis derechos como miembro beneficiario de servicios de DMC-ODS?

Usted tiene derecho a Medi-Cal y reside en un condado que participa del programa piloto de DMC-ODC, por lo que tiene derecho a recibir servicios de tratamiento para trastornos por uso de sustancias (SUD) médicamente necesarios de parte del plan de su condado. Usted tiene derecho a:

- Ser tratado con respeto, y que se considere su derecho a confidencialidad y se mantenga la confidencialidad de su información médica.
- Recibir información sobre opciones de tratamiento y alternativas disponibles, presentadas de manera apropiada a su propia situación médica y habilidad de comprender.
- Participar en decisiones relativas a la atención médica de su trastorno por uso de sustancias (SUD), lo que comprende el derecho a rechazar un tratamiento.
- Recibir acceso oportuno a la atención médica, incluso a servicios disponibles las 24 horas del día, los 7 días de la semana, cuando haya necesidad médica de tratar una afección de emergencia o una crisis de forma urgente.
• Recibir la información contenida en este manual sobre los servicios de tratamiento de SUD que cubre el plan de DMC-ODS de su condado, otras obligaciones del plan de su condado y sus derechos que se encuentran descritos aquí.
• Que se proteja su información médica confidencial.
• Solicitar y recibir copia de sus registros médicos, y solicitar que se enmienden o corrijan según se estipula en las secciones 164.524 y 164.526 del título 45 del Código de Reglamentos Federales.
• Recibir materiales por escrito en otros formatos (como Braille, letra grande de imprenta, y audio) a solicitud y en tiempo apropiado para el formato que se solicite.
• Recibir servicios de interpretación oral para el idioma de su preferencia.
• Recibir servicios para el tratamiento de SUD de parte del plan de su condado según los requisitos del contrato que ese condado haya celebrado con el Estado en las áreas donde estén disponibles esos servicios, garantías de la adecuación de la capacidad y de los servicios, coordinación y continuidad de la atención médica, y cobertura y autorización de servicios.
• Acceder a servicios de consentimiento para menores, en caso de que usted sea menor.
• Acceder a servicios médicamente necesarios fuera de la red en tiempo, si el plan no cuenta con un empleado o un proveedor contratado que pueda proporcionar dichos servicios. Un “proveedor fuera de la red” es aquel que no figura en la lista de proveedores del plan de su condado. El condado debe garantizar que usted no paga nada extra por consultar a un proveedor fuera de la red. Comuníquese con la línea de acceso del Departamento de Behavioral Wellness al (888) 868-1649 para informarse sobre cómo acceder a los servicios de un proveedor fuera de la red.
• Solicitar una segunda opinión de parte de un profesional médico calificado dentro de la red del condado, o de uno fuera de esa red, sin costo adicional para usted.
• Presentar quejas formales, ya sea en forma verbal o escrita, sobre la institución o la atención médica recibida.
• Solicitar una apelación, ya sea verbalmente o por escrito, una vez recibido el aviso de determinación adversa de beneficios.
• Solicitar una audiencia imparcial del Estado de Medi-Cal, así como información sobre cuándo es posible solicitar una audiencia imparcial acelerada.
• No estar sujeto a ninguna forma de restricción o aislamiento usada como forma de coerción, disciplina, conveniencia o represalia.
• Tener la libertad de ejercer estos derechos sin que se afecte adversamente la forma en que usted sea tratado por el plan de su condado, por los proveedores o el Estado.

¿Cuáles son mis obligaciones como miembro beneficiario de servicios de DMC-ODS?

Como miembro beneficiario de servicios de DMC-ODS, sus obligaciones son:
• Leer con atención el material informativo para miembros que el plan de su condado le ha entregado. Ese material le permitirá entender los servicios que están disponibles y cómo recibir el tratamiento en caso de que lo necesite.
• Seguir su tratamiento según esté programado. Alcanzará los mejores resultados si sigue su plan de tratamiento. Si necesita faltar a una cita, llame a su proveedor con al menos 24 horas de anticipación para reprogramarla para otro día y hora.
• Llevar consigo su tarjeta de identificación de Medi-Cal (plan de su condado) y un documento de identificación con foto cuando asista a su tratamiento.
• Informar a su proveedor en caso de necesitar un intérprete, antes de la cita.
• Contarle a su proveedor todas las inquietudes médicas que tiene para que su plan sea lo más preciso posible. Cuanto más completa sea la información que nos brinda sobre sus necesidades, mejores resultados dará su tratamiento.
• Consultar a su proveedor todas las preguntas que tenga. Es muy importante que entienda completamente su plan de tratamiento y cualquier otra información que reciba durante ese tratamiento.
• Seguir el tratamiento acordado entre usted y su proveedor.
• Estar dispuesto a crear una fuerte relación de trabajo con el proveedor que lo esté tratando.
• Comuníquese con el plan de su condado por cualquier consulta que tenga sobre los servicios, o en caso de problemas con su proveedor que no pueda resolver.
• Informar de toda modificación de sus datos personales a su proveedor y al plan de su condado: dirección, número de teléfono, y toda otra información médica que pueda afectar su habilidad para participar en el tratamiento.
• Tratar con respecto y cortesía al personal que le proporcione el tratamiento.
• En caso de sospechar un fraude o delito, notificarlo. Llame a la línea de asistencia sobre cumplimiento al (805) 884-6855 o visite el sitio en línea: http://www.countyofsb.org/behavioral-wellness/compliance.sbc

El Manual para Miembros del Plan estará disponible en las salas de espera de los que atienden trastornos por uso de sustancias (SUD) y en línea en:
http://www.countyofsb.org/behavioral-wellness/beneficiaryinfo.sbc
**DIRECTORIO DE PROVEEDORES: REGIÓN DE SANTA BÁRBARA**

Para autorizaciones iniciales de tratamiento, comunícate con la Línea de Acceso: 1-888-868-1649

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<th>Agencia: CADA – Concilio sobre alcoholismo y abuso de drogas - Daniel Bryant Youth &amp; Family</th>
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<td>Contacto: Jill Frandsen, LMFT, Directora</td>
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<td><strong>Contacto: Nancy Gottlieb, LMFT, Directora Interina</strong></td>
<td><strong>Correo electrónico: <a href="mailto:ngottlieb@cadasb.org">ngottlieb@cadasb.org</a></strong></td>
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<td><strong>Agencia: CADA – Concilio sobre alcoholismo y abuso de drogas - Proyecto de recuperación</strong></td>
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<td><strong>Correo electrónico: <a href="mailto:ngottlieb@cadasb.org">ngottlieb@cadasb.org</a></strong></td>
<td><strong>Teléfono/Fax: (805) 963-1433 / (805) 963-4099</strong></td>
</tr>
<tr>
<td><strong>Agencia: CADA – Concilio sobre alcoholismo y abuso de drogas - Daniel Bryant Youth &amp; Family</strong></td>
<td><strong>Contacto: Adriana Almazan, Coordinadora</strong></td>
</tr>
<tr>
<td><strong>Sitio web: <a href="http://www.cadasb.org">www.cadasb.org</a></strong></td>
<td><strong>Correo electrónico: <a href="mailto:aalmazan@cadasb.org">aalmazan@cadasb.org</a></strong></td>
</tr>
<tr>
<td><strong>Tipo de servicio: Servicios ambulatorios (Nivel 1.0); Servicios ambulatorios intensivos (Nivel 2.1)</strong></td>
<td><strong>Sitio web: <a href="http://www.cadasb.org">www.cadasb.org</a></strong></td>
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<td><strong>Especialidad: Servicios para adultos, Servicios perinatales, Tratamiento asistido con medicamentos</strong></td>
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<td><strong>NPI: 1649376351</strong></td>
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<tr>
<td><strong>Santa Barbara, CA 93101</strong></td>
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<tr>
<td><strong>Teléfono/Fax: (805) 564-6057 / (805) 963-8849</strong></td>
<td><strong>Santa Barbara, CA 93101</strong></td>
</tr>
<tr>
<td><strong>Contacto: Nancy Gottlieb, Directora Interina</strong></td>
<td><strong>Teléfono/Fax: (805) 963-1433 / (805) 963-4099</strong></td>
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REGIÓN DE SANTA BÁRBARA
Para autorizaciones iniciales de tratamiento, comuníquese con la Línea de Acceso: 1-888-868-1649

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<th>Agencia: Agencia de servicios familiares (Family Service Agency – FSA)</th>
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<td><strong>Teléfono/Fax:</strong> (805) 963-1433 / (805) 963-4099</td>
<td><strong>Teléfono/Fax:</strong> (805) 965-1001</td>
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<tr>
<td><strong>Contacto:</strong> Ramon Velazquez, Director del programa</td>
<td><strong>Contacto:</strong> Ashleigh Irving, Manejadora</td>
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<td><strong>Correo electrónico:</strong> <a href="mailto:rvelazquez@cadasb.org">rvelazquez@cadasb.org</a></td>
<td><strong>Correo electrónico:</strong> <a href="mailto:ashleigh@fascares.org">ashleigh@fascares.org</a></td>
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<td><strong>Agencia:</strong> Futuros líderes de América (Future Leaders of America – FLA)</td>
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<td><strong>Dirección:</strong> 1528 Chapala St. #308, Santa Barbara, CA 93101</td>
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<td><strong>Teléfono/Fax:</strong> (805) 642-6208</td>
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<td><strong>Contacto:</strong> Eder Gaona-Macedo, Director Ejecutivo</td>
<td><strong>Contacto:</strong> Nancy Ranck, LMFT #29688</td>
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<td><strong>Correo electrónico:</strong> <a href="mailto:eder@futureleadersnow.org">eder@futureleadersnow.org</a></td>
<td><strong>Correo electrónico:</strong> <a href="mailto:ken@pacificpridefoundation.org">ken@pacificpridefoundation.org</a></td>
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### REGIÓN DE SANTA MARIA

Para autorizaciones iniciales de tratamiento, comuníquese con la Línea de Acceso: 1-888-868-1649

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<tr>
<th>Agencia</th>
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<th>Contacto</th>
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<tr>
<td>Aegis Centros de Tratamiento</td>
<td>115 E. Fesler St.</td>
<td>(806) 922-6597 / (805) 922-5978</td>
<td>Jeffrey Curtis, Manejador</td>
<td><a href="mailto:jeffrey.curtis@aegistreatmentcenters.com">jeffrey.curtis@aegistreatmentcenters.com</a></td>
<td><a href="http://www.aegistreatmentcenters.com">www.aegistreatmentcenters.com</a></td>
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<tr>
<td>CADA – Concilio sobre alcoholismo y abuso de drogas – Santa María</td>
<td>526 E. Chapel St., Santa María, CA 93454</td>
<td>(805) 925-8860</td>
<td>Brittan Stanley, Director de Operaciones</td>
<td><a href="mailto:bstanley@cadasb.org">bstanley@cadasb.org</a></td>
<td><a href="http://www.cadasb.org">www.cadasb.org</a></td>
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<tr>
<td>Central Coast Headway</td>
<td>318 W. Carmen Lane</td>
<td>(805) 922-2106; 922-2751</td>
<td>Clemencia Figueroa, Manejadora</td>
<td><a href="mailto:smcch@utect.net">smcch@utect.net</a></td>
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<td>Coast Valley Substance Abuse Treatment Center (CVSATC)</td>
<td>1414 S. Miller St. #11, Santa María, 93454</td>
<td>(805) 739-1512 / (805) 739-2855</td>
<td>Deshon Chavez, Supervisor</td>
<td><a href="mailto:deshon@coastvalleysatc.com">deshon@coastvalleysatc.com</a></td>
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<td>Dirección: 412 B E. Tunnel St.</td>
<td>Dirección: 245 E. Inger Dr., #103B</td>
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<tr>
<td>Teléfono/Fax: (805) 925-0315 / (866) 594-7933</td>
<td>Teléfono/Fax: (805) 346-8185 / (805) 346-8656</td>
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<td>Contacto: Eileen Ortiz, Manejadora</td>
<td>Contacto: Lyndi Morabito, Manejadora</td>
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<tr>
<td>Correo electrónico: <a href="mailto:eortiz@goodsamaritanshelter.org">eortiz@goodsamaritanshelter.org</a></td>
<td>Correo electrónico: <a href="mailto:Imorabito@goodsamaritanshelter.org">Imorabito@goodsamaritanshelter.org</a></td>
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<td>Teléfono/Fax: (805)347-3338 X102 / (866)729-9741</td>
<td>Teléfono/Fax: (805) 332-4568 / (805) 332-3487</td>
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<td>Contacto: Christina Vasquez, Manejadora</td>
<td>Contacto: Michelle Walker, Administradora</td>
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<td>Correo electrónico: <a href="mailto:cvasquez@goodsamaritanshelter.org">cvasquez@goodsamaritanshelter.org</a></td>
<td>Correo electrónico: <a href="mailto:mwalker@lagsrecovery.com">mwalker@lagsrecovery.com</a></td>
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SOLICITUD PARA REALIZAR LA TRANSICIÓN DE SERVICIOS

¿En qué momento puedo solicitar seguir consultando a mi proveedor anterior, que ahora no pertenece a la red?

- Una vez que ingresa al Plan del Condado, puede solicitar mantener a un proveedor que no pertenezca a la red en los siguientes casos:
  - Si pasar a consultar a un nuevo proveedor perjudicará su salud o aumentara el riesgo de hospitalización o institucionalización; y
  - Si usted recibía tratamiento del proveedor que no pertenece a la red antes de ingresar al Plan del Condado.

¿Cómo solicito mantener a mi proveedor que no pertenece a la red?

- Usted podrá presentar una solicitud por escrito al Plan del Condado, o lo pueden hacer sus representantes autorizados o su proveedor actual. También puede contactar al servicio para miembros llamando al 1-888-868-1649 para que le informen cómo solicitar servicios de un proveedor que no pertenece a la red.
  - El Plan del Condado enviará por escrito una constancia de haber recibido su solicitud, y en los siguientes tres (3) días hábiles comenzará a procesar dicha solicitud.

¿Qué ocurre si yo hubiera seguido consultando a mi proveedor, que no pertenece a la red, después de haber ingresado al Plan del Condado?

- Presente una solicitud para realizar una transición retroactiva de servicios dentro de los treinta (30) días calendario de que ese proveedor le haya brindado servicios.

¿Por qué razón el Plan del Condado podría rechazar mi solicitud para realizar una transición de servicios?

- El Plan del Condado puede rechazar la solicitud para mantener a un proveedor que ya no pertenece a la red en el siguiente caso:
  - Cuando el Plan del Condado haya registrado problemas en materia de calidad de servicios con ese proveedor.

¿Qué ocurre si se rechaza mi solicitud para realizar la transición de servicios?

- Si el Plan del Condado rechaza su solicitud para realizar la transición de servicios:
  - Se lo notificará por escrito;
  - Le brindará al menos un proveedor de la red alternativo que ofrezca el mismo nivel de servicios que el proveedor anterior; y
  - Le informará sobre el derecho que usted tiene de presentar una queja en caso de no estar de acuerdo con dicho rechazo.

- Si el Plan del Condado le ofrece varias opciones de proveedores de la red y usted no elije ninguno, entonces le asignará uno, o le recomendará uno, y se lo notificará por escrito.

¿Qué ocurre si se aprueba mi solicitud para realizar la transición de servicios?

- Dentro de los siguientes siete (7) días de aprobar la transición de servicios, le Plan del Condado le presentará:
La aprobación de la solicitud;
La duración del plan para la transición de servicios;
Cómo será el proceso una vez que culmine el período de continuación para la transición de sus servicios; y
Su derecho a elegir otro proveedor de la red de proveedores del Plan del Condado en cualquier momento.

¿Qué tan rápidamente se procesará mi solicitud para realizar la transición de mis servicios?

- A partir de la fecha en que el Plan del Condado recibe su solicitud para realizar la transición de servicios, este tendrá treinta (30) días calendario para completar el examen de dicha solicitud.

¿Qué ocurrirá cuando culmine la transición de mis servicios?

- El Plan del Condado se comunicará por escrito treinta (30) días calendario antes de que culmine dicha transición para notificarle sobre cómo se hará esa transición a un proveedor perteneciente a la red.
1. PURPOSE

1.1. To ensure compliance with the requirements of the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver for the implementation and provision of Outpatient Treatment Services including Outpatient Services (ASAM Level 1.0), Intensive Outpatient Services (ASAM Level 2.1), and Opioid (Narcotic) Treatment Program (OTP) services. These are a covered benefit within the DMC-ODS and counties are responsible for coordinating a system of Outpatient Treatment Services for Substance Use Disorder (SUD) clients.¹

2. DEFINITIONS

The following terms are limited to the purposes of this policy:

2.1. Alcohol and Other Drug (AOD) Counselor – an individual employed or contracted by the county who has obtained credentials from an organization accredited by the National Commission For Certifying Agencies (NCCA) and recognized by the State Department of Health Care Services (DHCS) to provide AOD counseling services in a DHCS-licensed or certified facility.

2.2. Licensed Practitioner of the Healing Arts (LPHA) – an individual employed or contracted by the county who is licensed in the state of California as a physician (MD/DO), nurse practitioner (NP), physician’s assistant (PA), registered nurse (RN), registered pharmacist (RPh), licensed clinical psychologist, licensed clinical social worker (LCSW), licensed professional clinical counselor (LPCC), licensed marriage

¹ For more information on the DMC-ODS waiver program in Santa Barbara County, please refer to policy ADP-7.006 "Drug Medi-Cal Organized Delivery System (DMC-ODS) Continuum of Care." A comprehensive implementation plan may also be accessed at this link: http://countyofsb.org/behavioral-wellness/Asset.c/3866.
and family therapist (LMFT), or license-eligible practitioner working under the supervision of a licensed clinician.

2.3. **Medication Assisted Treatment (MAT)** – the use of prescription medication for the treatment of substance use disorders (SUD), in combination with counseling and behavioral therapies, to provide a whole-person approach to treatment.

3. **POLICY**

3.1. It is the policy of the Alcohol and Drug Program (ADP), a division of the Santa Barbara County Department of Behavioral Wellness (hereafter “the Department”), to comply with and adhere to all requirements as outlined in the Department of Health Care Services (DHCS) approved DMC-ODS waiver and the Centers for Medicare & Medicaid Services (CMS) Special Terms and Conditions (STCs). The Department shall hold responsibility for implementation, oversight and quality management of all programmatic components.

3.2. The Department and its contracted providers shall ensure the provision of DMC-ODS Outpatient Services and OTP Services in accordance with the American Association of Addiction Medicine (ASAM) guidelines, contractual requirements, and applicable federal, state and local laws.

3.3. All DMC-ODS contracted providers are expected to individualize treatment and use the full continuum of services available to ensure that beneficiaries receive the appropriate treatment at the appropriate time.

3.4. This policy applies to all County-operated programs and contracted providers responsible for the provision of DMC-ODS services.

4. **LEVELS OF CARE**

The ASAM Criteria form an outcome-oriented, results-based set of guidelines for Outpatient Treatment Services, which include treatment criteria, placement, continued stay and transfer/discharge of individuals with addiction and co-occurring conditions.

4.1. **Outpatient Services (ASAM Level 1.0)** – outpatient counseling services provided to beneficiaries, up to nine (9) hours a week for adults and less than six (6) hours a week for adolescents, when determined to be medically necessary and in accordance with an individualized treatment plan.

4.2. **Intensive Outpatient Services (ASAM Level 2.1)** – structured programming services provided to beneficiaries, a minimum of nine (9) hours with a maximum of 19 hours a week for adults and a minimum of six (6) hours with a maximum of 19 hours a week for adolescents, when determined to be medically necessary and in accordance with an individualized treatment plan.

4.3. **Opioid (Narcotic) Treatment Program (OTP)** – provides opioid medication assisted treatment services for beneficiaries addicted to opiates, when determined to be medically necessary and in accordance with an individualized treatment plan.
5. **PROGRAM OVERVIEW**

5.1. Outpatient Services (ASAM Level 1.0) and Intensive Outpatient Services (ASAM Level 2.1) will be provided in the context of an individualized treatment plan with specific, quantifiable treatment objectives, related to the beneficiary’s substance use disorder diagnosis and multidimensional assessment. Services shall include the identified interventions/modalities and will include a proposed frequency and duration of services using the ASAM Criteria and medical necessity determination.

1. Contracted providers offering Outpatient Services and Intensive Outpatient Services must be Drug Medi-Cal (DMC) certified by DHCS.

2. A LPHA and/or an AOD counselor, acting within the scope of their respective practice and competency, may provide Outpatient Services and Intensive Outpatient Services. The individual providing these services must be linked to a DMC-certified site/facility and must be proficient in Motivational Interviewing (MI), Cognitive Behavioral Treatment (CBT), relapse prevention, and trauma-informed care.

3. Outpatient Services (ASAM Level 1.0) and Intensive Outpatient Services can be delivered to beneficiaries in the following ways:
   a. Face-to-face in the certified facility;
   b. By telephone (for Case Management and Recovery Services only);
   c. By telehealth (for Case Management and Recovery Services only); or
   d. In the community (for Case Management and Recovery Services only).

5.2. Opioid (Narcotic) Treatment Program Services (OTP) will provide opioid medication assisted treatment to those persons addicted to opiates to help the client become and/or remain productive members of society.

1. Contracted providers offering Opioid Treatment Program Services must be licensed by DHCS as a Narcotic Treatment Program.

2. Medically necessary services are provided in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber and approved and authorized according to the State of California requirements.

3. Opioid (Narcotic) Treatment Program Services (OTP) are delivered to beneficiaries in a licensed Narcotic Treatment Program and in accordance with regulatory requirements in Title 9, Chapter 4.

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2 Please refer to the Department's DMC-ODS Case Management Policy for details regarding additional service locations for these specified services.

3 Please refer to the Department's DMC-ODS Recovery Services Policy for details regarding additional service locations for these specified services.

4 Please refer to the Drug Medi-Cal Organized Delivery System Place of Service Codes for Professional Claims for details regarding allowable places of service.
4. Opioid (Narcotic) Treatment Programs are required to offer and prescribe medication to clients, covered under the DMC-ODS formulary including:
   a. Methadone;
   b. Buprenorphine;
   c. Naloxone;
   d. Disulfiram; and
   e. Naltrexone.

5. Opioid (Narcotic) Treatment Programs must provide clients with a minimum of fifty minutes of counseling sessions with a LPHA or counselor for up to 200 minutes per calendar month, although additional services may be provided based on medical necessity.

6. ELIGIBILITY

6.1. To be eligible to receive DMC-ODS Outpatient Treatment Services, adult and adolescent beneficiaries must:
   1. Be enrolled in Medi-Cal;
   2. Reside in Santa Barbara County;
   3. Meet medical necessity criteria as defined in the DMC-ODS Standard Terms and Conditions, hereafter “STCs” (note that per the DMC-ODS STCs, the initial medical necessity determination and any reauthorizations for medical necessity must be performed by a Medical Director, licensed physician or a LPHA, and signed by a physician); and
   4. Meet the ASAM Criteria definition of medical necessity, in which all of the following must be true:
      a. The client must be diagnosed with a substance-related and addictive disorder in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V);
      b. The services requested are needed to identify or treat an illness that has been diagnosed or suspected;
      c. Treatment services are consistent with the diagnosis, treatment of the condition and the standards of good medical practice; and
      d. Treatment services are required for reasons other than convenience.

7. AUTHORIZATION, ASSESSMENT AND TREATMENT PLANNING

7.1. A LPHA or AOD counselor shall conduct an initial ASAM Level of Care (LOC) Screening to determine the indicated level of care and will provide an initial treatment authorization for the indicated level(s) of care for the client.
7.2 A comprehensive assessment, conducted by a LPHA or AOD counselor, shall support the actual LOC placement with any variance in placement being documented and reported to the Department's Quality Care Management (QCM) division and DHCS.

7.3 Periodic reassessment, using the ASAM Criteria within the ASAM LOC Screening, will determine ongoing level of care placement and eligibility for the continuation of services. Assessment is an ongoing process and all documentation must reflect that the client meets medical necessity at any point in treatment. Reassessment is particularly important anytime there is a significant change in the client's status or diagnosis. Reassessment may be requested by the Department’s Quality Care Management (QCM) division, the Medical Director, assigned LPHA, and/or the client. A client found to no longer meet medical necessity shall be transitioned to a lower level of care or to community supports.5

7.4 Comprehensive assessments conducted as a part of all Outpatient Treatment Services will assess for opioid use disorders and alcohol use disorders that may benefit from MAT and these beneficiaries will be referred to a MD, PA, or nurse practitioner (NP) for further evaluation. The licensed physician or licensed prescriber will utilize the ASAM criteria and the Readiness for Medication Assisted Treatment (MAT) Survey6 to determine client eligibility and readiness for MAT services. Clients deemed eligible and willing to participate in MAT will be linked with an Opioid (Narcotic) Treatment Program (OTP) or considered for MAT treatment within a contracted SUD provider.

7.5 A LPHA or AOD counselor shall assume responsibility to develop and periodically revise the client treatment plan for treatment needs. Client treatment plans must have specific, measurable, time-limited goals that are individualized based on the client's comprehensive assessment with all required components as indicated in section 8.8. All plan development will actively involve and encourage the client's full participation.

7.6 Opioid (Narcotic) Treatment Program (OTP) services shall conduct assessment and treatment planning in accordance with the California Code of Regulations, Title 9, Chapter 4.7

5 For more information regarding transitioning level of care, please refer to the Department’s policy “Drug Medical Organized Delivery System (DMC-ODS) Continuum of Care.”
6 For more information, please refer to the Department’s policy “Medication Assisted Treatment (MAT).”
7 For additional information regarding Opioid (Narcotic) Treatment Program Services (OTP) regulatory requirements for assessment and treatment planning, please reference Title 9, Chapter 4.
PROGRAM COMPONENTS

A LPHA or AOD counselor may provide any of the Outpatient Services, Intensive Outpatient Services, and Opioid (Narcotic) Treatment Program (OTP) services stated below within the scope of their respective practice and competency:

8.1 **Intake, Assessment and Treatment Planning** is the process of determining that a client meets the Medical Necessity criteria\(^8\) and admitting the client into a substance use disorder treatment program. Intake may include:

1. Completion of all intake paperwork;
2. Evaluation or analysis of substance use disorders;
3. Diagnosis of substance use disorders; and
4. Assessment of treatment needs to provide medically necessary services;
5. A physical examination and laboratory testing necessary for substance use disorder treatment; and
6. Treatment planning.

8.2 **Individual and Group Counseling** involves contact between a client and a LPHA or counselor. Groups must have a minimum of two (2) clients and a maximum of twelve (12) clients to be DMC reimbursable.

8.3 **Patient Education** involves providing research-based education on addiction, treatment, recovery, and associated health risks.

8.4 **Family Therapy or Family Counseling / Education** is crucial because the effects of addiction are far-reaching; a client's family members and loved ones are often affected by the disorder. Including family members in the treatment process means conveying education about factors that are important to the client's recovery. Family members can provide social support to the client, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery.

8.5 **Medication Services** involves the prescription or administration of medication related to substance use treatment services. It also involves the assessment of side effects and results of that medication, conducted by staff lawfully authorized to provide such services (and/or order laboratory testing) within their scope of practice or licensure.

8.6 **Collateral Services** include sessions with LPHAs or counselors and significant persons in the life of the client, focused on the treatment needs of the client. This includes supporting the client's treatment goals. "Significant persons" are individuals that have a personal, not official or professional, relationship with the client.

\(^8\) For more information on establishing Medical Necessity, please refer to the Department's policy ADP-7.006 “Drug Medi-Cal Organized Delivery System (DMC-ODS) Continuum of Care”.
8.7 **Crisis Intervention Services** involves contact between a LPHA or counselor and a client in crisis. Services shall focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance which presents to the client an imminent threat of relapse. Crisis Intervention Services shall be limited to the stabilization of the client’s emergency situation.

8.8 **Treatment Planning** is when the provider prepares an individualized written treatment plan, based upon information obtained in the intake and assessment process. A treatment plan must be completed upon intake and then updated every subsequent 90 days unless there is a change in treatment modality or significant event that would require a new treatment plan. The treatment plan will be consistent with the qualifying diagnosis and will be signed by the client and the Medical Director or LPHA. The treatment plan must include:

1. A statement of problems to be addressed;
2. Goals to be reached which address each problem;
3. Action steps which will be taken by the provider and/or client to accomplish identified goals;
4. Target dates for accomplishment of action steps and goals, and a description of services including the type of counseling to be provided and the frequency thereof;
5. Specific, quantifiable goal/treatment objectives related to the client’s substance use disorder diagnosis and multidimensional assessment; and
6. The proposed type(s) of interventions/modalities and proposed frequency and duration for each intervention/modality.

8.9 **Discharge Services** are the process by which the client is prepared for referral into another level of care, post-treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing, and human services.

8.10 **Medical Psychotherapy** is an additional Program Component for Opioid (Narcotic) Treatment Program (OTP) services only. This type of counseling service consists of a face-to-face discussion conducted by the Medical Director of the OTP on a one-on-one basis with the client.

8.11 **Case Management (CM)** includes services to assist beneficiaries in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services with a focus on SUD care and integrations around primary care. All CM services must link back to the stated goals and interventions described in the client’s treatment plan.\(^9\)

8.12 **Recovery services** assist beneficiaries in the recovery and wellness process and are provided in the context of an individualized client plan that includes specific goals.

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\(^9\) For more information, please reference the Department’s “DMC-ODS Case Management” policy.
Recovery services are available to beneficiaries after completing their course of treatment.\textsuperscript{10}

9. **SPECIAL POPULATIONS**

9.1. Outpatient Treatment Services provided to adolescents shall be provided in accordance with the Youth Treatment Guidelines.\textsuperscript{11}

1. Clients of these services must meet the ASAM adolescent treatment criteria, as outlined in the Youth Treatment Guidelines.

9.2. Perinatal services shall be provided in accordance with the "Perinatal Service Network Guidelines,"\textsuperscript{12} and shall address treatment and recovery issues specific to pregnant and postpartum women,\textsuperscript{13} such as relationships, sexual and physical abuse, and development of parenting skills.

1. These services shall be provided in a "perinatal certified substance use disorder program," meaning a Medi-Cal certified program which provides substance use disorder services to pregnant and postpartum women with substance use disorder diagnoses.

2. Medical documentation that substantiates the client’s pregnancy and the last day of pregnancy shall be maintained in the client record.

3. Perinatal services shall include:
   a. Mother/child habilitative and rehabilitative services (e.g., development of parenting skills, training in child development);
   b. Services access (e.g., provision of or arrangement for transportation to and from medically necessary treatment);
   c. Education to reduce harmful effects of alcohol and drugs on the mother and fetus or the mother and infant; and
   d. Coordination of ancillary services (e.g., assistance in accessing and completing dental services, social services, community services, education/vocational training and other services which are medically necessary to prevent risk to fetus or infant).

9.3. No client who meets medical necessity and who is authorized for Outpatient Treatment Services and receiving Medication Assisted Treatment (MAT) will be denied services. Level 1.0 and Level 2.1 services may provide MAT services including MAT assessment, medication prescription and medication management. Opioid (Narcotic)  

\textsuperscript{10} For more information, please reference the Department's "DMC-ODS Recovery Services" policy.
\textsuperscript{11} For adolescent service requirements, please reference the "State of California Youth Treatment Guidelines."
\textsuperscript{12} For more information, please reference the DHCS Perinatal Service Network Guidelines FY 16-17.
\textsuperscript{13} For more information regarding the definition of the postpartum eligibility period, please reference Title 22, Section 50260: “60-Day Postpartum Services Program."
Treatment Program (OTP) services will be required to provide MAT services to clients who meet medical necessity.\textsuperscript{14}

REFERENCE

Centers for Medicare and Medicaid Services (CMS)
Special Terms and Conditions: California Medi-Cal 2020 Section 1115(1) Demonstration #11-W-00193/9, pgs. 89-121

California Department of Health Care Services (DHCS)
Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice NO: 15-032, August 20, 2015. Drug Medi-Cal Organized Delivery System Waiver Approval

California Department of Health Care Services (DHCS)
Intensive Outpatient Treatment and the DMC-ODS Pilot Program Frequently Asked Questions, September 2016

Code of Federal Regulations
Title 42, Part 2

California Code of Regulations – Drug Medi-Cal
Title 22, Section 51341.1 and Section 50260

California Code of Regulations – Rehabilitative and Developmental Services
Title 9, Chapter 4. Narcotic Treatment Programs

State of California County Contract, County of Santa Barbara #14-90100

California Department of Health Care Services (DHCS)
Drug Medi-Cal Organized Delivery System Place of Service Codes for Professional Claims, August 2017

California Department of Health Care Services (DHCS)
Perinatal Services Network Guidelines, FY 2016-17

State of California
Youth Treatment Guidelines, Revised August 2002

RELATED POLICIES

ADP-7.006 – Drug Medi-Cal Organized Delivery System (DMC-ODS) Continuum of Care

\textsuperscript{14} For more information regarding MAT, please reference the Department's "DMC-ODS Expanded Medication Assisted Treatment Policy."
Culturally and Linguistically Competent Policies
The Department of Behavioral Wellness is committed to the tenets of cultural competency and understands that culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse individuals. All policies and procedures are intended to reflect the integration of diversity and cultural literacy throughout the Department. To the fullest extent possible, information, services and treatments will be provided (in verbal and/or written form) in the individual's preferred language or mode of communication (i.e. assistive devices for blind/deaf).
Attachment D
1. **PURPOSE**

1.1. To ensure compliance with the requirements of the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver for the implementation and provision of case management services. Case management is a covered benefit within the DMC-ODS and counties are responsible for coordinating a system of case management services for SUD clients.\(^1\)

2. **DEFINITIONS**

The following terms are limited to the purposes of this policy:

2.1. **American Society of Addiction Medicine (ASAM) Criteria** – an outcome-oriented, results-based set of guidelines for treatment criteria, placement, continued stay, and transfer/discharge of individuals with addiction and co-occurring conditions.

2.2. **Case Management (CM)** – a service to assist beneficiaries in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. These services focus on coordination of substance use disorder (SUD) care, integration around primary care (especially for beneficiaries with a chronic SUD), and interaction with the criminal justice system, if needed.

2.3. **Certified Alcohol and Other Drug (AOD) Counselor** – an individual employed or contracted by the county who has obtained credentials from an organization accredited by the National Commission For Certifying Agencies (NCCA) and

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\(^1\) For more information on the DMC-ODS waiver program in Santa Barbara County, please refer to policy ADP-7.006 "Drug Medi-Cal Organized Delivery System (DMC-ODS) Continuum of Care." A comprehensive implementation plan may also be accessed at this link: http://countyofsb.org/behavioral-wellness/Asset.c/3866
recognized by the State Department of Health Care Services (DHCS) to provide AOD counseling services in a DHCS-licensed or certified facility.

2.4. **Licensed Practitioner of the Healing Arts (LPHA)** – an individual employed or contracted by the county who is licensed in the state of California as a physician (MD/DO), nurse practitioner (NP), physician's assistant (PA), registered nurse (RN), registered pharmacist (RPh), licensed clinical psychologist, licensed clinical social worker (LCSW), licensed professional clinical counselor (LPCC), licensed marriage and family therapist (LMFT), or license-eligible practitioner working under the supervision of a licensed clinician.

2.5. **Warm hand-off** – a transfer of care that is conducted in person or over the phone, between two members of a treatment team or from one provider to another, with the client and/or family present. Warm hand-offs can help (1) engage patients and families and encourage them to ask questions, (2) allow clients to clarify or correct the information exchanged, and (3) ensure a smooth and positive transition in care.

3. **POLICY**

3.1. It is the policy of the Alcohol and Drug Program (ADP), a division of the Santa Barbara County Department of Behavioral Wellness (hereafter “the Department”), to comply with and adhere to all requirements as outlined in the Department of Health Care Services (DHCS) approved DMC-ODS waiver and the Centers for Medicare & Medicaid Services (CMS) Special Terms and Conditions (STCs). The Department shall hold responsibility for implementation, oversight, and quality management of all programmatic components.

3.2. The Department and its contracted providers shall ensure the provision of DMC-ODS CM services in accordance with the ASAM guidelines, contractual requirements, and applicable federal, state and local laws.

3.3. All DMC-ODS contracted providers are expected to individualize treatment and use the full continuum of services available to ensure that beneficiaries receive the appropriate treatment at the appropriate time. CM will be provided to assist beneficiaries as they move through levels of care and to easily access treatment and ancillary services to support their recovery.

3.4. This policy applies to all County-operated programs and contracted providers responsible for the provision of DMC-ODS services.

3.5. This policy shall be effective upon the implementation of the DMC-ODS system within Santa Barbara County.
4. ELIGIBILITY

4.1. To be eligible to receive DMC-ODS CM services, adult and adolescent beneficiaries must:

1. Be enrolled in Medi-Cal;
2. Reside in Santa Barbara County; and
3. Meet medical necessity criteria as defined in the DMC-ODS Standard Terms and Conditions, hereafter “STCs” (note that per the DMC-ODS STCs, the initial medical necessity determination and any reauthorizations for medical necessity must be performed by a Medical Director, licensed physician or a LPHA, and signed by a physician); and
4. Meet the ASAM Criteria definition of medical necessity, in which all of the following must be true:
   a. The client must be diagnosed with a substance-related and addictive disorder in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V);
   b. The services requested are needed to identify or treat an illness that has been diagnosed;
   c. Treatment services are consistent with the diagnosis, treatment of the condition, and the standards of good medical practice;
   d. Treatment services are required for reasons other than convenience; and
   e. Client may not succeed in treatment and or recovery services without CM services.

5. PROGRAM OVERVIEW

5.1. CM will be provided to assist beneficiaries in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services with a focus on SUD care and integrations around primary care. All CM services must link back to the stated goals and interventions described in the client's treatment plan.

5.2. CM services will be provided to beneficiaries with special treatment needs in alignment with the Perinatal Services Network Guidelines FY 2016-17 and the Youth Treatment Guidelines.

5.3. CM services may also be utilized to serve the difficult-to-engage individuals with complex need who have not been successful in previous treatment episodes, such as frequent utilizers of multiple health, criminal justice and social services systems, and older adults with co-occurring physical health and substance use issues.

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2 Please refer to the "Behavioral Wellness ADP Documentation Manual" for more information regarding medical necessity.
5.4. Contracted providers offering CM services must be Drug Medi-Cal (DMC) certified.

5.5. A LPHA and/or a certified AOD counselor, acting within the scope of their respective practice and competency, may provide CM Services. The individual providing CM services must be linked to a DMC-certified site/facility and must be proficient in Motivational Interviewing (MI), Cognitive Behavioral Treatment, and trauma-informed care.

5.6. CM services can be delivered to beneficiaries in a face-to-face setting, by telephone, by telehealth (e.g., video conferencing), or in the community.  

1. When CM services are provided in the community, the contracted provider delivering the service must be linked to a DMC-certified site. All services must be provided in allowable places of service, which may include (but not be limited to) the following:
   a. Schools;
   b. Homeless shelters;
   c. Offices;
   d. Places of employment; and
   e. Clinics.

2. However, CM services are excluded at some locations, which may include (but not be limited to) following:
   a. Private residences;
   b. Prison/correctional facilities;
   c. Surgical centers;
   d. Military treatment facilities;
   e. Psychiatric residential treatment centers; and
   f. Comprehensive rehabilitation facilities.

3. Any questions regarding allowable and excluded places of service for CM services that are provided in the community should be directed to the Department's Alcohol and Drug Program.

6. PROGRAM COMPONENTS
   A LPHA or a certified AOD counselor may provide any of the CM services stated below within the scope of their respective practice and competency:

6.1. Transition to a higher or lower level of substance use disorder (SUD) care. Transfers to the next service provider will be completed through “warm hand-offs.”

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3 Please refer to “Drug Medi-Cal Organized Delivery System Place of Service Codes for Professional Claims” for details regarding allowable places of service.
6.2. **Communication, coordination, referral and related activities.** These activities help link the beneficiary with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the client plan.

6.3. **Monitoring service delivery to ensure beneficiary access to service and the service delivery system.** Monitoring and associated follow-up activities are necessary to adequately address the beneficiary’s needs, and may be done with the beneficiary, family members, service providers, or other entities or individuals and may be conducted as frequently as necessary.

6.4. **Monitoring the beneficiary’s progress.** This includes making any necessary modifications to the beneficiary’s client plan and updating service arrangements with providers. Monitoring does not include evaluation or "check-ins" with a beneficiary when all client plan goals have been met.

6.5. **Patient advocacy, linkages to physical and mental health care, transportation and retention in primary care services.** All services, including transportation for the purposes of continuous engagement, support and linkage to treatment services, must link back to the stated goals and interventions in the client’s treatment plan.

7. **ASSESSMENT AND TREATMENT PLANNING FOR CASE MANAGEMENT**

A LPHA or certified AOD counselor shall be responsible for a comprehensive assessment and periodic reassessment to determine the need for continuation of CM services. Assessment and periodic reassessment for case management services is to be conducted at a minimum of once every six (6) months to determine if a beneficiary’s needs, condition, and/or preferences have changed.

7.1. A LPHA or certified AOD counselor shall assume responsibility to develop and periodically revise the client treatment plan for case management service needs. Client treatment plans must have specific, measurable, time-limited goals that directly address medical, educational, social, prevocational, vocational, rehabilitative, or other case management service needs identified during assessment activities. All plan development will actively involve and encourage the beneficiary’s full participation.

**REFERENCE**

Centers for Medicare and Medicaid Services (CMS)
*Special Terms and Conditions: California Medi-Cal 2020 Section 1115(1) Demonstration #11-W-00193/9, pgs. 89-121*

California Department of Health Care Services (DHCS)
*Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice NO: 15-032, August 20, 2015. Drug Medi-Cal Organized Delivery System Waiver Approval*
California Department of Health Care Services (DHCS)

Code of Federal Regulations
Title 42, Part 2

California Code of Regulations – Drug Medi-Cal
Title 22, Section 51341.1

State of California County Contract, County of Santa Barbara #14 90100

California Department of Health Care Services (DHCS)
Perinatal Services Network Guidelines, FY 2016-17

State of California, Department of Alcohol and Drug Programs
Youth Treatment Guidelines, Revised August 2002

California Department of Health Care Services (DHCS)
Drug Medi-Cal Organized Delivery System Place of Service Codes for Professional Claims, August 2017

RELATED POLICIES
ADP-7.006 – Drug Medi-Cal Organized Delivery System (DMC-ODS) Continuum of Care

REVISION RECORD

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Culturally and Linguistically Competent Policies
The Department of Behavioral Wellness is committed to the tenets of cultural competency and understands that culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse individuals. All policies and procedures are intended to reflect the integration of diversity and cultural literacy throughout the Department. To the fullest extent possible, information, services and treatments will be provided (in verbal and/or written form) in the individual’s preferred language or mode of communication (i.e. assistive devices for blind/deaf).
1. **PURPOSE**

1.1. To ensure compliance with the requirements of the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver for the implementation and provision of Recovery Services. Recovery Services are a covered benefit within the DMC-ODS, and counties are responsible for coordinating a system of recovery services for SUD clients.\(^1\)

2. **DEFINITIONS**

The following terms are limited to the purposes of this policy:

2.1. **American Society of Addiction Medicine (ASAM) Criteria** – an outcome-oriented, results-based set of guidelines for treatment criteria, placement, continued stay, and transfer/discharge of individuals with addiction and co-occurring conditions.

2.2. **Recovery Services** – a service to assist beneficiaries in the recovery and wellness process. Recovery Services are designed to emphasize the beneficiary’s central role in managing their health, promote the use of effective self-management support strategies, and provide internal and community resources to support ongoing self-management. Recovery services are available to beneficiaries after completing their course of treatment.

2.3. **Remission** – as defined in the Diagnostic and Statistical Manual of Mental Disorders, 5\(^{th}\) edition ("DSM-V"), a client is in remission if, after full criteria for a substance use disorder were previously met, none of the criteria have been met for at least 3 months.

\(^1\) For more information on the DMC-ODS waiver program in Santa Barbara County, please refer to policy ADP-7.006 "Drug Medi-Cal Organized Delivery System (DMC-ODS) Continuum of Care." A comprehensive implementation plan may also be accessed at this link: http://countyofsb.org/behavioral-wellness/Asset.c/3866.
(A client is considered in remission even if Criterion A4 in the DSM-V, a strong craving for the substance, is still met.)

2.4. **Alcohol and Other Drug (AOD) Counselor** – an individual employed or contracted by the county who has obtained credentials from an organization accredited by the National Commission For Certifying Agencies (NCCA) and recognized by the State Department of Health Care Services (DHCS) to provide AOD counseling services in a DHCS-licensed or certified facility.

2.5. **Licensed Practitioner of the Healing Arts (LPHA)** – an individual employed or contracted by the county who is licensed in the state of California as a physician (MD/DO), nurse practitioner (NP), physician’s assistant (PA), registered nurse (RN), registered pharmacist (RPh), licensed clinical psychologist, licensed clinical social worker (LCSW), licensed professional clinical counselor (LPCC), licensed marriage and family therapist (LMFT), or license-eligible practitioner working under the supervision of a licensed clinician.

2.6. **SUD Peer Support Staff** – an individual who completes training and receives county designation as SUD peer support staff as specified in the DHCS- approved County SUD Peer Support Training Plan. Peer support staff must obtain a basic set of competencies necessary to perform and document the peer support function as outlined in the Peer Support Training Plan.\(^2\)

3. **POLICY**

3.1. It is the policy of the Alcohol and Drug Program (ADP), a division of the Santa Barbara County Department of Behavioral Wellness (hereafter “the Department”), to comply with and adhere to all requirements as outlined in the Department of Health Care Services (DHCS) approved DMC-ODS waiver and the Centers for Medicare & Medicaid Services (CMS) Special Terms and Conditions (STCs). The Department shall hold responsibility for implementation, oversight and quality management of all programmatic components.

3.2. The Department and its contracted providers shall ensure the provision of DMC-ODS recovery services in accordance with the ASAM guidelines, contractual requirements, and applicable federal, state and local laws.

3.3. All DMC-ODS contracted providers are expected to individualize treatment and use the full continuum of services available to ensure that beneficiaries receive the appropriate treatment at the appropriate time. Recovery services will be provided to assist beneficiaries after completing their course of treatment.

3.4. This policy applies to all County-operated programs and contracted providers responsible for the provision of DMC-ODS services.

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\(^2\) Please refer to the Behavioral Wellness SUD Peer Support Training Plan for SUD Peer Support Staff designation and training requirements.
3.5. This policy shall be effective upon the implementation of the DMC-ODS system within Santa Barbara County.

4. **ELIGIBILITY**

4.1. To be eligible to receive DMC-ODS recovery services, adult and adolescent beneficiaries must meet all of the following criteria:

1. Be enrolled in Medi-Cal;
2. Reside in Santa Barbara County;
3. Have completed their course of SUD treatment;
4. Meet medical necessity criteria\(^3\) as defined in the DMC-ODS Standard Terms and Conditions, hereafter "STCs" (note that per the DMC-ODS STCs, the initial medical necessity determination and any reauthorizations for medical necessity must be performed by a Medical Director, licensed physician or a LPHA, and signed by a physician); and
5. Meet the ASAM Criteria definition of medical necessity, in which all of the following must be true:
   a. The client must have been previously diagnosed with a substance-related and addictive disorder in the DSM-V;
   b. The client must currently be in a state of "remission," due to the chronic nature of substance use disorders, with a corresponding and valid ICD-10 diagnosis code for remission;\(^4\)
   c. The services requested are needed to provide assistance to and address beneficiaries who are triggered, have relapsed, or as a measure to prevent relapse;
   d. Recovery services are consistent with the prior diagnosis, treatment of the condition, and the standards of good medical practice; and
   e. Recovery services are required for reasons other than convenience. It is not anticipated that all DMC-ODS clients will need recovery services. Only those clients whose recovery will be jeopardized without recovery services and who are motivated to be engaged in said services shall be provided those services.

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\(^3\) Please refer to the "Behavioral Wellness ADP Documentation Manual" for more information regarding medical necessity.

5. PROGRAM OVERVIEW

5.1. Recovery services will be provided to assist beneficiaries in the recovery and wellness process. Recovery Services are designed to emphasize the beneficiary's central role in managing their health, promote the use of effective self-management support strategies, and provide internal and community resources to support ongoing self-management. All recovery services should be provided in the context of an individualized client plan that includes specific goals and identifies Substance Abuse Assistance services including peer-to-peer services and relapse prevention as needed.

5.2. Contracted providers offering recovery services must be Drug Medi-Cal (DMC) certified.

5.3. A LPHA, AOD counselor, and/or a SUD Peer Support Staff, acting within the scope of their respective practice and competency, may provide recovery services. The individual providing recovery services must be linked to a DMC-certified site/facility and must be proficient in Motivational Interviewing (MI), Cognitive Behavioral Treatment, and trauma-informed care.

5.4. Recovery services can be delivered to beneficiaries in a face-to-face setting, by telephone, by telehealth (e.g., video conferencing), or in the community.\(^5\)

1. When recovery services are provided in the community, the contracted provider delivering the service must be linked to a DMC-certified site. All services must be provided in allowable places of service, which may include (but not be limited to) the following:
   a. Schools;
   b. Homeless shelters;
   c. Offices;
   d. Places of employment; and
   e. Clinics.

2. However, recovery services are excluded at some locations, which may include (but not be limited to) following:
   a. Private residences;
   b. Prison/correctional facilities;
   c. Surgical centers;
   d. Military treatment facilities;
   e. Psychiatric residential treatment centers; and
   f. Comprehensive rehabilitation facilities.

\(^5\) Please refer to "Drug Medi-Cal Organized Delivery System Place of Service Codes for Professional Claims" for details regarding allowable places of service.
3. Any questions regarding allowable and excluded places of service for recovery services that are provided in the community should be directed to the Department's Alcohol and Drug Program.

5.5. All clients are entitled to culturally- and linguistically-competent services in their preferred language. If required or requested by a client, language services will be provided via the Department's translation and interpretation service options.6

6. PROGRAM COMPONENTS

6.1. A LPHA or AOD counselor may provide any of the recovery services stated below within the scope of their respective practice and competency. Additionally, SUD Peer Support Staff may provide substance abuse assistance.

1. **Outpatient counseling services** can be in the form of individual or group counseling, which are intended to stabilize the beneficiary and then reassess if the beneficiary needs further care.

2. **Recovery monitoring** includes recovery coaching and monitoring via telephone, telehealth, and the internet.

3. **Substance Abuse Assistance** includes peer-to-peer services and relapse prevention provided by SUD Peer Support Staff. The amount, duration, and scope of peer-to-peer services must be specified in the client’s plan. Services must be provided by qualified peer support staff who assist beneficiaries with recovery from their SUDs in accordance with the Peer Support Training Plan.

4. **Support for education and job skills** includes linkages to life skills, employment services, job training, and education services.

5. **Family support** includes linkages to childcare, parent education, child development support service, family/marriage education.

6. **Support groups** include linkages to self-help and faith-based support groups.

7. **Ancillary services** includes linkages to housing assistance, transportation, case management, and individual services coordination.

7. ROLE OF SUD PEER SUPPORT STAFF

7.1. As part of supported services, SUD peer support staff may provide recovery services only. All peer-led recovery services shall be provided within the context of a comprehensive, individualized client plan.

7.2. All SUD peer support staff shall receive specific supervision and training as described in the Department’s SUD Peer Support Training Plan. Training provided to SUD peer support staff shall follow a methodology consistent with the requirements outlined in the STCs and guidance by the DHCS.

6 Please refer to the "Cultural and Linguistic Competency" policy for further information on language services.
8. **ASSESSMENT AND TREATMENT PLANNING FOR RECOVERY SERVICES**

8.1 A LPHA or AOD counselor shall be responsible for a comprehensive assessment and periodic reassessment with particular attention to Dimension 6, Recovery Environment of the ASAM Criteria, to determine the need for continuation of recovery services. Assessment and periodic reassessment for recovery services is to be conducted at a minimum of once every three (3) months to determine if a beneficiary's needs, condition, and/or preferences have changed.

8.2 A LPHA or AOD counselor shall assume responsibility to develop and periodically revise the client treatment plan for recovery service needs. Client treatment plans must have specific, measurable, time-limited goals that may include the plan for ongoing recovery and relapse prevention that was developed during discharge planning when treatment was completed. All plan development will actively involve and encourage the beneficiary's full participation.

**REFERENCE**

Centers for Medicare and Medicaid Services (CMS)
Special Terms and Conditions: California Medi-Cal 2020 Section 1115(1) Demonstration #11-W-00193/9, pgs. 89-121

California Department of Health Care Services (DHCS)
Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice NO: 15-032, August 20, 2015. Drug Medi-Cal Organized Delivery System Waiver Approval

California Department of Health Care Services (DHCS)
Recovery Services: Frequently Asked Questions, Revised August 2017

California Department of Health Care Services (DHCS)

California Department of Health Care Services (DHCS)

Code of Federal Regulations
Title 42, Part 2

California Code of Regulations – Drug Medi-Cal
Title 22, Section 51341.1

State of California County Contract, County of Santa Barbara #14-90100

County of Santa Barbara Department of Behavioral Wellness Substance Use Disorder (SUD) Peer Support Training Plan
Culturally and Linguistically Competent Policies
The Department of Behavioral Wellness is committed to the tenets of cultural competency and understands that culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse individuals. All policies and procedures are intended to reflect the integration of diversity and cultural literacy throughout the Department. To the fullest extent possible, information, services and treatments will be provided (in verbal and/or written form) in the individual’s preferred language or mode of communication (i.e. assistive devices for blind/deaf).
DATE: July 27, 2017

MHSUDS INFORMATION NOTICE NO.: 17-034

TO: COUNTY BEHAVIORAL HEALTH DIRECTORS
COUNTY DRUG & ALCOHOL ADMINISTRATORS
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION OF CALIFORNIA
CALIFORNIA COUNCIL OF COMMUNITY BEHAVIORAL HEALTH AGENCIES
COALITION OF ALCOHOL AND DRUG ASSOCIATIONS
CALIFORNIA ASSOCIATION OF ALCOHOL & DRUG PROGRAM EXECUTIVES, INC.
CALIFORNIA ALLIANCE OF CHILD AND FAMILY SERVICES
CALIFORNIA OPIOID MAINTENANCE PROVIDERS

SUBJECT: International Classification of Diseases, Tenth Revision (ICD-10)
Substance Use Disorder (SUD) Remission Codes for the Drug Medi-Cal Organized Delivery System (DMC ODS)

PURPOSE: To provide a valid ICD-10 diagnosis code for remission to enable claiming for recovery services.

DISCUSSION

When a DMC ODS beneficiary accesses recovery services, they will need to have a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis and the claim will need to use an ICD-10 code. A beneficiary receiving recovery services will be in a state of “remission” due to the chronic nature of substance use disorders. Currently, the ICD-10 only includes a remission code for prior diagnoses of “dependence” disorders.

Beneficiaries who did not have an ICD-10 dependence diagnosis recorded in their medical history will still need a SUD remission diagnosis for billing Short Doyle Medi-Cal. The available ICD-10 remission codes are not sufficient to record these beneficiaries' remission diagnosis. The ICD-10 code – Z87898 describes a “personal history of other specified conditions” and this code will satisfy the requirement for a remission diagnosis for the beneficiaries that did not have a dependence diagnosis in the past. Providers will need to use this Z code for any beneficiary with a prior ICD-10 diagnosis for substance abuse for claiming recovery services.
The following table displays the current and proposed ICD-10 remission codes for recovery services on the DMC ODS claims:

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>ICD-10 Code Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1021</td>
<td>Alcohol dependence, in remission</td>
</tr>
<tr>
<td>F1121</td>
<td>Opioid dependence, in remission</td>
</tr>
<tr>
<td>F1221</td>
<td>Cannabis dependence, in remission</td>
</tr>
<tr>
<td>F1321</td>
<td>Sedative, hypnotic or anxiolytic dependence, in remission</td>
</tr>
<tr>
<td>F1421</td>
<td>Cocaine dependence, in remission</td>
</tr>
<tr>
<td>F1521</td>
<td>Other stimulant dependence, in remission</td>
</tr>
<tr>
<td>F1621</td>
<td>Hallucinogen dependence, in remission</td>
</tr>
<tr>
<td>F1821</td>
<td>Inhalant dependence, in remission</td>
</tr>
<tr>
<td>F1921</td>
<td>Other psychoactive substance dependence, in remission</td>
</tr>
<tr>
<td>Z87898</td>
<td>Personal history of other specified conditions</td>
</tr>
</tbody>
</table>

The effective date for using the Z87898 ICD-10 code will be July 1, 2017.

Questions regarding this Informational Notice should be addressed to Eleazer Munoz, AGPA, at eleazer.munoz@dhcs.ca.gov.

Sincerely,

Original signed by

Karen Baylor, Ph.D., LMFT, Deputy Director
Mental Health & Substance Use Disorder Services
Drug Medi-Cal Organized Delivery System  
Place of Service Codes for Professional Claims

The following table includes clarification on the use of place of service (POS) codes when claiming Drug Medi-Cal Organized Delivery System (DMC-ODS) services.

<table>
<thead>
<tr>
<th>Place of Service Code(s)</th>
<th>Place of Service Name</th>
<th>Place of Service Description</th>
<th>POS codes allowed in DMC-ODS</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Pharmacy</td>
<td>A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.</td>
<td>Allowed</td>
</tr>
<tr>
<td>02</td>
<td>Telehealth</td>
<td>The location where health services and health related services are provided or received, through a telecommunication system.</td>
<td>Allowed</td>
</tr>
<tr>
<td>03</td>
<td>School</td>
<td>A facility whose primary purpose is education.</td>
<td>Allowed</td>
</tr>
<tr>
<td>04</td>
<td>Homeless Shelter</td>
<td>A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).</td>
<td>Allowed</td>
</tr>
<tr>
<td>05</td>
<td>Indian Health Service Free-standing Facility</td>
<td>A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.</td>
<td>Pending Phase V</td>
</tr>
<tr>
<td>Place of Service Code(s)</td>
<td>Place of Service Name</td>
<td>Place of Service Description</td>
<td>POS codes allowed in DMC-ODS</td>
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</tr>
<tr>
<td>06</td>
<td>Indian Health Service Provider-based Facility</td>
<td>A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.</td>
<td>Pending Phase V</td>
</tr>
<tr>
<td>07</td>
<td>Tribal 638 Free-standing Facility</td>
<td>A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.</td>
<td>Pending Phase V</td>
</tr>
<tr>
<td>08</td>
<td>Tribal 638 Provider-based Facility</td>
<td>A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.</td>
<td>Pending Phase V</td>
</tr>
<tr>
<td>09</td>
<td>Prison/Correctional Facility</td>
<td>A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.</td>
<td>Not allowed</td>
</tr>
<tr>
<td>10</td>
<td>Unassigned</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Place of Service Code(s)</td>
<td>Place of Service Name</td>
<td>Place of Service Description</td>
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</tr>
<tr>
<td>11</td>
<td>Office</td>
<td>Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.</td>
<td>Allowed</td>
</tr>
<tr>
<td>12</td>
<td>Home</td>
<td>Location, other than a hospital or other facility, where the patient receives care in a private residence.</td>
<td>Allowed</td>
</tr>
<tr>
<td>13</td>
<td>Assisted Living Facility</td>
<td>Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.</td>
<td>Allowed</td>
</tr>
<tr>
<td>14</td>
<td>Group Home</td>
<td>A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).</td>
<td>Allowed</td>
</tr>
<tr>
<td>15</td>
<td>Mobile Unit</td>
<td>A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.</td>
<td>Allowed</td>
</tr>
<tr>
<td>Place of Service Code(s)</td>
<td>Place of Service Name</td>
<td>Place of Service Description</td>
<td>POS codes allowed in DMC-ODS</td>
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</tr>
<tr>
<td>16</td>
<td>Temporary Lodging</td>
<td>A short-term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.</td>
<td>Allowed</td>
</tr>
<tr>
<td>17</td>
<td>Walk-in Retail Health Clinic</td>
<td>A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.</td>
<td>Not allowed</td>
</tr>
<tr>
<td>18</td>
<td>Place of Employment-Worksite</td>
<td>A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual.</td>
<td>Allowed</td>
</tr>
<tr>
<td>19</td>
<td>Off Campus-Outpatient Hospital</td>
<td>A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require</td>
<td>Allowed</td>
</tr>
<tr>
<td>20</td>
<td>Urgent Care Facility</td>
<td>Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.</td>
<td>Allowed</td>
</tr>
<tr>
<td>Place of Service Code(s)</td>
<td>Place of Service Name</td>
<td>Place of Service Description</td>
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</tr>
<tr>
<td>21</td>
<td>Inpatient Hospital</td>
<td>A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.</td>
<td>Allowed</td>
</tr>
<tr>
<td>22</td>
<td>On Campus-Outpatient Hospital</td>
<td>A portion of a hospital’s main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.</td>
<td>Allowed</td>
</tr>
<tr>
<td>23</td>
<td>Emergency Room – Hospital</td>
<td>A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.</td>
<td>Allowed</td>
</tr>
<tr>
<td>24</td>
<td>Ambulatory Surgical Center</td>
<td>A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.</td>
<td>Not allowed</td>
</tr>
<tr>
<td>25</td>
<td>Birthing Center</td>
<td>A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.</td>
<td>Not allowed</td>
</tr>
<tr>
<td>26</td>
<td>Military Treatment Facility</td>
<td>A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).</td>
<td>Not allowed</td>
</tr>
<tr>
<td>27-30</td>
<td>Unassigned</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Place of Service Code(s)</td>
<td>Place of Service Name</td>
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</tr>
<tr>
<td>31</td>
<td>Skilled Nursing Facility</td>
<td>A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.</td>
<td>Allowed</td>
</tr>
<tr>
<td>32</td>
<td>Nursing Facility</td>
<td>A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than individuals with intellectual disabilities.</td>
<td>Allowed</td>
</tr>
<tr>
<td>33</td>
<td>Custodial Care Facility</td>
<td>A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.</td>
<td>Allowed</td>
</tr>
<tr>
<td>34</td>
<td>Hospice</td>
<td>A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.</td>
<td>Allowed</td>
</tr>
<tr>
<td>35-40</td>
<td>Unassigned</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>Ambulance – Land</td>
<td>A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.</td>
<td>Not allowed</td>
</tr>
<tr>
<td>42</td>
<td>Ambulance – Air or Water</td>
<td>An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.</td>
<td>Not allowed</td>
</tr>
<tr>
<td>Place of Service Code(s)</td>
<td>Place of Service Name</td>
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</tr>
<tr>
<td>43-48</td>
<td>Unassigned</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>49</td>
<td>Independent Clinic</td>
<td>A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.</td>
<td>Allowed</td>
</tr>
<tr>
<td>50</td>
<td>Federally Qualified Health Center</td>
<td>A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.</td>
<td>Allowed</td>
</tr>
<tr>
<td>51</td>
<td>Inpatient Psychiatric Facility</td>
<td>A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.</td>
<td>Allowed</td>
</tr>
<tr>
<td>52</td>
<td>Psychiatric Facility – Partial Hospitalization</td>
<td>A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital- affiliated facility.</td>
<td>Allowed</td>
</tr>
<tr>
<td>Place of Service Code(s)</td>
<td>Place of Service Name</td>
<td>Place of Service Description</td>
<td>POS codes allowed in DMC-ODS</td>
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</tr>
<tr>
<td>53</td>
<td>Community Mental Health Center</td>
<td>A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.</td>
<td>Allowed</td>
</tr>
<tr>
<td>54</td>
<td>Intermediate Care Facility/Individuals with Intellectual Disabilities</td>
<td>A facility which primarily provides health-related care and services above the level of custodial care to individuals but does not provide the level of care or treatment available in a hospital or SNF.</td>
<td>Allowed</td>
</tr>
<tr>
<td>55</td>
<td>Residential Substance Abuse Treatment Facility</td>
<td>A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.</td>
<td>Allowed</td>
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<tr>
<td>Place of Service Code(s)</td>
<td>Place of Service Name</td>
<td>Place of Service Description</td>
<td>POS codes allowed in DMC-ODS</td>
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<tr>
<td>56</td>
<td>Psychiatric Residential Treatment Center</td>
<td>A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.</td>
<td>Not allowed</td>
</tr>
<tr>
<td>57</td>
<td>Non-residential Substance Abuse Treatment Facility</td>
<td>A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.</td>
<td>Allowed</td>
</tr>
<tr>
<td>58-59</td>
<td>Unassigned</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>Mass Immunization Center</td>
<td>A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.</td>
<td>Not allowed</td>
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<tr>
<td>Place of Service Code(s)</td>
<td>Place of Service Name</td>
<td>Place of Service Description</td>
<td>POS codes allowed in DMC-ODS</td>
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<tr>
<td>61</td>
<td>Comprehensive Inpatient Rehabilitation Facility</td>
<td>A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.</td>
<td>Not allowed</td>
</tr>
<tr>
<td>62</td>
<td>Comprehensive Outpatient Rehabilitation Facility</td>
<td>A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.</td>
<td>Not allowed</td>
</tr>
<tr>
<td>63-64</td>
<td>Unassigned</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>65</td>
<td>End-Stage Renal Disease Treatment Facility</td>
<td>A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.</td>
<td>Not allowed</td>
</tr>
<tr>
<td>66-70</td>
<td>Unassigned</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>71</td>
<td>Public Health Clinic</td>
<td>A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.</td>
<td>Allowed</td>
</tr>
<tr>
<td>72</td>
<td>Rural Health Clinic</td>
<td>A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.</td>
<td>Allowed</td>
</tr>
<tr>
<td>Place of Service Code(s)</td>
<td>Place of Service Name</td>
<td>Place of Service Description</td>
<td>POS codes allowed in DMC-ODS</td>
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</tr>
<tr>
<td>73-80</td>
<td>Unassigned</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>81</td>
<td>Independent Laboratory</td>
<td>A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.</td>
<td>Not allowed</td>
</tr>
<tr>
<td>82-98</td>
<td>Unassigned</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>99</td>
<td>Other Place of Service</td>
<td>Other place of service not identified above.</td>
<td>Allowed only in the case where another POS code is unavailable.</td>
</tr>
</tbody>
</table>
1. **Client Plan Development, Documentation, Supervision, and Oversight:**

   A. Substance Use Disorder (SUD) peer support services will be provided within the context of a comprehensive, individualized client plan that includes specific goals with associated interventions specific to peer support services. The amount and duration of the peer support services will be identified in the description section of the treatment plan. The scope of the peer support services will be outlined in each applicable intervention and may be described in further detail in the description notes section. Peer support services will vary based on client input, client preference, and the scope of treatment plan goals.

   B. Person-centered treatment planning will be implemented throughout the SUD system of care. Provider staff, both Licensed Practitioners of the Healing Arts (LPHA’s) and Certified or Registered Alcohol and Other Drug (AOD) Counselors, acting within their scope of practice, will facilitate person-centered treatment planning. Person-centered treatment planning will include an interactive process conducted during an individual session with the LPHA/Counselor, the client, and peer support staff as available. Individual treatment planning sessions will review client information from the intake and assessment and may include motivational interviewing. A collaborative exchange of ideas between staff and the client will be used to facilitate client-identified problem statements, client exploration regarding possible interventions in order to address identified problems, and development of client-selected goals. Problem statements, interventions, and goals will address issues directly related to the client’s Substance Use Disorder to be addressed as part of SUD treatment. Identification of problems unrelated to the client’s Substance Use Disorder may be addressed through referrals to ancillary services as needed and may indicate client need for Case Management services. In this way, all client-identified problems will be addressed and an individualized treatment plan will be developed in collaboration with the client.

   C. Peer support staff will be integrated into the treatment planning process in order to provide support and advocate for the client’s desires to be the focus of the treatment plan. Peer support staff will assist the client with communicating their needs and desires to the LPHA/Counselor. They may also provide information about community resources and activities to support client recovery. Additionally, peer support staff will have the opportunity to share their lived experience for the purpose of empowering the client to better understand the uniqueness of the recovery process. For example, peer support staff may share skills related specifically to health, wellness, and recovery in order to inspire hope within the client and provide practical examples. Peer support staff will assist with designing an individualized treatment plan with measurable goals and will help identify
specific areas for peer-to-peer substance abuse assistance. Although peer support staff may be incorporated into treatment planning throughout all treatment modalities, this will be an essential part of the treatment planning process for Recovery Services. All Recovery Services shall indicate on the treatment plan how peer-to-peer services will be used to support relapse prevention and the overall recovery process.

D. SUD peer support staff will receive on-site supervision by the designated “Peer Support Coordinator”. Each contracted SUD provider will be required to identify a Peer Support Coordinator for each facility and program that offers Recovery Services. The Peer Support Coordinator will provide regular face-to-face meetings with all peer support staff and will ensure that they are in compliance with the following minimum requirements:

- Peer support staff meet all Personnel Policy requirements as outlined in the Minimum Quality Drug Treatment Standards for DMC;
- Peer support staff participate in all mandatory trainings;
- Peer-to-peer services are provided in alignment with SAMHSA’s Core Competencies for Peer Workers in Behavioral Health Services; and
- Completion of annual performance evaluations.

2. Training and Designation:

A. The County will follow a two-step process to ensure that SUD peer support staff complete training and receive a county SUD Peer Support designation. The first step in this process will mandate that all peer support staff comply with the County’s Staff Credentialing and Licensing Departmental Policy and Procedure (Policy #4.015). Peer support staff will be required to submit all necessary documentation to ensure that they are properly credentialed and verified for eligibility to participate in Medi-Cal claiming and related activities. The credentialing process includes eligibility verification using required State and Federal databases, determination of the level of qualification and scope-of-practice category, and determination of appropriate facility-program associations. Once the entire credentialing process has been completed by County staff, the peer support staff and Peer Support Coordinator will be notified. The second step in the process is completion of the Introductory to SUD Peer Support Services Training. Upon completion of the training, a signed Training Attestation form will be submitted to County staff in order for the peer support staff to receive SUD Peer Support designation.

B. The County has identified that SUD peer support staff must obtain a basic set of competencies which include Peer Workers Core Competencies and Technical Competencies in order to perform and document the peer support function. In order to ensure that peer support staff obtain necessary core competencies, the County will
develop the *Introductory to SUD Peer Support Services Training* in alignment with SAMHSA’s *Core Competencies for Peer Workers in Behavioral Health Services*. Nationally recognized foundational principles and values for peers support staff will be addressed in the training as follows: recovery-oriented, person-centered, voluntary, relationship-focused, trauma-informed. Additionally, the training will address core competencies with specific examples for implementation of these core competencies into all peer-to-peer services. These core competencies will serve as a guide to the delivery of services and the standard to promote best practices. SAMHSA’s Core Competencies for Peer Workers in Behavioral Health Services are as follows:

- Engages peers in collaborative and caring relationships
- Provides support
- Shares lived experiences of recovery
- Personalizes peer support
- Supports recovery planning
- Links to resources, services, and supports
- Provides information about skills related to health, wellness, and recovery
- Helps peers to manage crises
- Values communication
- Supports collaboration and teamwork
- Promotes leadership and advocacy
- Promotes growth and development

Peer Support Coordinators will be responsible for providing this standardized training to all newly hired peer support staff. The *Introductory to SUD Peer Support Services Training* must also be provided annually and otherwise as needed. Peer Support Coordinators will use a variety of training methods to ensure that these core competencies are obtained by peer support staff. These methods may include one-on-one training, role-play, mentoring, and ongoing supervision.

Additionally, peer support staff will be required to obtain the Technical Competencies in order to document peer-to-peer services. Technical Competencies will include participation in mandatory ADP-Clinician’s Gateway (Electronic Health Record) Trainings and Documentation Trainings. Peer support staff will be on “note review status” within Clinician’s Gateway in order to ensure that all services provided are submitted to a site supervisor for review. Peer support staff will receive feedback as needed and site supervisors will communicate with the Peer Support Coordinator regarding any areas identified as training needs in order peer support staff to be in compliance with both the Peer Workers Core Competencies and Technical Competencies.
C. The County will evaluate the peer’s ability to support the recovery of clients from SUDs by looking at qualitative and quantitative feedback both specific to the peer support staff and generalized using program outcome data. County staff will review performance evaluations and training participation as part of the annual provider administrative audits. Performance evaluations will include the peer’s ability to implement core competencies. Both performance evaluations and training participation will be used as one method to evaluate the peer’s ability to support client recovery. Additionally, client Treatment Perceptions Surveys will be used in order to measure overall client satisfaction with services being offered and may influence County recommendations regarding peer support services. Lastly, program outcome data including successful completions of treatment and particularly successful completion of Recovery Services, will be used as an indicator regarding peer support staff ability to support the recovery of clients. Analysis of this data will be used to evaluate the overall impact of peer support services within the SUD system of care. Ongoing evaluation of peer support services and the implementation of the core competencies will guide the delivery of peer-to-peer services and will continue to promote best practices. Peer Support Coordinators will then be able to use this feedback, and core competencies within performance evaluations to set goals for peer support staff in to continue to develop these competencies and improve client recovery.
Attachment I
1. PURPOSE/SCOPE

1.1. To improve engagement and treatment services for clients with co-occurring severe and persistent mental illness (SPMI) and severe substance use disorders (SUD).

1.2. To establish standardized criteria and treatment practices for Medication Assisted Treatment (MAT) services and improve client outcomes.

2. POLICY

2.1. The Santa Barbara County Department of Behavioral Wellness (hereafter "the Department") is committed to providing evidence-based treatment services to its clients. Medication Assisted Treatment (MAT) is an evidence-based practice (EBP) that is indicated for clients who need medical interventions to reduce the harm caused by active substance use. Clients with co-occurring SPMI and severe SUD sometimes need medications to stabilize his/her conditions, engage in treatment and recovery, or to even stay alive. Therefore, MAT will be provided to select voluntary Department clients with co-occurring SPMI and severe SUD who need medications to ameliorate their SUD in order to address each client’s primary mental health condition(s).

3. DEFINITIONS

The following terms are limited to the purposes of this policy:

3.1. Medication Assisted Treatment (MAT) – the use of medications (controlled and non-controlled substances) to stabilize clients with severe opioid or alcohol use disorders in order to engage clients in mental health clinical treatment addressing a primary mental health disorder.
4. **SCREENING, ASSESSMENT AND TREATMENT AUTHORIZATION**

4.1. During the course of a mental health intake or clinical assessment, clinicians will inquire on past and current substance use. If there is a suspicion of a current severe opioid or alcohol disorder, or information gathered indicates a current severe opioid or alcohol disorder, staff will refer the client to a psychiatrist/physician (MD), physician’s assistant (PA) or nurse practitioner (NP) for evaluation. The evaluator will utilize the American Association of Addiction Medicine (ASAM) criteria and the *Readiness for Medication Assisted Treatment (MAT) Survey* (see Attachment A) to determine eligibility and readiness for MAT services.

4.2. Clients deemed eligible and willing to participate will be referred to the integrated Co-occurring Treatment Team for consideration for MAT services.

4.3. Prior to commencing MAT services, clinic staff will:

1. Obtain voluntary, written informed consent to treatment from the client before admission to MAT treatment.
2. Obtain a treatment agreement outlining the responsibilities and expectations of the treatment team and the client.
3. Make reasonable efforts to obtain releases of information (ROI) for any health care providers or others important for the coordination of care to the extent allowed by Welfare and Institutions Code (WIC), HIPAA and 42 CFR, Part 2.

5. **TREATMENT SERVICES**

5.1. All MAT clients will be referred to the integrated Co-occurring Treatment Team. Services may include, but are not limited to, the following:

1. Comprehensive assessment;
2. Psychiatric assessment;
3. Development of an integrated co-occurring disorder (COD) treatment plan;
4. Individual and group counseling and/or psychotherapy, as indicated;
5. Ongoing medication management and support;
6. Ongoing case management;
7. Drug testing, as indicated; and/or
8. Recovery support services.

5.2. Evidence-based practices indicate the need for coordinated mental health and MAT treatment services. Ongoing efforts will be made by the Co-occurring Treatment Team to involve the client in coordinated mental health and SUD services. If the client refuses services for a specified period of time, continuation of MAT medications will be reevaluated by the Co-occurring Treatment Team and recommendations documented on the Team-based Care Checklist.
5.3. Indicated medications for MAT services, including controlled and non-controlled substances, may include, but are not limited to, the following:

1. Buprenorphine – for opioid use disorder
2. Naltrexone injectable – for alcohol and/or opioid use disorder
3. Acamprosate – for alcohol use disorder
4. Naltrexone – for alcohol use disorder
5. Antabuse – for alcohol use disorder

5.4. The type and length of MAT services will be individualized per the client’s needs and reevaluated by the Co-occurring Treatment Team on an ongoing basis. Multidisciplinary Treatment (MDT) meetings will be held on a quarterly basis (or more frequently based on the client’s severity) to ensure appropriate monitoring of progress and transition planning as indicated.

5.5. All staff involved in the assessment, selection and treatment of MAT clients will be trained in co-occurring mental health and substance use disorders and ASAM criteria.

ASSISTANCE
John Doyel, MA, LAADC, ADP Division Chief
Ana Vicuña, LCSW, Division Chief of Clinical Operations

REFERENCE
Code of Federal Regulations
Title 42, Chapter 1, Subchapter A, Part 8

ATTACHMENTS
Attachment A – Readiness for Medication Assisted Treatment (MAT) Survey

REVISION RECORD

<table>
<thead>
<tr>
<th>DATE</th>
<th>VERSION</th>
<th>REVISION DESCRIPTION</th>
</tr>
</thead>
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Culturally and Linguistically Competent Policies
The Department of Behavioral Wellness is committed to the tenets of cultural competency and understands that culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse individuals. All policies and procedures are intended to reflect the integration of diversity and cultural literacy throughout the Department. To the fullest extent possible, information, services and treatments will be provided (in verbal and/or written form) in the individual’s preferred language or mode of communication (i.e. assistive devices for blind/deaf).
Group Log- Sign-in Sheet

DMC-ODS Provider: __________________________________________________________

Date of the counseling group: ______________________________________________

Time the group started: ____________        Time the group ended: ____________

Billable Minutes for this group: ____________

Topic of the group session: ______________________________________________________

<table>
<thead>
<tr>
<th></th>
<th>Typed or printed participant name</th>
<th>Signature of each participant</th>
<th>ASAM Level of Care</th>
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<tbody>
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<td>12.</td>
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* A progress note should be filled out for each client in the group documenting his or her progress in relation to “the beneficiary’s progress on the treatment plan problems, goals, actions steps, objectives, and/or referrals” (source: Title 22 Regulations).

I hereby certify that this Group Sign-in Sheet is accurate and complete:

_________________________________________  ______________________________________
Printed name of Therapist/Counselor  Signature of the Therapist/Counselor

Date: ________________
Attachment K
Minimum Quality Drug Treatment Standards for DMC

Compliance with the following Minimum Quality Treatment Standards is required in addition to CCR Title 9 and 22 regulations for all SUD treatment programs either partially or fully funded through DMC. If conflict between regulations and standards occurs, the most restrictive shall apply.

A. Personnel Policies

1. Personnel files shall be maintained on all employees and volunteers/interns and shall contain the following:
   a) Application for employment and/or resume;
   b) Signed employment confirmation statement/duty statement;
   c) Job description;
   d) Performance evaluations;
   e) Health records/status as required by program or Title 9;
   f) Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries);
   g) Training documentation relative to substance use disorders and treatment;
   h) Current registration, certification, intern status, or licensure;
   i) Proof of continuing education required by licensing or certifying agency and program; and
   j) Program Code of Conduct and for registered, certified, and licensed staff, a copy of the certifying/licensing body’s code of conduct as well.

2. Job descriptions shall be developed, revised as needed, and approved by the Program’s governing body. The job descriptions shall include:
   a) Position title and classification;
   b) Duties and responsibilities;
   c) Lines of supervision; and
   d) Education, training, work experience, and other qualifications for the position.

3. Written code of conduct for employees and volunteers/interns shall be established which addresses at least the following:
a) Use of drugs and/or alcohol;

b) Prohibition of social/business relationship with beneficiary’s or their family members for personal gain;

c) Prohibition of sexual contact with beneficiary’s;

d) Conflict of interest;

e) Providing services beyond scope;

f) Discrimination against beneficiary’s or staff;

g) Verbally, physically, or sexually harassing, threatening, or abusing beneficiary’s, family members or other staff;

h) Protection beneficiary confidentiality;

i) The elements found in the code of conduct(s) for the certifying organization(s) the program’s counselors are certified under; and

j) Cooperate with complaint investigations.

4. If a program utilizes the services of volunteers and or interns, procedures shall be implemented which address:

a) Recruitment;

b) Screening;

c) Selection;

d) Training and orientation;

e) Duties and assignments;

f) Scope of practice;

g) Supervision;

h) Evaluation; and

i) Protection of beneficiary confidentiality.

5. Written roles and responsibilities and a code of conduct for the medical director shall be clearly documented, signed and dated by a program representative and physician.

B. Program Management
1. Admission or Readmission

   a) Each program shall include in its policies and procedures written admission and readmission criteria for determining beneficiary’s eligibility and suitability for treatment. These criteria shall include, at minimum:

      i. DSM diagnosis;
      ii. Use of alcohol/drugs of abuse;
      iii. Physical health status; and
      iv. Documentation of social and psychological problems.

   b) If a potential beneficiary does not meet the admission criteria, the beneficiary shall be referred to an appropriate service provider.

   c) If a beneficiary is admitted to treatment, a consent to treatment form shall be signed by the beneficiary.

   d) The medical director shall document the basis for the diagnosis in the beneficiary record.

   e) All referrals made by program staff shall be documented in the beneficiary record.

   f) Copies of the following documents shall be provided to the beneficiary upon admission:

      i. Beneficiary rights, share of cost if applicable, notification of DMC funding accepted as payment in full, and consent to treatment.

   g) Copies of the following shall be provided to the beneficiary or posted in a prominent place accessible to all beneficiaries:

      i. A statement of nondiscrimination by race, religion, sex, ethnicity, age, disability, sexual preference, and ability to pay;
      ii. Complaint process and grievance procedures;
      iii. Appeal process for involuntary discharge; and
      iv. Program rules, expectations and regulations.

   h) Where drug screening by urinalysis is deemed medically appropriate the program shall:

      i. Establish procedures which protect against the falsification and/or contamination of any urine sample; and
      ii. Document urinalysis results in the beneficiary’s file.
2. Treatment

A. Assessment for all beneficiaries shall include:
   i. Drug/Alcohol use history;
   ii. Medical history;
   iii. Family history;
   iv. Psychiatric/psychological history;
   v. Social/recreational history;
   vi. Financial status/history;
   vii. Educational history;
   viii. Employment history;
   ix. Criminal history, legal status; and
   x. Previous SUD treatment history.

B. Treatment plans shall be developed with the beneficiary and include:
   i. A problem statement for all problems identified through the assessment whether addressed or deferred;
   ii. Goals to address each problem statement (unless deferred);
   iii. Action steps to meet the goals that include who is responsible for the action and the target date for completion;
   iv. Typed or legibly printed name, signature, and date of signature of primary counselor, beneficiary, and medical director; and
   v. All treatment plans shall be reviewed in accordance with CCR Title 22 requirements and updated to accurately reflect the beneficiary’s progress or lack of progress in treatment.

C. Progress notes shall document the beneficiary’s progress toward completion of activities and achievement of goals on the treatment plan.

D. Discharge documentation shall be in accordance with CCR Title 22 51341.
   i. A copy of the discharge plan shall be given to the beneficiary.
Attachment L
DEPARTMENT OF BEHAVIORAL WELLNESS
ALCOHOL & DRUG PROGRAM
ADMINISTRATIVE DESK AUDIT

COUNTY: ___________________________ DATE: ___________________________

<table>
<thead>
<tr>
<th>AGENCY NAME:</th>
<th>ADMINISTRATIVE OFFICE</th>
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<tbody>
<tr>
<td>ADDRESS:</td>
<td>DAYS/HOURS OF OPERATION:</td>
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<td>PHONE NUMBER:</td>
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<td>FAX:</td>
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| ADP REVIEWERS: | AGENCY ADMINISTRATIVE REPRESENTATIVES: |

<table>
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<th>AGENCY PROGRAMS</th>
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<tr>
<td>PRIMARY PREVENTION</td>
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<tr>
<td>SECONDARY PREVENTION</td>
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<tr>
<td>PC 1000/Drug Diversion</td>
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<tr>
<td>SACPA/OTP</td>
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<td>DUI</td>
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## GENERAL MANAGEMENT

### A. Governing Body

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<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Do the agency’s Articles of Incorporation and By-laws define the authority, responsibilities and duties of the proprietor and/or governing body, the program director, and any advisory groups associated with the program.</td>
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<td>2.</td>
<td>Is there a schedule showing how frequently the agency’s governing body meets?</td>
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<td>3.</td>
<td>Number of Board members? If applicable, note any potential conflict of interest with County of Santa Barbara advisory boards or commissions. Attach a listing of current members and the boards they serve on.</td>
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<td>4.</td>
<td>Are the minutes of governing body meetings kept and are available for public review, and for how long?</td>
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<td>5.</td>
<td>Minutes of the governing body reflect the development and approval of policies and procedures for agency operations in the areas of: policy and resource development; financial and personnel management</td>
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<tr>
<td>6.</td>
<td>An organization chart is available, is current, and reflects the program placement within the organization. (Attach copy of chart)</td>
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<tr>
<td>7.</td>
<td>Attach copy of 501 C3, Business License or applicable legal licenses.</td>
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<tr>
<td>8.</td>
<td>Attach copy of the latest agency audit and any current financial statements</td>
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</table>

### B. Chief Executive Officer (CEO)/Executive Director

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Documentation Provided</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.a.</td>
<td>Have there been any changes in the executive director or CEO in the last five years?</td>
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<tr>
<td>1.b.</td>
<td>How many years has the Director or CEO served in the current position?</td>
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</table>
### C. POLICY AND PROCEDURE MANUAL

<table>
<thead>
<tr>
<th>Documentation Provided</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
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<tbody>
<tr>
<td><strong>1.</strong> Does the agency maintain a copy of their Agency policy and procedure manual and does it contain the following information:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>A. Organizational Policies &amp; Procedures</td>
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<tr>
<td>1. Facilities Management</td>
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<tr>
<td>2. Emergency Response Plan</td>
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<tr>
<td>3. Client Admission Priority Policy</td>
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<tr>
<td>4. Client waitlist</td>
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<tr>
<td>5. Client Discharge and Readmission Policy</td>
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<tr>
<td>6. Case Record Management (Treatment only)</td>
<td></td>
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<td>7. 42 CFR Part 2 Confidentiality</td>
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<tr>
<td>8. Charitable Choice Title 42, CRF Part 54 Implementation</td>
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<tr>
<td>9. HIPAA Implementation and Procedure</td>
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<tr>
<td>10. Nicotine addiction treatment Policy</td>
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<tr>
<td>11. Drug Free environment Policy</td>
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<tr>
<td>12. TVPA of 2000 compliance Policy</td>
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<tr>
<td><strong>D. FINANCIAL MANAGEMENT POLICIES &amp; PROCEDURES</strong></td>
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<tr>
<td>Documentation Provided</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td><strong>1.</strong> Do agency policies and procedures specify that different people prepare checks, sign checks, reconcile bank accounts, and have access to bank accounts?</td>
<td></td>
<td></td>
<td>If No, explain:</td>
</tr>
<tr>
<td><strong>2.</strong> Do agency policies and procedures identify the individuals in the organization who are authorized to sign checks?</td>
<td></td>
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<tr>
<td><strong>3.</strong> Do agency policies and procedures require the check signer to review documents in support of checks presented for his/her signature?</td>
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<tr>
<td><strong>4.</strong> Are tax deposits up to date (FICA, Withholding, FUDA, and EDD)?</td>
<td></td>
<td>Tax Receipts:</td>
<td></td>
</tr>
<tr>
<td><strong>5.</strong> Does an inspection of agency’s last bank statements, deposit slips, etc. trace the last deposit of county</td>
<td></td>
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<tr>
<td>C. POLICY AND PROCEDURE MANUAL</td>
<td>Documentation Provided</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>6. Does the agency have back-up documents (pay ledgers, invoices, etc.) to support the last Monthly Financial Report/Request for Funds?</td>
<td>☐</td>
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<table>
<thead>
<tr>
<th>FISCAL &amp; CONTRACT COMPLIANCE</th>
<th>Documentation Submitted</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Quarterly Cost/Expenditure Reports are compiled and reviewed monthly.</td>
<td>☐</td>
<td>☐</td>
<td></td>
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<tr>
<td>2. Review Monthly Billing Reports (Services Rendered) Invoice and reporting submissions meet County standards and contract.</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>3. Reconcile Invoices with Case Record Entries.</td>
<td>☐</td>
<td>☐</td>
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<td>4. Residential services require authorization prior to placement.</td>
<td>☐</td>
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<tr>
<td>5. CalOMS submissions are reviewed to ensure compliance with Santa Barbara County ADP contract.</td>
<td>☐</td>
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<tr>
<td>6. Provider complies with Trafficking Victims Protection Act of 2000 section 106 (g).</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>7. Provider has Policies and offers training to staff on trafficking Victims Protection.</td>
<td>☐</td>
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<tr>
<td>8. Services are not denied to Medi-Cal eligible beneficiaries based on the client’s inability to pay.</td>
<td>☐</td>
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<tr>
<td>9. All necessary licenses, permits and certifications required to provide services are current and in good standing?</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>10. Does the agency have a current written policy that specifically prohibits discrimination of employees and applicants for employment?</td>
<td>☐</td>
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<tr>
<td>11. Does that policy directly address each of the following: race, religious creed, color, national origin, ancestry, medical condition, marital status, gender, sexual orientation, age, HIV status or condition of disability?</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Review Monthly Billing Reports (Services Rendered) Invoice and reporting submissions meet County standards and contract.</td>
<td>☐</td>
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</table>
### D. ORGANIZATION COMMUNICATION

<table>
<thead>
<tr>
<th>Documentation Provided</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>1. Agency conducts regular staff meetings (frequency)</td>
<td>□</td>
<td>□</td>
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<tr>
<td>2. Agency communicates to staff updates on policy and procedure changes</td>
<td>□</td>
<td>□</td>
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<tr>
<td>3. Agency has regular Board Meetings (frequency)</td>
<td>□</td>
<td>□</td>
<td>If not applicable, explain:</td>
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</table>

### E. ADVERTISING/OUTREACH

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<tr>
<th>Documentation Submitted</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>1. Has the agency developed a marketing and outreach plan? (Attach copy)</td>
<td>□</td>
<td>□</td>
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<tr>
<td>2. Has agency documentation of Public Service Announcements (PSA’s)?</td>
<td>□</td>
<td>□</td>
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<tr>
<td>3. Do all agency publications contain acknowledge receipt of ADMHS funding?</td>
<td>□</td>
<td>□</td>
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<tr>
<td>4. Does agency conduct client satisfaction surveys (CSS) on all programs?</td>
<td>□</td>
<td>□</td>
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<tr>
<td>5. How are CSS’s used in continuous quality improvement process?</td>
<td>□</td>
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</table>
CLAS Standards
To ensure equal access to quality care by diverse populations, each service provider receiving funds from the County of Santa Barbara, Behavioral Wellness/Alcohol Drug Program shall adopt the Office of Minority Health (OMH) Culturally and Linguistically Appropriate Service (CLAS) national standards. The OMH CLAS standards are at: http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53

Cultural Competency and CLAS Assessment

1. What is your agency’s process for ensuring the CLAS are followed? ________________________________________________________________

2. Describe how each CLAS standard is being implemented by your agency:

Standard 1: Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. ________________________________________________________________

Standard 2: Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources. ______________________________________________________________________________________

Standard 3: Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area. ______________________________________________________________________________________

Standard 4: Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis. ______________________________________________________________________________________

Standard 5: Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services. ______________________________________________________________________________________

Standard 6: Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing. ______________________________________________________________________________________

Standard 7: Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided. ______________________________________________________________________________________

Standard 8: Provide easy-to-understand print and multimedia materials and signage in languages commonly used by the populations in the service area. ______________________________________________________________________________________

Standard 9: Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization’s planning and operations. ______________________________________________________________________________________
Standard 10: Conduct ongoing assessments of the organization’s CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities. ______________________

Standard 11: Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and inform service delivery. ______________________

Standard 12: Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area. ______________________

Standard 13: Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness. ______________________

Standard 14: Create conflict grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints. ______________________

Standard 15: Communicate the organization’s progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public. ______________________

3. Please describe any barriers your agency is experiencing in implementing any of the above CLAS standards.

4. What languages are spoken in the area your agency serves? ______________________

5. What languages are spoken by counseling and other direct service staff in your agency? ______________________

6. In what language(s) is your agency’s posted signage? ______________________
### I. Youth & Family Treatment Documentation

<table>
<thead>
<tr>
<th>Documentation Required</th>
<th>Yes</th>
<th>No</th>
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</table>

#### 1. Client Files Reviewed
- A. Client Enrollment/Discharge Verifiable Residential Treatment CalOMS

#### 2. Service Geographic Area
- Service Geographic Area Verbal

#### 3. Curriculum and Counseling Content
- A. Does program have curriculum?
- B. Is curriculum best practices?
- C. Is there evidence that curriculum is being consistently followed?
- D. Does curriculum meet contract requirements?
- E. Is program Licensed/Certified?
- F. Are services integrated and include ancillary services?

#### 4. Minor Specific Services—does program ensure that clients 17 years of age or younger do not participate in groups with anyone 18 years of age or older?

#### 5. Gender Services—does program have separate groups for young women?

#### 6. Do you provide any Gang Prevention/Intervention services

#### 7. Youth Treatment Ancillary Services
- A. Case Management
- B. Family Engagement
- C. Recovery Activities
- D. Educational Activities
- E. Parenting Activities
- F. Drug Testing
- G. Vocational Activities
- H. Job Search

#### 7. Client Demographics Percentage
- A. Gender %
- B. Ethnicity %
- C. Gang Member or affiliates %
- D. Drug of Choice
- E. Other Service Coordination

### Restriction on Distribution of Sterile Needles
No funds shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug.

Does ADP Contractor understand and acknowledge?
## CHECKLIST FOR DISABILITY ACCESSIBILITY TO ALCOHOL & DRUG PROGRAM

### Accessible Approach/Entrance

<table>
<thead>
<tr>
<th>Accessible Approach/Entrance</th>
<th>YES</th>
<th>NO</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A) PARKING WALKWAYS: MINIMUM CONSIDERATIONS</strong></td>
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<tr>
<td>1) If off-street parking is available, it is as close to the accessible entrance as possible?</td>
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<tr>
<td>2) Are walkways with necessary ramps and curb cuts available from the parking area to the accessible entrance? NOTE: Route travel should be at least 36” wide.</td>
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<tr>
<td>3) Are designated reserved parking spaces provided for persons with disabilities?</td>
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<tr>
<td><strong>B) ENTRANCES: MINIMUM CONSIDERATIONS</strong></td>
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<tr>
<td>1) Is at least one primary building entrance accessible at ground level or ramped with no steps? NOTE: Ramp slope should not exceed 1:12. (One foot of ramp is equal to one foot of height.)</td>
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<td>2) Are accessible entrances identified with proper signage? (NOTE: A primary entrance is one that is a commonly used public entrance which does not involve transit through kitchens, storage facilities or similar areas.)</td>
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<tr>
<td>3) Are accessible primary entrances left unlocked or are provisions made for a signaling device that is accessible if the entrance must be locked during certain hours for security purposes?</td>
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<tr>
<td>4) Do entrance doors have a minimum clear opening of 32”?</td>
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<tr>
<td>5) Is the pressure required to open exterior doors 8 lbs. or less? (NOTE: Fish scales are helpful in determining door pressure.)</td>
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<tr>
<td>6) If revolving doors or turnstiles are located at a primary entrance, is there an accessible door as part of the same entrance?</td>
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### Access to Goods & Services

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<tr>
<th>Access to Goods &amp; Services</th>
<th>YES</th>
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<th>Comments</th>
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<tbody>
<tr>
<td><strong>C) INTERIOR CIRCULATION: MINIMUM CONSIDERATIONS</strong></td>
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<tr>
<td>1) Do all essential public areas have interior access for persons using a wheelchair or have other mobility impairments? (NOTE: This means the absence of steps to essential public areas and does not require leaving the facility to access an essential area that others can access without going outside.)</td>
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</table>
2) If the facility has multiple stories and if essential services or activities are provided on various levels, is elevator service available?  

3) If elevators are present do they have the following features?  
   a) Self Leveling?  
   b) Do the elevator doors stay open a minimum of five seconds?  
   c) Controls no more than 48” high, 54” to the top button or equipped with an adaptive device (wand)?  

4) Do interior door to public areas (not including guest rooms) have a minimum clear opening of 32”?  

   **INTERIOR CIRCULATION (cont’d)** | YES | NO | Comments  
--- | --- | --- | ---  
5) Is the pressure required to open the door five lbs. or less? (NOTE: Fish scales are helpful in determining door pressure.)  

6) Are interior ramps:  
   a) Permanent?  
   b) Have a non-slip surface with handrails on at least one side?  
   c) Is the slope a maximum of 1” rise for 12” of run? (NOTE: If the answer is no, please indicate slope. In rare situations, a ratio of 1 in 8 will be acceptable if it does not prohibit participation in a meeting, conference, training session, group session or public hearing of persons with disabilities.)  

**D) TOILET ROOMS & BATHING FACILITIES: MINIMUM CONSIDERATIONS** | YES | NO | Comments  
--- | --- | --- | ---  
1) Does the Facility have accessible public restrooms for men and women?  
   a) Are there accessible unisex restrooms available?  

2) Does the restroom entrance door have a minimum clear opening of 32”?  
   a) Is there adequate space to permit a wheelchair user to approach fixtures? A 36” wide path to all fixtures is required.  
   b) Is there adequate space to permit a wheelchair user to turn and enter stall? (NOTE: A person in a wheelchair needs 36 inches of clear width for forward movement, and a five foot diameter or T-shaped clear space to make turns.  

3) Is the pressure required to open the entrance door five lbs. or less?  

4) Do public toilet rooms have at least one fixture of each type, such as towel dispenser, sink, soap dispenser, etc., that is accessible and useable by persons using a wheelchair?  

5) Do public Toilet rooms, either individual or group, have a minimum clear floor space of 5 ft. and / or permit a wheelchair user to turn and enter the stall?
6) If stalls are provided, are they a minimum of 36” wide and 72” deep, or 48” wide and 57” deep, and have doors with a 30” clear opening? (NOTE: A 32” clear opening is preferred.)

7) Is the toilet set 17” to 19” high?

8) Is the sink rim no higher than 34”?

9) Is there at least 29” from the floor to the bottom of the sink apron (excluding pipes)?

10) Are exposed drain and hot water pipes insulated?

11) Can the faucet be operated with one closed fist?

12) Are other fixed objects located so as not to impede wheelchair access into stalls or other facilities?

13) Does appropriate signage identify accessible toilet facilities? (NOTE: If all restrooms are accessible then signage identifying accessibility is not required.)

---

### E) MEETING/HEARING ROOM FACILITIES: MINIMUM CONSIDERATIONS

1) Are there meeting rooms that can only be accessed by steps? NOTE: If so identify ____________________________

2) If amplifiers and/or sound equipment are used, are individual handheld or lavaliere microphones available?
   a) Are provisions made for assistive listening devices upon request for persons using hearing impairments?

3) Can meeting room seating be arranged to accommodate and include persons using wheelchairs in an integrative manner?

### F) RESIDENTIAL FACILITIES ONLY: LODGING ACCOMMODATIONS: MINIMUM CONSIDERATIONS

1) What is the total number of sleeping rooms provided? ____________________
   a) How many sleeping rooms are accessible for people with mobility limitations? ____________________

2) Door entrance door to guest rooms have a minimum clear opening of at least 32”?

3) Do accessible guest rooms allow sufficient turning space (5 ft. in diameter) to allow a person using a wheelchair to move about?

4) If there is a phone in the room is there an unobstructed approach to the phone for a person using a wheelchair?

### G) AUXILIARY AIDS: MINIMUM CONSIDERATIONS

---
1) Is there a written disability admission and referral policy in place?
2) Does the facility have a TTY?
   a) If no, has staff been trained to use the California Relay System (CRS)?
3) Does the alarm system have both visual and audible features?
4) Do public televisions have closed caption capability?
5) Are written materials available in alternative formats?
   a) If no, is there a policy in place for obtaining alternative formats?
6) Are service dogs allowed in the facility:
   a) If no, explain: ____________________________________________________________
7) Is there a written medication policy in place that does not discriminate against persons with disabilities?
8) Is there a written ADA plan on file?

### Nondiscrimination Questionnaire

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
<th>Comments</th>
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<tbody>
<tr>
<td>1. Is nondiscriminatory treatment, equally afforded to other individuals, given directly or through contractual licensing or other arrangements to people with disabilities in the full and equal enjoyment of the goods, facilities, privileges, advantages, or accommodations offered?</td>
<td></td>
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<tr>
<td>2. Are the goods, services, facilities, privileges, advantages, or accommodations provided differently or separately to individuals with disabilities and individuals without disabilities?</td>
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<tr>
<td>3. Are the goods, services, facilities, privileges, advantages, and accommodations offered to individuals with disabilities in the most integrated setting appropriate to the needs of the specific individual in question?</td>
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<tr>
<td>4. If separate or different programs or activities are provided to individuals with disabilities, may those individuals still participate in the activities that are not separate or different?</td>
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<tr>
<td>5. Do you use, directly, and/or through a contractual or other arrangements, standards, criteria, or methods of administration that do not have the effect of discrimination by others?</td>
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<tr>
<td>6. Are people with friends, associates, or relatives with a disability provided foods, services, facilities, privileges, advantages, advantages, accommodations, and other opportunities on a nondiscriminatory basis?</td>
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<tr>
<td>7.</td>
<td>Do your eligibility criteria screen in, not out, individuals with disabilities (unless such criteria can be shown to be necessary for the provision of goods, services, etc., being offered)?</td>
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<tr>
<td>8.</td>
<td>Are reasonable modifications made to policies, practices, or procedures when such modifications are necessary to offer goods or services, etc., to individuals with disabilities?</td>
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<tr>
<td>9.</td>
<td>Are people with disabilities included, allowed services, integrated, and otherwise treated the same as others through the provision of auxiliary aids and services?</td>
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<tr>
<td>10.</td>
<td>Are architectural barriers and communication that are structural in nature (including permanent, temporary, or moveable structures, such as furniture, equipment, and display racks) removed from existing facilities?</td>
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<tr>
<td>11.</td>
<td>Where removal of barriers is not “readily achievable” are the goods, services, etc., made available through alternative methods?</td>
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<td>12.</td>
<td>Has new construction been designed to be readily accessible to an usable by individuals with disabilities?</td>
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<tr>
<td>13.</td>
<td>If you are altering a facility, have the alterations been made in such a manner that, to the maximum extent feasible, the altered portions of the facility are readily accessible to and usable by individuals with disabilities including individuals who use a wheelchair?</td>
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</tbody>
</table>

**Disclaimer:** This document provides general information to promote compliance with the Americans with Disabilities Act (ADA). It was prepared under a technical assistance grant from the California Department of Alcohol and Drug Programs and does not constitute the Department’s or CAARR’s legal analysis or interpretation. For legal guidance, the ADA statute (42 U.S.C. 1210) and the US Department of Justice ADA regulations (28 C.F.R. Parts 35 and 36) should be consulted.
Attachment M
### Santa Barbara County Department of Behavioral Wellness Alcohol and Drug Program

**Substance Use Disorder Treatment Provider Programmatic Site Visit Monitoring Tool**

<table>
<thead>
<tr>
<th>Date of Review: __________________________________________</th>
<th>Review for County Fiscal Year: _____- _____</th>
</tr>
</thead>
</table>

**Provider Name:** __________________________________________

<table>
<thead>
<tr>
<th>Types of Reviews: ☐ DMC  ☐ NNA/SAPT  ☐ Youth and Family Tx  ☐ Perinatal  ☐ Residential/TLC</th>
</tr>
</thead>
</table>

**Provider DMC Certified?**  ☐ Yes  ☐ No

**Modality of Service (check all that apply):**

| ☐ Outpatient Drug Free  ☐ Intensive Outpatient Treatment  - Perinatal?:  ☐ Yes  ☐ No  - Adolescent?:  ☐ Yes  ☐ No |

**ADP Reviewer(s):** __________________________________________

**Contact Information:**

- **Email:** __________________________________________
- **Phone:** __________________________________________

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

**Provider Representative(s):**

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Print Name</th>
</tr>
</thead>
</table>
Compliance Ratings Key: Y = Yes; N = Needs Improvement; IA = Immediate Action; NA = Not Applicable

<table>
<thead>
<tr>
<th>Compliance Review Section</th>
<th>Regulatory Authority</th>
<th>Y</th>
<th>NI</th>
<th>IA</th>
<th>NA</th>
<th>Compliance Findings/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Client Individual Patient Records</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>- The provider establishes an individual client record for each client admitted to the program? All of the documentation in the client’s individual client record is maintained for a minimum of 7 years from the date of the last face-to-face contact?</td>
<td>DTS B.1-2</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>- All client individual records include all of the following client personal information:</td>
<td>AOD Cert. Stds §12020</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>&gt; Client identifier (e.g. name, number);</td>
<td>Title 9 §10160</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; Client date of birth, gender, and race and/or ethnicity;</td>
<td>Title 22 §51341.1(g)(1)(A)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>&gt; Client address and telephone number; and</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>&gt; Client next of kin or emergency contact; plus</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>&gt; For pregnant and postpartum women, medical documentation substantiating client’s pregnancy and last day of pregnancy.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>- All client individual records include the following client treatment episode info &amp; documentation of reimbursed services?</td>
<td>AOD Cert. Stds §7020</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>&gt; Intake and admission data (including, if applicable, a physical examination);</td>
<td>DTS B.1-2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; Completed Health Questionnaire;</td>
<td>Title 9 §10165</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; Initial and updated treatment plans with required review, approvals, type/legibly printed names, signatures, and dates;</td>
<td>Title 22 §51341.1(g)(1)(A)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; Evidence of compliance with provider and client contact requirements for treatment modalities or a written and signed determination by a licensed physician that fewer client contacts are appropriate and the client is progressing toward treatment plan goals;</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>&gt; Progress notes;</td>
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<td></td>
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<td></td>
<td></td>
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<tr>
<td>&gt; Continuing services justifications;</td>
<td></td>
<td></td>
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<tr>
<td>&gt; Laboratory test orders and results;</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>&gt; Referrals;</td>
<td></td>
<td></td>
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<tr>
<td>&gt; Counseling notes;</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>&gt; Discharge plan;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; Discharge summary (for lost contacts/involuntary discharges);</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>&gt; Evidence of compliance with multiple billing requirements;</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>&gt; Evidence of compliance with specific treatment modality service requirements (Title 22 §51341.1(d)); and</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>&gt; Any other information relating to services claimed for reimbursement.</td>
<td></td>
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</tbody>
</table>
### 1. Client Individual Patient Records continued

<table>
<thead>
<tr>
<th>Question</th>
<th>Regulatory Authority</th>
<th>Y</th>
<th>NI</th>
<th>IA</th>
<th>NA</th>
<th>Compliance Findings/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- All client records are written legibly in ink or typed? Signed and dated?</td>
<td>AOD Cert Stds §12020 (d) Title 22§51341.1(g)(1)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>- All client records contain the following documents signed by client:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▶ Admission Agreement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▶ Release of Information</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>▶ Referrals, referral source, and reason for referral</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>▶ Client Rights form</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>- All client records contain a record of current medications with prescribing physician and instructions for use</td>
<td>AOD Cert Stds §12020 (b)(1)</td>
<td></td>
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</tr>
<tr>
<td>- Program retains Multiple Billing Override Certification (MC6700) as required?</td>
<td>County of Santa Barbara Contract 17-94102</td>
<td></td>
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### 2. Intake & Admission: Requirements

<table>
<thead>
<tr>
<th>Question</th>
<th>Regulatory Authority</th>
<th>Y</th>
<th>NI</th>
<th>IA</th>
<th>NA</th>
<th>Compliance Findings/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Conducts initial interview with client to determine whether admission eligibility criteria are met?</td>
<td>AOD Cert Stds §7010 Title 22§51341.1 (h)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>- Documents how client meets admission criteria in client record?</td>
<td>AOD Cert Stds §7010 Title 22 §51341.1 (h)</td>
<td></td>
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</tr>
<tr>
<td>- Documents personal, medical and substance use history at intake including, at a minimum:</td>
<td></td>
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</tr>
<tr>
<td>▶ Social, economic, and family background?</td>
<td>AOD Cert Stds §7010 Title 22§51341.1 (h)</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>▶ Education?</td>
<td>AOD Cert Stds §7010 Title 22 §51341.1 (h)</td>
<td></td>
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<tr>
<td>▶ Vocational achievements?</td>
<td>AOD Cert Stds §7010 Title 22 §51341.1 (h)</td>
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<tr>
<td>▶ Criminal history and legal status?</td>
<td>AOD Cert Stds §7010 Title 22 §51341.1 (h)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>▶ Medical history?</td>
<td>AOD Cert Stds §7010 Title 22 §51341.1 (h)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>▶ Drug history?</td>
<td>AOD Cert Stds §7010 Title 22 §51341.1 (h)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▶ Previous treatment?</td>
<td>AOD Cert Stds §7010 Title 22 §51341.1 (h)</td>
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</tr>
<tr>
<td>- Completes Health Questionnaire for all clients?</td>
<td>AOD Cert Stds §7020</td>
<td></td>
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</tr>
</tbody>
</table>
### 3. Intake & Admission: DSM IV/5 Diagnosis

- A licensed physician, therapist, physician assistant or nurse practitioner has evaluated each client to diagnose whether clients have a substance use disorder within 30 calendar days of the client’s admission to treatment date as evidenced by a written basis for the diagnosis in the client’s individual patient record that is legible, signed and dated?

  - From Title 22 §51341.1(h)(1)(A)(v)

<table>
<thead>
<tr>
<th>Compliance Ratings Key: Y = Yes; N = Needs Improvement; IA = Immediate Action; NA = Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ ☐ ☐ ☐</td>
</tr>
</tbody>
</table>

- Where a licensed physician did not determine the client DSM IV/5 substance use disorder diagnosis, a licensed physician has reviewed and approved each client’s diagnosis as evidenced by a physician’s legibly printed or typed name, signature and date in a client’s treatment plan?

  - From Title 22 §51341.1(h)(1)(A)(v)

<table>
<thead>
<tr>
<th>Compliance Ratings Key: Y = Yes; N = Needs Improvement; IA = Immediate Action; NA = Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ ☐ ☐ ☐</td>
</tr>
</tbody>
</table>

### 4. Intake & Admission: Medical Necessity

- All clients meet medical necessity requirements as evidenced by a written and dated Verification of Medical Necessity Form signed by a licensed physician in the client’s individual patient record within 30 calendar days of a client’s admission to treatment date following the physician review of each client’s personal, medical and substance use history?

  - From Title 22 §51341.1(h)(1)(A)(vi)

<table>
<thead>
<tr>
<th>Compliance Ratings Key: Y = Yes; N = Needs Improvement; IA = Immediate Action; NA = Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ ☐ ☐ ☐</td>
</tr>
</tbody>
</table>
### 5. Intake and Admission: Additional Requirements

**Physical Examination Requirements**
- A licensed physician reviews the client’s most recent physical examination **within 30 calendar days** of client’s admission to treatment date for clients who have had a physical examination within the twelve-month period prior to admission to treatment date as evidenced by documentation in the client’s individual patient record?
- When the provider has not been able to obtain documentation of a client’s most recent physical examination, there is written documentation in the client’s individual patient record of efforts made to obtain the documentation on the client’s behalf?
- Where a physician, registered nurse practitioner, or physician’s assistant performs a physical examination of the client within 30 calendar days of the client’s admission to treatment date, there is written documentation of findings within the client’s individual record?
- Where there is no physical examination documentation or an examination performed by a physician, registered nurse practitioner or physician’s assistant, there is a goal incorporated within the initial and updated treatment plans of obtaining a physical examination until the exam goal has been met?
- Where a client’s physical examination in the past 12 months indicates a client has a significant medical illness, there is evidence of a goal in the treatment plan that the client obtain appropriate treatment for the illness?

<table>
<thead>
<tr>
<th>Regulatory Authority</th>
<th>Y</th>
<th>NI</th>
<th>IA</th>
<th>NA</th>
<th>Compliance Findings/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title 22</strong> §51341.1(h)(1)(A)(iv)(a) through (c)</td>
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<td>☐</td>
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</tr>
<tr>
<td><strong>Title 22</strong> §51341.1(h)(2)(A)(i)(h)(i)</td>
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<td>☐</td>
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</table>
### 6. Initial Treatment Plan

<table>
<thead>
<tr>
<th>Activity Description</th>
<th>Regulatory Authority</th>
<th>Y</th>
<th>NI</th>
<th>IA</th>
<th>NA</th>
<th>Compliance Findings/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Develops initial treatment plan within 30 calendar days from the client’s admission to treatment which includes the following:</td>
<td>AOD Cert Stds §7090</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>▪ Individualized based on intake and assessment process?</td>
<td>AOD Cert Stds §7090</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>▪ Statement of challenge(s) to be addressed in treatment?</td>
<td>AOD Cert Stds §7090</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>▪ Statement of goal(s) to be reached which address the challenge(s)?</td>
<td>AOD Cert Stds §7090</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>▪ Action steps which will be taken by the program and/or client to accomplish goal(s)?</td>
<td>AOD Cert Stds §7090</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<td></td>
</tr>
<tr>
<td>▪ Target date(s) for accomplishment of action step(s), goal(s), and when possible, resolution of challenge(s)?</td>
<td>AOD Cert Stds §7090</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>- A description of services including the types of counseling to be provided and the frequency thereof?</td>
<td>Title 22 § 51341.1(h)(2)(A)(i)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>- Assignment of a primary therapist or counselor?</td>
<td>Title 22 § 51341.1(h)(2)(A)(i)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>- Client’s diagnosis?</td>
<td>Title 22 § 51341.1(h)(2)(A)(i)</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
<td></td>
</tr>
<tr>
<td>- Goal to have a physical examination if client has not had a physical exam within the 12-month period prior to the admission to treatment date?</td>
<td>Title 22 § 51341.1(h)(2)(A)(i)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>- Goal to obtain appropriate treatment for significant medical illness documented on a physical examination of the client that was performed during the 12 months prior to the admission to treatment date?</td>
<td>Title 22 § 51341.1(h)(2)(A)(i)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>▪ Initial treatment plan signed and dated by therapist/counselor within 30 calendar days of the admission to treatment date?</td>
<td>Title 22 § 51341.1(h)(2)(A)(i)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>▪ Client review and approval of initial treatment plan with typed or legibly printed name, signature and date within 30 calendar days of the admission to treatment date?</td>
<td>Title 22 § 51341.1(h)(2)(A)(i)</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
<td></td>
</tr>
<tr>
<td>▪ If client refuses, documentation of reason for refusal to sign the treatment plan and strategy to engage the client to participate in treatment?</td>
<td>Title 22 § 51341.1(h)(2)(A)(i)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>▪ Physician reviews initial treatment plan for medical necessity and type or legibly print their name, and sign and date the treatment plan within 15 calendar days of the signature by the therapist or counselor?</td>
<td>Title 22 § 51341.1(h)(2)(A)(i)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tbody>
</table>
### Compliance Ratings Key
- **Y** = Yes
- **NI** = Needs Improvement
- **IA** = Immediate Action
- **NA** = Not Applicable

<table>
<thead>
<tr>
<th>7. Treatment Plan Review and Updates</th>
<th>Regulatory Authority</th>
<th>Y</th>
<th>NI</th>
<th>IA</th>
<th>NA</th>
<th>Compliance Findings/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist or counselor completes, types or legibly prints name, signs and dates updated treatment plan no later than 90 calendar days after signing the initial treatment plan, and no later than every 90 calendar days thereafter, or when a change in problem identification or focus of treatment occurs, whichever comes first?</td>
<td>Title 22 §51341.1(h)(2)(A)(iii)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<td></td>
</tr>
<tr>
<td>Clients review, approve, type or legibly print their name and sign and date updated treatment plans within 30 calendar days of the signature by the therapist or counselor?</td>
<td>Title 22 §51341.1(h)(2)(A)(iii)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>If client refuses to sign updated treatment plan, provider documents reason for refusal and strategy for to engage client to participate in treatment?</td>
<td>Title 22 §51341.1(h)(2)(A)(iii)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Physicians review each updated treatment plan to determine whether services are medically necessary?</td>
<td>Title 22 §51341.1(h)(2)(A)(iii)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Physicians type or legibly print their name and sign and date updated treatment plans within 15 calendar days of the signature of the therapist or counselor when they determine services in updated treatment plan are medically necessary?</td>
<td>Title 22 §51341.1(h)(2)(A)(iii)</td>
<td>☐</td>
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8. Progress Notes

<table>
<thead>
<tr>
<th>For Outpatient Drug Free/Intensive Outpatient Treatment:</th>
<th>Regulatory Authority</th>
<th>Y</th>
<th>NI</th>
<th>IA</th>
<th>NA</th>
<th>Compliance Findings/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Therapists or counselors record a progress note for each individual or group counseling session for each client who participates in the session and type or legibly print their name and sign and date the progress note within 7 calendar days of the counseling session?</td>
<td>Title 22 §51341.1(h)(3)</td>
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<tr>
<td>- Progress notes include all of the following?</td>
<td>Title 22 §51341.1(h)(3)</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>▪ Topic of the session?</td>
<td>Title 22§51341.1(h)(3)</td>
<td>☐</td>
<td>☐</td>
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<td></td>
</tr>
<tr>
<td>▪ Type of counseling format (e.g. individual, group)?</td>
<td>Title 22 §51341.1(h)(3)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>▪ Description of client’s progress on the treatment plan challenges, goals, action steps, objectives and/or referrals?</td>
<td>Title 22§51341.1(h)(3)</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>▪ Information on the client’s attendance, including the date, start and end times of each individual and group counseling session?</td>
<td>Title 22 §51341.1(h)(3)</td>
<td>☐</td>
<td>☐</td>
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</tbody>
</table>
### 9. Frequency of Services, Services Referrals and Group Counseling Requirements

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Regulatory Authority</th>
<th>Y</th>
<th>NI</th>
<th>IA</th>
<th>NA</th>
<th>Compliance Findings/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Meets frequency of service requirements?</td>
<td>Title 22§51341.1 1(h)(5)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>▪ For Outpatient Drug Free, clients are provided a minimum of 2 counseling sessions per 30 day period except when physician determines fewer client contacts are clinically appropriate or the client is progressing toward treatment plan goals?</td>
<td>Title 22 §51341.1 1(h)(5)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>▪ For Intensive Outpatient, clients are provided a minimum of 3 hours of counseling session 3 days a week except when physician determines fewer client contacts are clinically appropriate or the client is progressing toward treatment plan goals?</td>
<td>Title 22 §51341.1 1(h)(5)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>- Assesses need for the following minimum services and provides or makes referrals directly to an ancillary service to meet service needs:</td>
<td>AOD Cert Stds §8000</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>▪ Education opportunity?</td>
<td>AOD Cert Stds §8000</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>▪ Vocational counseling and training?</td>
<td>AOD Cert Stds §8000</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
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<tr>
<td>▪ Job referral and placement?</td>
<td>AOD Cert Stds §8000</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
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<tr>
<td>▪ Legal services?</td>
<td>AOD Cert Stds §8000</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>▪ Medical services and dental services?</td>
<td>AOD Cert Stds §8000</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>▪ Social/recreational services?</td>
<td>AOD Cert Stds §8000</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>▪ Individual counseling and group counseling for clients, spouses, domestic partners, parents and other significant people?</td>
<td>AOD Cert Stds §8000</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>- Documents service referrals in client records?</td>
<td>AOD Cert Stds §8000</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>- Provides or refers clients to the following services if needed:</td>
<td>AOD Cert Stds §7060-7070</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
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<tr>
<td>▪ Emergency?</td>
<td>AOD Cert Stds §7060-7070</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>▪ Medical consulting? Detoxification when deemed appropriate?</td>
<td>AOD Cert Stds §7060-7070</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>- Meets group size requirements for counseling sessions?</td>
<td>Title 22 §51341. (b)(11)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>▪ No less than 2, no more than 12 clients at the same time.</td>
<td>Title 22 §51341. (b)(11)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>- Meets confidential session setting requirements?</td>
<td>Title 22 §51341. (b)(11)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>- Ensures client’s age 17 or younger do not participate with clients age 18 and older except at school sites?</td>
<td>Title 22 §51341. (b)(11)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>
### Compliance Ratings Key:
- Y = Yes
- N = Needs Improvement
- IA = Immediate Action
- NA = Not Applicable

<table>
<thead>
<tr>
<th>10. Continuing Services</th>
<th>Regulatory Authority</th>
<th>Y</th>
<th>NI</th>
<th>IA</th>
<th>NA</th>
<th>Compliance Findings/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Therapist or counselor no sooner than 5 months and no later than 6 months after client admission to treatment dates or the date of completion of the most recent justification for continuing services, reviews the client’s progress and eligibility to continue to receive treatment services and recommends whether the client should or should not continue to receive treatment services using the Justification to Continue Treatment Form?</td>
<td>Title 22 §51341.1(h)(5)(A)(i)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>- Physician determines whether continued services are medically necessary and documents determination in client record, using the Justification to Continue Treatment Form. Physician documentation includes consideration of all of the following: client’s personal, medical, and substance use history; documentation of the client’s most recent physical examination; client’s progress notes and treatment plan goals; and client’s prognosis?</td>
<td>Title 22 §51341.1(h)(5)(A)(i)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>- Client discharged when physician determined continuing treatment services not medically necessary?</td>
<td>Title 22 §51341.1(h)(5)(A)(i)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<td></td>
</tr>
</tbody>
</table>
### 11. Discharge Plan and Discharge Summary

<table>
<thead>
<tr>
<th>Regulatory Authority</th>
<th>Y</th>
<th>NI</th>
<th>IA</th>
<th>NA</th>
<th>Compliance Findings/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Therapists or counselors complete a discharge plan for each client except for clients with whom the provider loses contact?</td>
<td>Title 22 §51341.1(b)(6)(A)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>- Discharge plan prepared within 30 calendar days prior to the date of the last face-to-face treatment with the client that includes all of the following at a minimum:</td>
<td>Title 22 §51341.1(b)(6)(A)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>▪ Description of each of the client’s relapse triggers and a plan to assist the client to avoid relapse when confronted with triggers?</td>
<td>Title 22 §51341.1(b)(6)(A)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>▪ A support plan?</td>
<td>Title 22 §51341.1(b)(6)(A)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>- Therapists or counselors and clients type or print legibly their names, sign and date the discharge plans?</td>
<td>Title 22 §51341.1(b)(6)(A)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>- Clients provided a copy of discharge plan by therapist or counselors at last face-to-face treatment with client?</td>
<td>AOD Cert. Stds. §7120 Title 22 §51341.1(b)(6)(B)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>- Staff completes discharge summaries for each client, within 30 calendar days of the date of the provider’s last face-to-face treatment contact with the client, that include:</td>
<td>AOD Cert. Stds. §7120 Title 22 §51341.1(b)(6)(B)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>▪ Description of treatment episodes or recovery services?</td>
<td>AOD Cert. Stds. §7120</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>▪ Current alcohol and/or other drug usage?</td>
<td>AOD Cert. Stds. §7120</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>▪ Vocational and educational achievements?</td>
<td>AOD Cert. Stds. §7120</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>▪ Legal status?</td>
<td>AOD Cert. Stds. §7120</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>▪ Reason for discharge and whether the discharge was involuntary or a successful completion?</td>
<td>AOD Cert. Stds. §7120</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>▪ Client’s continuing recovery or treatment exit plan?</td>
<td>AOD Cert. Stds. §7120</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>▪ Transfers and referrals?</td>
<td>AOD Cert. Stds. §7120</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>▪ Client’s comments?</td>
<td>AOD Cert. Stds. §7120</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
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</tbody>
</table>
### 12. Client Fair Hearing Rights

<table>
<thead>
<tr>
<th>Regulatory Authority</th>
<th>Y</th>
<th>NI</th>
<th>IA</th>
<th>NA</th>
<th>Compliance Findings/Notes</th>
</tr>
</thead>
</table>
| - Providers comply with client notification of fair hearing requirements that involve the denial, involuntary discharge, or reduction in DMC substance use disorder services as it relates to their eligibility for benefits by providing written notification at least 10 calendar days prior to the effective date of the intended action to terminate or reduce services that includes:  
  - Statement of action to be taken;  
  - Reason for intended action; Citation of the specific regulations supporting intended action;  
  - Explanation of client’s right to fair hearing for purpose of appealing the intended action;  
  - Explanation that client may request a fair hearing by submitting a written request to the Department of Social Services; and  
  - Explanation that provider will continue treatment services pending a fair hearing decision? | ☐ | ☐ | ☐ | ☐ | Title 22 §51341.1(h)(7) |
| - Copy of written notification in client individual patient record? | ☐ | ☐ | ☐ | ☐ | Title 22 §51341.1(h)(7) |

### 13. Program Curriculum and Counseling Content

<table>
<thead>
<tr>
<th>Regulatory Authority</th>
<th>Y</th>
<th>NI</th>
<th>IA</th>
<th>NA</th>
<th>Compliance Findings/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Does program have curriculum?</td>
<td>Provider Contract</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>- Is curriculum best practices?</td>
<td>Provider Contract</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>- Is there evidence that curriculum is being consistently followed?</td>
<td>Provider Contract</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>- Does curriculum meet contract requirements?</td>
<td>Provider Contract</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>- Is program Licensed/Certified?</td>
<td>Provider Contract</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>- Is DOPE literature available in the lobby area?</td>
<td>Provider Contract</td>
<td>☐</td>
<td>☐</td>
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</table>
### 14. Drug Testing Protocols, Policy and Procedures

<table>
<thead>
<tr>
<th>Regulatory Authority</th>
<th>Y</th>
<th>NI</th>
<th>IA</th>
<th>NA</th>
<th>Compliance Findings/Notes</th>
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<tbody>
<tr>
<td>- Drug Testing Site</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>AOD Cert. Stds. §7050</td>
</tr>
<tr>
<td>▪ Drug testing supplies</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>▪ Bathroom inspection</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>▪ Locked Storage</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>- Drug Testing Policy and Procedures utilized</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>AOD Cert. Stds. §7050</td>
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<tr>
<td>- Confirmatory Drug Test Protocols</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>AOD Cert. Stds. §7050</td>
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<tr>
<td>- Positive Drug Test Protocols</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>AOD Cert. Stds. §7050</td>
</tr>
<tr>
<td>▪ Admission statement</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>▪ Confirmatory test</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>▪ Report to probation</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>- Drug testing log used</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>AOD Cert. Stds. §7050</td>
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<tr>
<td>- Drug testing frequency compliance</td>
<td>☐</td>
<td>☐</td>
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</table>

### 15. Group Logs

<table>
<thead>
<tr>
<th>Regulatory Authority</th>
<th>Y</th>
<th>NI</th>
<th>IA</th>
<th>NA</th>
<th>Compliance Findings/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Group sign-in sheets for every group counseling session which shall include all of the following:</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>Title 22 §51341.1(b)</td>
</tr>
<tr>
<td>▪ Typed (or legibly printed) name of counselor</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>▪ Counselor signature</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>▪ Date of counseling session</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>▪ Group topic</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>▪ Start and end time</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>▪ Typed (or legibly printed) name of participant</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>▪ Participant signature</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
</tbody>
</table>
### 16. Physical Environment Review

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Regulatory Authority</th>
<th>Y</th>
<th>NI</th>
<th>IA</th>
<th>NA</th>
<th>Compliance Findings/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Programs clean, safe, sanitary, and in good repair as follow by being</td>
<td>AOD Cert. Stds. §20000</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>free of the following:</td>
<td></td>
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<tr>
<td>- Broken glass, filth, litter, or debris</td>
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<tr>
<td>- Flies, insects, or other vermin</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Toxic chemicals or noxious fumes or odors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Exposed electrical wiring</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- Other health or safety hazards</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Carpets and floors are free from filth, holes, cracks, tears, broken tiles,</td>
<td>AOD Cert. Stds. §20000</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
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<tr>
<td>or other safety hazards?</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- All outdoor and indoor passageways, stairways, inclines, ramps, and</td>
<td>AOD Cert. Stds. §20000</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>other areas of potential hazard shall be kept free of obstruction and</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>lighted for safety of all clients?</td>
<td></td>
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</tr>
<tr>
<td>- Program equipment and supplies is stored in an appropriate space and</td>
<td>AOD Cert. Stds. §20000</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>is not stored in a space designated for other activities?</td>
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<tr>
<td>- Program maintains a valid fire clearance and working smoke alarms</td>
<td>AOD Cert. Stds. §20000-</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>and fire extinguishers?</td>
<td>20010</td>
<td></td>
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</tr>
<tr>
<td>- Copy of the clients rights is posted in a location visible to all clients</td>
<td>AOD Cert. Stds. §16000</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>and the general public?</td>
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<tr>
<td>- Copy of the program hours of operation is posted in a location visible</td>
<td>AOD Cert. Stds. §20020</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>to all clients and general public? Including emergency telephone services</td>
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<tr>
<td>- Copy of complaint process and grievance procedures posted</td>
<td>DTS B. 1.g</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>prominently and/or made accessible to all clients?</td>
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</tbody>
</table>

### 15. Additional Program Requirements

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Regulatory Authority</th>
<th>Y</th>
<th>NI</th>
<th>IA</th>
<th>NA</th>
<th>Compliance Findings/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Program submitting CalOMS Tx admission, discharge, annual update,</td>
<td>County of Santa Barbara</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>resubmission or records containing errors or in need of corrections as</td>
<td>Contract 17-94102</td>
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<tr>
<td>required?</td>
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<tr>
<td>- Program submitting monthly DATAR reports by the 10th of the</td>
<td>County of Santa Barbara</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>following month?</td>
<td>Contract 17-94102</td>
<td></td>
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<tr>
<td>- Program in compliance with all DHCS Corrective Action Plans?</td>
<td>County of Santa Barbara</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>County submits/submitted DHCS Form 8049?</td>
<td>Contract 17-94102</td>
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</tbody>
</table>
### Compliance Ratings Key: Y = Yes; N = Needs Improvement; IA = Immediate Action; NA = Not Applicable

<table>
<thead>
<tr>
<th>16. Youth &amp; Family Treatment</th>
<th>Regulatory Authority</th>
<th>Y</th>
<th>NI</th>
<th>IA</th>
<th>NA</th>
<th>Compliance Findings/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Is your program familiar with the Youth Treatment Guidelines?</td>
<td>Youth Treatment Guidelines</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>▪ As an educational resource for program staff?</td>
<td></td>
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<tr>
<td>▪ To ensure that adolescent programs are safe, appropriate, and cost effective?</td>
<td></td>
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<tr>
<td>- Minor Specific Services:</td>
<td>Title 22 §51341.1(b)(11)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>▪ Does program ensure that clients 17 years of age or younger do not participate in groups with anyone 18 years of age or older?</td>
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<tr>
<td>- Gender Services:</td>
<td>Youth Treatment Guidelines</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
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<tr>
<td>▪ Does program have separate groups for young women?</td>
<td></td>
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<tr>
<td>▪ Do you provide any Gang Prevention/Intervention services?</td>
<td>Youth Treatment Guidelines</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
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<tr>
<td>- Youth Treatment Ancillary Services provided:</td>
<td>Youth Treatment Guidelines</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>▪ Case Management</td>
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<tr>
<td>▪ Family Engagement</td>
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<tr>
<td>▪ Recovery Activities</td>
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<td>▪ Educational Activities</td>
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<tr>
<td>▪ Parenting Activities</td>
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<tr>
<td>▪ Drug Testing</td>
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<td>▪ Vocational Activities</td>
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<tr>
<td>▪ Employment Activities</td>
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<tr>
<td>▪ Other Service Coordination</td>
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<tr>
<td>- Client Demographics Percentage</td>
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<td>☐</td>
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<tr>
<td>▪ Gender</td>
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<tr>
<td>▪ Ethnicity</td>
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<tr>
<td>▪ Gang Members or affiliates</td>
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<tr>
<td>▪ Drug of Choice</td>
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</tr>
</tbody>
</table>
**Compliance Ratings Key:** Y = Yes; N = Needs Improvement; IA = Immediate Action; NA = Not Applicable

<table>
<thead>
<tr>
<th>17. Perinatal Programs</th>
<th>Regulatory Authority</th>
<th>Y</th>
<th>NI</th>
<th>IA</th>
<th>NA</th>
<th>Compliance Findings/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>- Is your program familiar with the Perinatal Services Network Guidelines?</strong></td>
<td>Perinatal Services Network Guidelines FY2016-17</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Program implementation incorporates requirements as outlined in the Perinatal Service Network Guidelines in order to adhere to federal and state regulations?</td>
<td></td>
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</tr>
<tr>
<td><strong>- Target Populations- serve women who are either:</strong></td>
<td>Perinatal Services Network Guidelines (45 CFR 96.124 and HSC 10.5, 11757.59(a))</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Pregnant and substance using; or</td>
<td></td>
<td></td>
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<tr>
<td>Parenting and substance using, with a child(ren) ages birth through 17 (including those with dependents and attempting to regain legal custody)</td>
<td></td>
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</tr>
<tr>
<td><strong>- Admission Priority- serve women in the following priority order:</strong></td>
<td>Perinatal Services Network Guidelines FY2016-17</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Pregnant injection drug users;</td>
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<tr>
<td>Pregnant substance users;</td>
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<tr>
<td>Parenting injection drug users; and</td>
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<td></td>
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<tr>
<td>All others</td>
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</tr>
<tr>
<td><strong>- Medical documentation that substantiates client pregnancy and last day of pregnancy?</strong></td>
<td>Title 2 §51341.1(g)(1)(iii)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td><strong>- Referral to Other Programs and Interim Services:</strong></td>
<td>Perinatal Services Network Guidelines FY2016-17 (42 CFR 96.121 and 96.131)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<td></td>
</tr>
<tr>
<td>When program is unable to admit a substance-using pregnant woman due to insufficient capacity or program does not provide the necessary services, referral to another program must be made and documented.</td>
<td></td>
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<tr>
<td>Are pregnant women referred to another program or provided with interim services no later than 48 hours after seeking treatment services?</td>
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<tr>
<td>Are pregnant women receiving interim services placed at the top of the waiting list for program admission?</td>
<td></td>
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<tr>
<td>Were injection drug-using women admitted to a program no later than 14 days after making the request? Or 120 days if interim services were provided?</td>
<td></td>
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<tr>
<td><strong>- Interim Services provided:</strong></td>
<td>Perinatal Services Network Guidelines FY2016-17 (42 CFR 96.121 and 96.131)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Is counseling and education about HIV and TB, the risk of needle sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIB and TB transmission does not occur provided?</td>
<td></td>
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<tr>
<td>Are referrals for HIB or TB treatment services, if necessary, provided?</td>
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</tr>
<tr>
<td>Is counseling pregnant women on the effects of alcohol and other drug use on the fetus and referrals for prenatal care for pregnant women provided?</td>
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<tr>
<td>Are referrals based on individual assessments that may include, but are not limited to: self-help recovery groups, pre-recovery and treatment support groups, sources for housing food and legal aid provided?</td>
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</tbody>
</table>

**Regulatory Authority Abbreviations:** AOD Cert. Std.s = Alcohol and/or Other Drug Program Certification Standards (May 2017); DMC = Drug Medi-Cal Certification Standards for Substance Abuse Clinics (July 1, 2004; DTS = Minimum Quality Drug Treatment Standards for DMC (2017); Title 9 = California Code of Regulations, Title 9 - Narcotic Treatment Programs; Title 22 = California Code of Regulations Title 22 - Drug Medi-Cal (as amended by Emergency Regulations)
Does the program provide effective outreach to individuals needing treatment?

<table>
<thead>
<tr>
<th>17. Perinatal Programs Continued</th>
<th>Regulatory Authority</th>
<th>Y</th>
<th>NI</th>
<th>IA</th>
<th>NA</th>
<th>Compliance Findings/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Perinatal Services Network Guidelines FY2016-17</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>- Women Specific Treatment/Recovery Services:</td>
<td></td>
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</tr>
<tr>
<td>▪ Does program address issues of relationships, sexual and physical abuse, and parenting? Is treatment gender specific?</td>
<td>Perinatal Services Network Guidelines FY2016-17</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>- Case Management:</td>
<td>Perinatal Services Network Guidelines FY2016-17</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>▪ Does program arrange sufficient case management to ensure that women and their children have access to primary medical care, primary pediatric care, gender-specific substance abuse recovery and treatment, and other needed services? Who provides Case Management?</td>
<td>Perinatal Services Network Guidelines FY2016-17</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>- Transportation:</td>
<td>Perinatal Services Network Guidelines FY2016-17</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>▪ Does program offer transportation to and from the recovery and treatment site? To and from ancillary services? Who provides transportation?</td>
<td>Perinatal Services Network Guidelines FY2016-17</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>- Therapeutic services for Children:</td>
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</tr>
<tr>
<td>▪ Does the program provide or arrange therapeutic interventions for children in custody of women in treatment to address the children’s developmental needs and their issues of sexual abuse, physical abuse, and neglect?</td>
<td>Perinatal Services Network Guidelines FY2016-17</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>- Child care:</td>
<td>Perinatal Services Network Guidelines FY2016-17</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
<td></td>
</tr>
<tr>
<td>▪ Is childcare provided while women are receiving primary medical care?</td>
<td>Perinatal Services Network Guidelines FY2016-17</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>- Education Components:</td>
<td>Perinatal Services Network Guidelines FY2016-17</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
<td></td>
</tr>
<tr>
<td>▪ Does program provide or arrange for the following services:</td>
<td>Perinatal Services Network Guidelines FY2016-17</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<td></td>
</tr>
<tr>
<td>▪ Educational/vocational training and life skills resources?</td>
<td>Perinatal Services Network Guidelines FY2016-17</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>▪ TB/HIV education and counseling?</td>
<td>Perinatal Services Network Guidelines FY2016-17</td>
<td>☐</td>
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</tr>
<tr>
<td>▪ Education on the effects of AOD use during pregnancy and breastfeeding?</td>
<td>Perinatal Services Network Guidelines FY2016-17</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
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<tr>
<td>▪ Parenting skills and child development information?</td>
<td>Perinatal Services Network Guidelines FY2016-17</td>
<td>☐</td>
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<tr>
<td>- Primary Medical Care and Pediatric Care:</td>
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<tr>
<td>▪ Does program provide or arrange primary medical care for women in treatment, including referrals for prenatal care?</td>
<td>Perinatal Services Network Guidelines FY2016-17</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>▪ Does program provide or arrange primary pediatric care, including immunizations, for dependents?</td>
<td>Perinatal Services Network Guidelines FY2016-17</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>- Outreach Services:</td>
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<td>☐</td>
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</tr>
<tr>
<td>- Does the program provide effective outreach to individuals needing treatment?</td>
<td>Perinatal Services Network Guidelines FY2016-17</td>
<td>☐</td>
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</tbody>
</table>
### 18. Residential/ Transitional Living Centers Facility Review

<table>
<thead>
<tr>
<th>HEALTlh RELATED SERVICES</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
<th>4. FOOD SERVICE</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. If providing detoxification services, there shall be at least one person who is First Aid and CPR qualified always on the premises.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>A. Pesticides and other similar toxic substances shall not be stored in food storerooms, kitchen areas, food preparation areas or areas where kitchen equipment or utensils are stored.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>B. First aid supplies are maintained and available at the facility and contain items as stated in (A-H).</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>B. Soaps, detergents, and cleaning compounds are not stored with food supplies.</td>
<td>☐</td>
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</tr>
<tr>
<td>C. Licit medications shall be controlled as specified by the licensee’s written goals, objectives and procedures.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>C. All kitchen, food preparation and storage areas shall be kept clean, free from litter and rubbish.</td>
<td>☐</td>
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<tr>
<td>D. Prescription medications left by discharged residents have been destroyed.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>D. Food shall be protected against contamination.</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>3. FOOD SERVICE</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>E. All equipment, fixed or mobile, dishes and utensils shall be kept clean and maintained in good repair.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>A. The total daily diet for residents shall be of quality/quantity necessary in accordance with RDA.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>F. All dishes and utensils used for eating, drinking and preparing food shall be cleaned and sanitized after each usage.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>B. Where all food is provided by the facility, arrangements shall be made so that each resident has at least 3 meals per day.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>5. BUILDING AND GROUNDS</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>C. Menus shall be written 1 week in advance, dated and kept on file for at least 30 days.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>A. Facilities shall be clean, safe, sanitary and in good repair.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>D. All foods shall be selected, transported, stored, prepared and served so as to be free from contamination and spoilage and shall be fit for human consumption.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>B. All outdoor and indoor passageways, stairways, inclines, ramps, open porches and other areas of potential hazard shall be kept free of obstruction.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>E. All persons engaged in food preparation and service shall observe personal hygiene and food services sanitation practices which protect food from contamination.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>C. If female and male residents are housed in the same facility, the licensee shall have separate and adequate bathing facilities for females and males.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
### 17. Residential/Transitional Living Centers Facility Review

**F. All foods or beverages shall be stored in covered containers at 45 degrees Fahrenheit (7.2 degrees Celsius) or less.**

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
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<tbody>
<tr>
<td></td>
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</table>

**D. If female and male residents are housed in the same facility, the licensee shall have separate and adequate sleeping areas for females and males.**

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
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<tbody>
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</table>

### 6. BUILDING AND GROUNDS

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. The licensee shall have 24-hour staff coverage for co-ed facilities.</td>
<td>☐</td>
<td>☐</td>
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</tr>
</tbody>
</table>

### 7. STORAGE SPACE

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
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</thead>
<tbody>
<tr>
<td>A. There shall be space available for storage of residents’ belongings.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

### 9. FIXTURES, FURNITURE, EQUIPMENT AND SUPPLIES

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. All containers used for storage of solid waste shall have light-fitting covers</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
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</thead>
<tbody>
<tr>
<td>B. The licensee shall provide clean linen in good repair, warm blankets, top and bottom bed sheets, pillow cases, mattress pads, bath towels, and wash clothes.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
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</thead>
<tbody>
<tr>
<td>C. The licensee shall provide adequate bathing, hand washing and toilet facilities with the maximum ratio of one facility per eight residents.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

### 8. FIXTURES, FURNITURE, EQUIPMENT AND SUPPLIES

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>D. The facility shall provide each resident with an individual bed equipped with good springs and a clean mattress and supplied with pillow(s), linen and blankets which are clean and in good repair.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. All bathing facilities shall be maintained in safe and sanitary operating conditions.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Solid waste shall be stored, located and disposed in a manner that will not transmit communicable diseases, emit odors, create a nuisance, or provide a breeding place or food source for insects or rodents.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Number of Charts Reviewed: ____________________

Findings
Number of Yes: ______
Number of Needs Improvement: ______
Number of Immediate Action: ______
Program meets contractual requirements and goals? ______
Plan of Correction? _____Yes _____No

PROVIDER EVALUATION SUMMARY:

________________________________________
________________________________________
________________________________________

________________________________________

ADP Reviewer Printed Name __________________ Signature __________________ Date ___________
Attachment N
Quality Care Management Division Plan

Fiscal Year 2018-2019
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- Quality Care Management Division Introduction ................................................................. Page 3-4
- Departmental Sub Committees .................................................................................................. Page 5-6
- Glossary of Terms .................................................................................................................... Page 7
Quality Care Management Division
FY 2018-2019

Introduction

The Quality Care Management (QCM) Division monitors services that are provided by the Santa Barbara County Mental Health Plan (MHP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS) which includes services provided within the Department of Behavioral Wellness as well as by contract providers. Monitoring takes place to insure that the State contract, and State and Federal regulations are met. QCM develops implementation processes to continually monitor the quality of care that Behavioral Wellness beneficiaries receive. QCM accomplishes this in many ways including through regular audits, annual quality improvement work plans, annual quality improvement goals, annual work plan evaluations, performance improvement projects, collaboration with providers, and developing MHP and DMC-ODS related trainings and resources. Additionally, QCM maintains knowledge of current federal and state rules and regulations that guide our day to day operations.

The Behavioral Wellness Quality Care Management (QCM) Division is a Department of Health Care Services (DHCS) Mental Health Plan requirement. The QCM Division coordinates performance-monitoring activities throughout the Mental Health Plan (MHP), including:

- Service delivery capacity
- Accessibility of services
- Timeliness of services
- Beneficiary satisfaction and concerns
- Service delivery system monitoring and analysis
- Service coordination with physical healthcare and other agencies
- Monitoring provider appeals
- Tracking and resolution of beneficiary grievances, appeals, and fair hearings, as well as provider appeals
- Performance improvement projects
- Beneficiary and system outcomes
• Utilization and documentation management and review
• Credentialing
• Service authorizations
• Site certifications
• Policy and procedure development
• Administrative and programmatic monitoring
• Necrology review

The QCM Division is composed of:

• Chief Quality and Strategy Officer
• Quality Care Management (QCM) Manager
• QCM psychiatrist
• QCM Registered Nurse
• 7 QCM Coordinators
• QCM SUD Specialist
• 2 Access Line Screeners (with the addition of 2 screeners upon implementation of DMC-ODS)
• Utilization Review (UR) staff
• Research and Evaluation Staff
• Department Business Specialist
• Administrative Office Professional
The Quality Care Management Division meets bi-monthly. Meetings are facilitated by the Quality Care Program Manager, who is a licensed practitioner and oversees the Quality Care Management Division. Various members of the QCM Division meet on a regular basis with the following active departmental sub-committees to aid in the overall continuous quality improvement process. These subcommittees, although not under the umbrella of the QCM Division, provide input, recommendations and reports to the QCM Division.

- **Quality Improvement Committee**: Prioritizes and directs the implementation of agency-wide quality improvement projects and maintains adherence to the regulatory requirements of the MHP and DMC-ODS operations. (Meets monthly)

- **Grievance and Incidence Report Committee**: Reviews previous month’s grievances and incidence reports, ensuring they were responded to appropriately and using information learned to help shape future policy and procedures. (Meets monthly)

- **Clinical Documentation Committee**: Sub-committee of Compliance, reviews documentation data and reports in order to improve documentation and implements changes to future documentation trainings and standards. (Meets monthly)

- **Consumer and Family Advisory Committee**: Addresses issues related to beneficiary and family volunteer and employment opportunities within the Department of Behavioral Wellness and other means through which the role of beneficiaries and their families may participate in leadership, as well as ongoing activities of the department. (Meets monthly)

- **Collaborative Contract Provider Meetings**: Discusses various systems issues, documentation, DHCS review and contract issues. (Meets monthly)

- **Crisis and Acute Care Daily Triage Team**: Monitors and evaluates the flow and care provided to beneficiaries who are using high levels of services, particularly inpatient, SNF, IMD, crisis residential, and other residential care, in order to identify trends, improve efficiency and effectiveness of care and suggest improvements. (Meets daily)

- **Information Systems Steering Committee**: Monitors implementation as well as areas of possible improvement in the MHP’s electronic medical records, billing, and related information technology systems. The committee includes representatives from QCM, MIS, Fiscal, Programs, and CBO’s. (Meets monthly)

- **ADP Clinician’s Gateway User Groups**: Discusses Share/Care and Clinician’s Gateway User concerns, suggestions and updates. (Meets quarterly)
• **Community Treatment and Supports**: Weekly joint provider meeting to prioritize and triage transfer and placement of beneficiaries into appropriate programs of the system. (Meets Weekly in each region)

• **Clinical Leads**: Weekly meeting which includes management and supervisors from all aspects of the system to discuss clinical/operation issues and programs. Collective problem solving and program planning for the clinical operations of the overall system. (Meets Weekly)

• **Access & Transitions Workgroup**: Includes representatives from all levels of the Department of Behavioral Wellness. The purpose of the workgroup is to evaluate and improve how our teams are structured and function, the process by which beneficiaries access services and move through the system between levels of care, and how Department of Behavioral Wellness and partner programs work collaboratively to support beneficiaries in recovery. (Meets bi-monthly)

• **Data Meeting**: Meets every other week and includes representatives from various parts of the department including the MIS/IT Division Chief, Data and Evaluation team members and Leadership representation. System data reports are reviewed and refined prior to public posting. Review on how data collection occurs within the system and prioritization of data related system changes. (Meets bi-monthly)
Glossary of Terms

**CBO** – Community Based Organizational Provider

**DHCS** – Department of Health Care Services

**EHR** – Electronic Health Record

**FTE** – Full Time Equivalent (staff)

**IMD** – Institute for Mental Disease

**MHP** – Mental Health Plan

**MIS/IT** – Management Information Systems/Information Technology

**OQSM** - Office of Quality and Strategy Management

**PIP** – Project Improvement Plan

**QCM** – Quality Care Management

**QI** – Quality Improvement

**QIC** – Quality Improvement Committee

**SBCMHP** – Santa Barbara County Mental Health Plan

**SNF** – Skilled Nursing Facility

**UR** – Utilization Review
Attachment O
Quality Improvement Work Plan

Fiscal Year 2018-2019
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<td>Page 4-5</td>
</tr>
<tr>
<td>Departmental Sub Committees</td>
<td>Page 5-6</td>
</tr>
<tr>
<td>Evaluation of FY 17-18 Quality Improvement Committee Goals</td>
<td>Page 7-12</td>
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<tr>
<td>MHP Summary</td>
<td>Page 13-14</td>
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<tr>
<td>Quality Improvement Committee Goals FY 18-19</td>
<td>Page 15-20</td>
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<tr>
<td>Addendum: Santa Barbara County Behavioral Health Care System</td>
<td>Page 21-23</td>
</tr>
<tr>
<td>Glossary of Terms</td>
<td>Page 24</td>
</tr>
</tbody>
</table>
Quality Improvement Work Plan for
Objectives, Scope and Planned Activities for FY 2018-2019

Introduction

Quality Improvement and Continuous Quality Improvement are central tenants of how we work within the Santa Barbara County Department of Behavioral Wellness. It is a core business strategy and informs and influences all we do. This can be seen throughout the organizational structure of the department. Examples include the ongoing System Change efforts led directly by the Director, as well as the organization of the Office of Quality Care and Strategy Management (OQSM). The OQSM oversees the Quality Improvement Program and works to support continuous quality improvement throughout System Change efforts.

The Behavioral Wellness Quality Improvement (QI) Program is a Department of Health Care Services (DHCS) Mental Health Plan requirement. The QI Program coordinates performance-monitoring activities throughout the Mental Health Plan (MHP), including:

- Service delivery capacity
- Accessibility of services
- Timeliness of services
- Beneficiary satisfaction
- Service delivery system monitoring and analysis
- Service coordination with physical healthcare and other agencies
- Monitoring provider appeals
- Tracking and resolution of beneficiary grievances, appeals, and fair hearings, as well as provider appeals
- Performance improvement projects
- Consumer and system outcomes
- Utilization management
- Credentialing
The QI Program also assesses beneficiary and provider satisfaction and conducts clinical records review. The Mental Health Plan (MHP) QI Program is consulted in the contracting process for hospitals, as well as individual, group and organizational providers. The MHP QI Program has access to, and reviews as necessary, relevant clinical records to the extent permitted by State and Federal laws.

The Santa Barbara County Mental Health Plan Quality Improvement Committee embodies in its charter, the process of continuous quality improvement. The mission statement reflects the focus of review of the quality of specialty mental health services provided to beneficiaries and service recipients throughout the overall Behavioral Wellness system of care and recovery, focusing on continuous quality improvement. A very substantial aspect of that mandate relates to reviewing and selecting performance indicators and using data to evaluate and improve the performance of the Santa Barbara County Mental Health System of Care and Recovery.

Quality Improvement Committee Program Description

The QIC promotes the quality improvement program and supports recognition of both individual and team accomplishments. Its members are responsible for helping create a quality improvement culture. In this culture, employees use quality improvement principles and tools in their day-to-day work, with extensive support and guidance from leadership. The QIC reports to the Core Leadership Team and other management and staff work teams. Its executive sponsors play a critical role in maintaining leadership support.

The Quality Improvement Committee is responsible for:

1. Recommending policy decisions
2. Initiating, coordinating, reviewing and evaluating the results of Quality Improvement (QI) activities
3. Reviewing and evaluating performance improvement projects (PIPs)
4. Institution of needed QI actions
5. Guiding system-wide selection and application of quality improvement methods
6. Ensuring follow-up of QI processes
7. Documenting Quality Improvement Committee (QIC) meetings regarding decisions and actions taken
8. Developing the annual Quality Improvement Work Plan as well as the evaluation of the Work Plan.
9. Facilitation of routine committee activity reports

The Quality Improvement Committee (QIC) meets monthly throughout the year. Meetings are facilitated by the Quality Care Program Manager, who is a licensed practitioner and oversees the Quality Care Management Division. The QIC assigns and receives reports from QI sub-Committees and coordinates with the work of the Compliance Committee, reviews and evaluates the results of QI activities, recommends actions to appropriate departmental staff/divisions and ensures follow-up evaluation of actions. When appropriate, the QIC may recommend policy proposals for Santa Barbara County Mental Health Plan (SBCMHP) Executive Team consideration. On a quarterly basis, The QCM Manager presents the
activities and recommendations of the QIC activities to the SBCMHP Executive Leadership Team. QIC decisions and actions are memorialized by dated minutes that are signed by the QCM Manager.

The QI Committee (QIC) is composed of:

- Chief Quality Care and Strategy Officer (OQSM team)
- Research and Evaluation Program Coordinator (OQSM team)
- Santa Barbara County Mental Health Plan (SBCMHP) Chief of Compliance
- SBCMHP Medical Director
- SBCMHP Assistant Director of Programs
- Quality Care Management (QCM) Manager
- Utilization Review (UR) staff
- QCM psychiatrist
- The Department of Behavioral Wellness Regional Program Managers
- Management staff of Community Based Organizations (CBO’s)
- Division Chief of the Department of Behavioral Wellness Management Information Systems
- Consumers and Family Members
- Patient Rights Advocates
- Consumer Empowerment Manager
- Peer Support Employees

The following active departmental sub-committees aid in the overall continuous quality improvement process and meet on a regular basis. These subcommittees, although not under the umbrella of the QIC, provide input, recommendations and reports to the QIC:

- **The Peer Action Team**: Addresses issues related to consumer and family volunteer and employment opportunities within the Department of Behavioral Wellness and other means through which the role of consumers and their families may participate in leadership, as well as ongoing activities of the department. (Meets monthly)

- **Community Based Organization Collaborative Meeting**: Children and Adult Community Based Organization Provider Meeting: Discusses various system issues, service delivery issues, documentation, DHCS review and contract issues. (Meets monthly)

- **Crisis and Acute Care Daily Triage Team**: Monitors and evaluates the flow and care provided to consumers who are using high levels of services, particularly inpatient, SNF, IMD, crisis residential, and other residential care, in order to identify trends, improve efficiency and effectiveness of care and suggest improvements. (Meets daily)
• **Information Systems Steering Committee:** Monitors implementation as well as areas of possible improvement in the MHP's electronic medical records, billing, and related information technology systems. The committee includes representatives from QI, MIS, Fiscal, Programs, and CBO's. (Meets monthly)

• **MIS/Clinician’s Gateway User Groups:** Discusses Share/Care and Clinician’s Gateway User concerns, suggestions and updates. (Meets quarterly)

• **Community Treatment and Supports:** Weekly joint provider meeting to prioritize and triage transfer and placement of clients into appropriate programs of the system. (Meets Weekly in each region)

• **Clinical Leads:** Weekly meeting which includes management and supervisors from all aspects of the system to discuss clinical/operation issues and programs. Collective problem solving and program planning for the clinical operations of the overall system. (Meets Weekly)

• **Data Management Meeting:** Meets every other week and includes representatives from various parts of the department including the MIS/IT Division Chief, Data and Evaluation team members and Leadership representation. System data reports are reviewed and refined prior to public posting. Review on how data collection occurs within the system and prioritization of data related system changes.
Evaluation of FY 17-18 Quality Improvement Committee Goals

For fiscal year 2017-2018, the SBCMHP QI Committee focused on five key areas. The Quality Improvement Committee tracked and trended data throughout the previous year and identified the five-areas of priority for quality improvement activities. Each goal has an assigned subcommittee that developed and implemented interventions designed to improve the specific function of the MHP.

<table>
<thead>
<tr>
<th>Goal 1: Improve Client Service Experience and Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective</strong></td>
</tr>
<tr>
<td>Implement DHCS client and family member consumer perception surveys (CPS); share results.</td>
</tr>
<tr>
<td>Improve client and family member satisfaction with services</td>
</tr>
<tr>
<td>Formulate system recommendations and monitor improvement activities</td>
</tr>
<tr>
<td>Conduct Network Provider and Recipient surveys to assess the value of services received through contracted providers</td>
</tr>
<tr>
<td>Identify and implement brief client satisfaction survey tools to be pilot-tested and then utilized throughout the</td>
</tr>
<tr>
<td>System</td>
</tr>
</tbody>
</table>

**Goal 2: Improve Access to Care**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Indicator</th>
<th>Result/Status</th>
<th>Point Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Track timeliness of access across the Mental Health Plan</td>
<td>Monthly QIC tracking; Quarterly QIC reports</td>
<td>Monitoring on a monthly basis Reporting to QIC Quarterly.</td>
<td>Ana: implement Dr K: analyze</td>
</tr>
<tr>
<td>Increase completion of Health History Questionnaire (to 50%) and PCP</td>
<td>Monthly QIC tracking; Quarterly QIC reports</td>
<td>Monitoring on a monthly basis HHQ: Q1-3 avg BeWell= 62% (chart review) PCP: Q1-3 avg = 27% (MIS)</td>
<td>Ana: implement Careena: chart review Dr K: analyze</td>
</tr>
<tr>
<td>Establish standards for access to SUD treatment</td>
<td>1. Contact to assessment; 2. Contact to MAT 3. Contact to detox</td>
<td>Will track per EQRO and establish internal goals after year 1</td>
<td>John: establish Dr K: analyze</td>
</tr>
<tr>
<td>Conduct routine test calls to 24/7 Access line (4 per month)</td>
<td>Documentation of test calls Monthly QIC tracking; Quarterly QIC reports</td>
<td>Monitoring on a monthly basis Reporting to QIC Quarterly Q1-3 avg = 3 per month</td>
<td>QCM</td>
</tr>
<tr>
<td>Utilize data from test calls for improvement of Access line</td>
<td>Test call information shared with managers/supervisors as indicated/appropriate</td>
<td>CR is sharing as needed with JH</td>
<td>QCM</td>
</tr>
<tr>
<td>Timeliness of access across the MHP and ODS systems; Tracking and utilization of data for system improvement.</td>
<td>Definitions specified for measurement of wait times to see an outpatient psychiatrist or ODS provider</td>
<td>Monitoring on a monthly basis Reporting to QIC Quarterly</td>
<td>Ana: implement Dr K: analyze</td>
</tr>
</tbody>
</table>
| Improve attendance - children’s assessment appointments | 1. Track time between first contact to first assessment  
2. Track no show rate | Tracking time to first appointment  
Tracking no shows | Ana: implement  
Dr K: analyze |
<table>
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</thead>
<tbody>
<tr>
<td>Assess MIS/IT and make modifications necessary to track timeliness to SUD services</td>
<td>Changes made to MIS/IT</td>
<td>18 page self-assessment shared with JD and MR</td>
<td>John Marshall</td>
</tr>
</tbody>
</table>
| Provider utilization of Access Contact Sheet for entry of calls and walk-ins | 1. Train Providers  
| Improve identification of individuals with co-occurring mental health and substance use disorders who are served by the MHP | 1. Documentation of training on co-occurring disorders  
2. Documentation of SUD in EHR | 1. Training – available in Relias  
2. PDSA: % clients on Co-Occurring teams with secondary SUD diagnosis in SC  
Baseline = 24%  
September = 55% | Ana QCM |

### Goal 3: Improve Chart Documentation

<table>
<thead>
<tr>
<th>Objective</th>
<th>Indicator</th>
<th>Result/Status</th>
<th>Point Person</th>
</tr>
</thead>
</table>
| Improve % charts that have current:  
1. Assessments  
2. Treatment plans (Goal=90%) | 1. % current (from MIS report)  
2. % current (from MIS report) | PIP Monitoring on a quarterly basis through Dec 2017 (= 91.2% current tx plans) | Ana QCM |
| Provide monthly documentation trainings to improve frequency and quality of documentation | Provision and documentation of training | Trainings offered online instead in 17/18 | |
| Increase the timeliness and quality of reviewed charts  
1. within the Department  
2. with CBO’s | QCM report (monthly audit) | % Charts Meet Doc Standards  
Q1-Q3  
Avg BeWell 17%  
Avg CBO 31% | Careena |
| Increase % of completed corrective action plans, following chart review feedback  
| 1. within the Department  
| 2. with CBO’s  
| (Goal=90%) | QCM report  
| Past Month – %POC’s Completed by Deadline) | % POC’s Completed on Time:  
| Q1 –Q3  
| Avg BeWell 44%  
| Avg CBO 60% | Careena |
| Ensure the availability of a high quality documentation manual | Updated monthly; posted on line | 1/18 waiting for Ana’s approval/changes | QCM |
| Improve adherence to the team based care protocol and documentation of team based care planning  
| 1. common diagnosis  
| 2. work towards sameTx goals | Team based care progress note under development (JIRA) | Ana  
| Careena  
| Christine |

**Goal 4: Enhance Innovation, Collaboration and Integration**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Indicator</th>
<th>Result/Status</th>
<th>Point Person</th>
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</thead>
</table>
| Increase effectiveness of communication from the MHP administration | 1. Survey staff  
| 2. Implement new strategies, methods | Will be discussed after EQRO in new FY at Data Mtg | Leadership |
| Increase department and stakeholder knowledge of system updates through improved communication | Develop plan for implementation of strategies to increase effectiveness of communication | Brown Bag; Directors Report; Alice attending regional meetings. | Leadership |
| Improve how diversity data are captured within the EHR | Review and modify, as indicated, in CG:  
| 1. Language  
| 2. Ethnicity/race  
| 3. Sexual orientation/gender identity | Changed made to screening, assessment forms | Yaneris  
| MIS/IT |
| Investigate and address disparities in referrals, diagnosis and treatment for youth of color in the juvenile justice | 1. Conduct surveys and focus groups with clients and families  
| 2. Provide education to referral sources | 1. Done  
| 2. Done  
| 3. Training under | Yaneris  
<p>| Jill Sharkey |</p>
<table>
<thead>
<tr>
<th>System</th>
<th>3. Provide training for outpatient clinic based staff on implicit bias in clinical diagnosis</th>
<th>Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish a system for 24/7 toll free access, with prevalent languages, for prospective ADP clients</td>
<td>ADP calls referred to Access line</td>
<td>All calls to Access</td>
</tr>
<tr>
<td>Expand Access Screener staff, to advance the integration of SUD, MH and mental health and primary care services</td>
<td>Integrated, co-occurring capable (ADP/MH) Access line</td>
<td>Hiring 2 new staff; will provide training</td>
</tr>
<tr>
<td>Finalize ASAM Screening and Assessment tools</td>
<td>Finalize forms in GC</td>
<td>Under development</td>
</tr>
<tr>
<td>ADP CBO’s have access to the new Access Contact sheet in Clinician's Gateway</td>
<td>1. ADP CBO’s trained on access line and form 2. ADP CBO’s utilization (track AOD related, Dept/CBO’s access</td>
<td>Plan changed; centralized Access.</td>
</tr>
</tbody>
</table>

**Goal 5: Ensure Quality of Contracted MHP Service Providers**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Indicator</th>
<th>Result/Status</th>
<th>Point Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine review of contracted providers to ensure qualifications to provide specialty mental health services</td>
<td>1. Organizational providers receive recertification every three years 2. Individual Network Providers receive recertification every two years 3. Organizational providers who operate medication rooms are reviewed quarterly</td>
<td>1. QCM Tracking Log 2. QCM Tracking Log 3. QCM Tracking Log</td>
<td>QCM – Gizelle</td>
</tr>
<tr>
<td>Quarterly meetings with contract providers to assure adherence to medication room policy and procedures</td>
<td>Documentation of meetings/medication room review</td>
<td>December 2017, the lead on medication reviews was transitioned from QCM to Morgan, Laura, and Marianne; Reviews and POC reports on G drive</td>
<td>Morgan</td>
</tr>
<tr>
<td>Monthly site visits for all in-county contract providers to assure MHP regulatory requirements are met for MHP providers</td>
<td>Documentation of site visits</td>
<td>Occurring.</td>
<td>QCM</td>
</tr>
</tbody>
</table>
MHP Summary

Since the last QI Work Plan submission for FY 17-18, the MHP has experienced significant changes as a result of many developments, including major Systems Change efforts as well as changes and enhancements in overall program operations.

Highlights of significant MHP changes over the past year:

1. Provided a robust response to two community disasters; currently implementing FEMA grant
2. Hired a Pharmacist In-Charge for inpatient services
3. Continue to develop the Crisis System of Care, which included moving the Mobile/Triage Teams to a new facility adjacent to the CSU for improved collaboration and support
4. Established a new model for medical coverage at the PHF, which includes 16 hour medical shifts to provide support to other Crisis System services
5. Launched a new aspect to the Access Call Line which includes screening for crisis, alcohol and drug dependence, and sexual exploitation
6. Implemented Service Now platform for tracking IT Help Desk requests
7. Created an Informatics Manager position
8. Participating in regular coordination meetings with Medi-Cal Intermediary CenCal Health to improve integration of services and problem resolution for transitions of care
9. Enhanced collaboration with other Department partners such as Probation, District Attorney’s Office, Public Defender, Sheriff, Public Health Department
10. Accomplished PIP Goals of Improved Assessment and Treatment Planning with Increased Client Engagement
11. Improvement in recruitment and hiring for key clinical positions resulting in decreased vacancy rates.
12. Clinic staff developed multiple PDSAs to improve no show rates, for example: Triage staff began contacting clients for appointment reminders over the weekend; and staff began calling clients who have missed an appointment to find out if there are any barriers, etc.
13. Increased use of the language line and in-person translation, since January of last year

Current initiatives of the department include:

1. Created an In-Patient Pharmacy that will also support the CSU as a satellite facility
2. Preparing for ODS implementation in the Fall of 2018
3. Implementing Pilot Project for establishing a Medication Support Clinic at the Lompoc Recovery Learning Center
4. Collaborating with the Public Defender and the Courts to create a specialized Incompetent to Stand Trial (IST) court
5. Improving care to clients through Reducing Ethnic Disparities (RED) committee
6. Collaboration with Sherriff deputies using CIT cards to help identify clients who have had contact with law enforcement and may need increased mental health services
7. Collaborating with Project Recovery in order to expedite clients being admitted into their detox program, reducing the risk for hospitalization
8. Developing a joint MOU for Continuum of Care Reform with Social Services and Probation
9. New CRT opening in the Fall

All of these efforts are consistent with the broad strategy of strengthening prevention, early intervention and outpatient programs to reduce the demand on our higher intensity and more expensive services. The goal is to be more balanced and increase capacity at all level of care with seamless and coordinated transitions. Behavioral Wellness aims to focus on being more welcoming, inclusive, transparent, accountable, responsive, recovery oriented, trauma informed, culturally competent, integrated, co-occurring and complexity competent.
FY 18-19 QI Work Plan Goals

Goal #1: Improve Access to Care

Intended Outcome:
- Utilizing data collected through the Access Contact Sheet and centralized Access screeners, strengthen the system to track timeliness of access across the Mental Health Plan and utilize data for system improvement
- Increase completion of Health History Questionnaire and increase the completion of the identification of client Primary Care Provider (located within the Health History Questionnaire) to allow improved access to healthcare (i.e. number of individuals who have access to their Primary Health Care Physician)
- Establish a reasonable minimum standard for access to treatment including length of time between initial contact and first substance use disorder treatment and first Medication Assisted Treatment (MAT) appointment for those with opioid and alcohol disorders

Objectives:
- Ensure all MH and SUD services are available in prevalent non-English languages
- Address disparities in referrals, diagnosis and treatment for youth of color in the juvenile justice system
- Track and analyze data on Access line wait times
- Continue to train Access screener staff on SUD and MH procedures; centralize/cross train all QCM staff to assure coverage of the Access line at all times.
- Finalize Access tools - ASAM Screening and Assessment
- Ensure Beneficiaries have access to information regarding safety resources for MH and SUD crises.
- Examine walk-in data and address as needed
- Conduct routine test calls to 24/7 Access line (4 per month) including test calls in non-English languages
- Make modification as needed to EHR to monitor Access to SUD services

Measurement:
- Number of test calls completed and logged each month
- Number of test calls completed in non-English languages
- Number of urgent calls received and logged each month
- Number of routine calls received
- Number of crisis calls received
- Track wait time to first appointment
- Provide information/training on use of Language Line. During site visits QCM will monitor availability of language services.
- Provide a refined series of implicit bias training which will focus on evaluation and diagnosis, specifically targeting the departmental needs rather than the formerly offered general training. Included in this refined training will be a training of trainer program as well as system training – both to begin in the fall of 2018.
- Data reports to measure completion of Access Staff training on SUD and MH procedures
- Measure use of ASAM screening and assessment forms by Access Team
- Monitor: information on overdose prevention and emergency services at clinics for beneficiaries to easily access. Include in CAP for providers to correct if this goal is not met during monitoring visit.
- Monitor data for walk in consumers and timelines to appointment

**Key Work Groups:**
- Peer Action Team
- Clinical Operations
- Office of Quality and Strategy Management

**Goal #2: Improve Timeliness to Service**

**Intended Outcomes:**
- Improve overall timeliness of access to care for beneficiaries in the MHP and ODS systems
- Ensure that the network of providers within the system is adequate for the needs of the beneficiaries within Santa Barbara County

**Objectives:**
- Track timeliness of access across the MHP and ODS systems and utilize for system improvement.
- Develop reporting mechanisms to assess access and timeliness to SUD
- Track no show rates and utilize for system improvement
- Begin tracking timeliness separately for the adult and child systems of care; follow up as needed for continuous quality improvement
- Make modification as needed to EHR to track timeliness to SUD services

**Measurement:**
- Track time from contact to assessment
- Track time from contact to first face to face
- Track time from contact to MAT
- Track time from contact to detox
- Track time from residential to follow-up
- Reports developed from data collected in the Access Screening Template and EHR
Key Work Groups:
- Community Based Organization Collaborative Meeting
- Crisis and Acute Care Daily Triage Team
- Clinical Leads
- Data Management meeting

Goal #3: Improve Quality of Care Provided to Clients

Intended Outcomes:
- Improve access to resources available to beneficiaries
- Increase client feedback and utilization of feedback
- Increase the timeliness and quality of reviewed charts within the Department of Behavioral Wellness
- Increase the timeliness and quality of reviewed charts within the contracted community based organizations.
- Increase the number of departmental staff who complete corrective action plans following chart review feedback
- Increase the number of community based organizational provider staff who complete corrective action plans following chart review feedback
- Ensure the availability of a high quality documentation manual, including current regulatory changes or interpretations, to ensure best clinical practice and documentation
- Improve adherence to the team based care protocol and documentation of team based care planning

Objectives:
- Ensure Beneficiaries have access to information regarding safety resources for MH and SUD crises.
- Discuss and strategize Suggestion Box and development of a tool to gather outpatient client feedback and client satisfaction (mirroring PHF satisfaction survey) and utilize client feedback in MH and SUD clinics/programs. Such a survey would occur on a randomized basis and be easily accessible to clients at clinic sites.
- Establish baseline and goals for SUD documentation –charts meeting documentation standards
- Quarterly site visits for all in-county contract providers to assure MHP regulatory requirements are met for MH and SUD providers
- CPS/TPS: Based on the data, formulate system recommendations and monitor improvement activities
- Ensure that all MH and SUD grievances and appeals are logged and include name, date and nature of problem
- Ensure that all SUD grievances are reported to the State quarterly and MH are reported annually
• Revise/Improve Health History Questionnaire
• Increase completion of PCP identification (to 90%)
• Utilize data from test calls for quality improvement of Access line
• Improve identification of individuals with co-occurring mental health and substance use disorders who are served by the MHP
• Maintain 90% charts that have current assessments and treatment plans
• Increase percent of completed corrective action plans, following chart review feedback
• Increase the timeliness of reviewed charts within the Department and with CBO’s
• Track progress on PIPs
• Make modification as needed to EHR to monitor quality of SUD services
• Routine review of contracted providers to ensure qualifications to provide specialty mental health services
• Continuous availability of documentation training on Relias

Measurement:
• Information on overdose prevention and emergency services at clinics for beneficiaries to easily access
• Client feedback log maintained by QCM
• QCM will conduct monthly chart review for approx. 5% of charts, report to QIC monthly. Provide feedback and support to CBOs.
• Documentation of site visits
• Demonstrations of data presentations at various committees; utilization of data/results by administrators for decision-making purposes
• Grievance documentation; 100% of grievances received will be logged and responded to appropriately
• Grievance report
• Test call information shared with managers/supervisors as indicated/appropriate
• Continuous implementation of clinic-based satisfaction feedback/suggestion boxes and method for demonstrating action taken
• 100% of grievances are logged and responded to according to the Problem Resolution process (responding to the beneficiary)
• The MHP will review and respond to grievances at a system level to evaluate and make necessary changes and improvements in clinical practices.
• Evidence of team-based care (communication and coordination of care) as evidenced by a common diagnostic reference
  o MD, case manager, and ShareCare
  o In chart review, will check for team based care planning through documentation
    ▪ Treating Psychiatrist, case manager and ShareCare all reflect the same diagnoses
    ▪ Evidence in clinical notes of work toward same treatment goals
• Reviewed charts will have 90% of assessments
• Staff will complete plans of correction 90% of the time
• Community based organizational provider staff will complete plans of correction 90% of the time
• Semi-Annual PIP reports
- Metric log, maintained by designated QCM team member for staff certifications, to track certification and recertification of MHP contracted providers

**Key Work Groups:**
- Clinical Leads
- Peer Action Team
- Clinical Documentation Subcommittee
- Clinical Operations
- Office of Quality Care and Strategy Management

**Goal #4: Measure Outcomes and Utilize Data for System Improvement**

**Intended Outcomes:**
- Make system improvements as a result/in response to CPS/TPS client satisfaction data
- Communicate with clients about results of satisfaction surveys
- Improve administration of the CPS survey including client participation/response rate
- Increase client engagement
- Collection of data on client satisfaction, which can be used to steer system operations. The Behavioral Health Commission and The Department of Behavioral Wellness Leadership Teams will be informed of client satisfaction data on a regular basis

**Objectives:**
- Implement DHCS Consumer Perception Surveys (CPS) - share results.
- Maintain “high” (>=3.5) client and family member satisfaction with services – CPS
- Improve response rates and clinic participation – CPS
- Plan for and implement SUD Adult client Treatment Perception Survey (TPS)
- Implement and monitor results of CANS and PSC-35
- Track and analyze data on levels of care
- Conduct Network Provider and Recipient surveys to assess the value of services received through contracted providers
- Develop reporting mechanisms to assess readmission to SUD Tx
- Analyze and distribute ADP provider outcomes on a quarterly basis
- Make modification as needed to EHR to monitor outcomes of SUD services
- Produce semi-annual and annual data reports that address access, timeliness, quality and outcomes
**Measurement:**
- Client perception survey
- Treatment Perception Survey
- Documentation – presentation of CPS results
- Improve response rate
- Demonstrations of utilization of survey results by administrators for decision-making purposes
  - The measurement for utilization will be demonstrated by agendas and minutes reflecting discussion and recommendations/decisions made based on the findings presented.
- CANS and PSC reports produced
- ASAM
- LOCRI
- Provider service recipient survey implemented
- Provider satisfaction survey data presented to QIC for the development of system improvement activity recommendations

**Key Work Groups:**
- Peer Action Team
- Clinical Operations
- Office of Quality Care and Strategy Management
- Collaborative Contract Provider Meetings
Addendum

Santa Barbara County Behavioral Health Care System
The Department of Behavioral Wellness (Santa Barbara County Mental Health Plan – SBCMHP) provides treatment, rehabilitation and support service to approximately 9,600 clients with mental illness and 4,453 clients with substance use disorders annually. Individuals needing assistance may call an Access Line, 888-868-1649, which is available to the community 24 hours a day, seven days a week. Services are provided throughout the system of care for Early Childhood Mental Health, Juvenile Justice Mental Health, children/adolescents and families, transition-age youth, and adults throughout the outpatient system, inpatient system and crisis services system. Services provided and teams assigned are based on the individualized level of need of the individuals being served.

Outpatient Services
The regional County-operated children’s and adult outpatient clinics serve adults with serious and persistent mental illness, children with serious emotional disturbances who require long-term medication services, care coordination, case management and transition-age youth. Children and adults are also served through the provider network or contracted agencies. Aside from crisis services, access to services is provided regionally to ensure linkage to care in each individual client location. Screening and referral is provided by centralized Access screeners.

The SBCMHP maintains contracts with 10 individual in–county network providers and approximately 20 out-of-county providers. The MHP also uses contracted CBO’s as organizational network providers. In addition, the MHP has contracts with CBO’s for Crisis and longer term Residential Programs, Assertive Community Treatment Programs, Supported Housing Programs, Alcohol and Drug prevention and treatment programs, Recovery Learning Centers, Children’s Wraparound, Therapeutic Behavioral Services, Intensive In-Home Services and Prevention and Early Intervention programs. For individual needs that cannot be met within the community setting, the MHP contracts with IMD’s for adult care and contracts with out-of-county CBO’s and residential programs as needed for children’s care.

Inpatient Services
Adult consumers are served either through the 16-bed County-operated Psychiatric Health Facility (PHF) or through contracted psychiatric units at Aurora Vista Del Mar Hospital, however, this facility was burned in the Thomas Fire in December of 2017 at which time the facility could no longer be used. When all beds in these units are full, the MHP seeks the nearest bed available to the community in other contracted hospitals.

Children who need inpatient services are served through one of our contracted hospitals, usually Aurora Vista Del Mar, up through December 2017. In addition, to the extent that financial resources allow, the SBCMHP may contract with any hospital that has a bed available to provide inpatient services for either adults or children if such a contract is needed.

Crisis Services
Santa Barbara County Mental Health Plan has modified the previous system of care to improve urgent/emergent and routine access to care. Mobile Crisis Response teams and mobile Crisis Triage teams are located in Santa Barbara, Santa Maria and Lompoc and available throughout the county.
The Mobile Crisis program is responsible for 24/7 crisis response. This ensures that the response to all mental health crisis calls (to Crisis Services, Access, and 911), as well as mental health visits to Emergency Rooms are made by the Department of Behavioral Wellness clinical staff. This ensures both assessment of needs and connection to appropriate services. The Crisis Triage teams respond to urgent needs, helping connect individuals with necessary supports and provide support during their time of crisis.

**South County Crisis Services** based in Santa Barbara. Crisis Services is staffed by a multi-disciplinary team of licensed professionals, including a psychiatrist, nurse, LCSWs, and MFTs, as well as unlicensed paraprofessional staff. Of the 20 FTE staff at Crisis Services South, 7 FTE staff members are bilingual. The Santa Barbara site is open from 8:00 a.m. to 6:00 p.m. Monday through Friday. Field-based services are provided to homeless individuals by designated homeless outreach staff from 8:00 a.m. to 7:00 p.m. Access and Mobile Crisis services are available 24 hours per day/7 days per week/365 days per year. A key role of the Crisis Services program is to provide services to individuals in psychiatric crisis, as well as to be the triage point for persons new to our system that are being discharged from psychiatric inpatient facilities.

**North County Crisis Services** based in Santa Maria is staffed by a multi-disciplinary team of licensed professionals including a psychiatrist, nurse, and MFTs, as well as unlicensed paraprofessional staff who provide interventions for clients in crisis. Of the 18 staff members, 8 are bilingual. North County Crisis Services is open 8:00 a.m. to 5:00 p.m. Monday through Friday, serving the same purpose as South County Crisis Services. Access and Mobile Crisis services are available 24 hours per day/7 days per week/365 days per year.

**Lompoc CARES Mobile Crisis** staff is physically located at the Lompoc County-operated adult outpatient clinic seven days a week during regular business hours. During all after business hour periods, the Santa Maria and Lompoc staff share crisis response duties due to lower demand, with response provided to crises in Santa Maria, Lompoc and the neighboring Santa Ynez Valley.

**Crisis Residential Services:** The MHP contracts for provision of Crisis Residential programs located in both Santa Barbara and Santa Maria regions of the county. The Santa Maria Crisis Residential program is located in the same building as the Santa Maria CARES program. The Santa Barbara program is located in very close proximity to the MHP campus. The programs both provide short-term 24/7 support and crisis stabilization services to consumers experiencing acute symptoms requiring more than outpatient care but less than acute hospitalization. These are voluntary programs and are supported by licensed and peer staff in both program.

**Crisis Stabilization Unit:** Located in the South County in Santa Barbara. The CSU offer short-term, rapid stabilization for individuals experiencing psychiatric emergencies. The program serves as an integral component within the overall crisis services system. Brief evaluation, linkage and referral to follow-up care are available. This unit is open 24/7 and offers safe, nurturing short-term, voluntary emergency treatment as an option for individuals experiencing a mental health emergency. Services available up to 23 hours.

**Children’s Crisis Services:** Urgent and crisis needs for children are provided through the Safe Alternatives for Treating Youth (SAFTY) program. Casa Pacifica, a contracted organizational provider, operates the SAFTY program. This program works with children and families throughout Santa Barbara County on a short-term, intensive basis to help alleviate crisis situations and provide families with tools to prevent future
crises. This program operates on a 24/7 basis, and the staff are authorized by the County to write 5585 petitions with consultation from County staff.

In addition to 24/7 response, SAFTY provides expedited referrals to County-operated Adult and Children’s Outpatient Clinics as well as short-term, in-home crisis resolution services.
Glossary of Terms

CBO – Community Based Organizational Provider
DHCS – Department of Health Care Services
EHR – Electronic Health Record
FTE – Full Time Equivalent (staff)
IMD – Institute for Mental Disease
MHP – Mental Health Plan
MIS/IT – Management Information Systems/Information Technology
OQSM – Office of Quality and Strategy Management
PIP – Project Improvement Plan
QCM – Quality Care Management
QI – Quality Improvement
QIC – Quality Improvement Committee
SBCMHP – Santa Barbara County Mental Health Plan
SNF – Skilled Nursing Facility
UR – Utilization Review
Share Care

Consumer Search
Searching for Consumers in Share Care

When searching for consumers it is best to use either their date of birth or social security number.

The consumer name may not be spelled correctly or they may be going by another name.

Click Advanced Search

Type in date of birth and click on Search.
Consumer search

When searching a consumer with a social security number or date of birth a list of consumers will appear.

If your consumer appears on the list just click on the blue consumer ID link.

Next click on the Profile tab.
Create New Consumer Record
Entering Consumer Name

In the Profile section click on New.

On “Name Type” there is a drop down box, choose the correct type. For example if the consumers name is different than the name they are going by you must use “Billing Name (Medi-Cal)”. 

Consumer Name

The name must be entered in CAPITAL LETTERS.

The begin date will be the first day you see the consumer.

The Name must appear exactly as it appears in the State MEDS System.

This is what is called the Medi-Cal/Billing name.

Share Care will look for the default name to match the State MEDS System name.

**IMPORTANT:** If you process consumer notes in Clinicians Gateway, enter the information in the identification area of Share Care. This will prevent duplicate accounts.
Entering Identification

The purple areas must be populated as well as the CIN number. First pick the system of care from the dropdown, then the date of birth, social security number, and the CIN number.

If you see a message as above please pay attention to it. Write down the consumer number in the message and verify that it is the same consumer you are admitting. If it is your consumer continue to do the admission with the older account number. After you have completed your admission notify MIS of the two account numbers so they may be merged.
Entering Guarantor

In the Guarantor Tab click new.

If the consumer has Medi-Cal then click on Make Self Guarantor. **Never make a child a Self Guarantor.** If the consumer is on someone else’s account then you must make the primary account holder the guarantor enter the Name, Social Security number and date of birth of the guarantor add. **warning Share Care will date the guarantor the date of data entry, you must change this to the correct date.**
Correcting the Guarantor

If you need to change the guarantor for any reason. It is necessary to use the last date of service for the end date of the current guarantor. This can be found in the admission.

In the main menu go to Clinical, Admissions. Find the admission for your program and locate the last date of service.
To update the Guarantor go to Consumer and click the Guarantor tab. Find the System of care you need to change and click the open button.

Go to the identification button. Enter the end date click update. The old guarantor will disappear and you can enter the new guarantor.
Entering Consumer Address

Choose the type of address on the drop down menu.

If County of Residency and County of Liability are not Santa Barbara, then use the drop down menu to choose the correct County.

When entering the address use all capital letters and enter the full address on line 1.

Please do not use punctuation or symbols in the address.

Share Care will look for the default address to match the State MEDS screen address.
Entering Consumer Phone Number

Go to the Telephone flag and select Telephone Type and enter the area code and number. Use the date of intake.
Entering Demographics

When entering Demographics you must enter Gender, Marital Status, Living arrangement, Hispanic origin, race, language and check if the language is primary and preferred.

Click on update at the top of the screen.
Entering Education

On the Education Button use the drop down menu to choose the highest level of education.

Special Population

On the Special Population use the drop down menu to choose the correct population and enter the begin date.
Entering Contact information

Choose the Relation to Consumer, type of contact. Type in last name, first name, and social security number. Click add.

After you add the contact person enter their address and phone number information.
ShareCare

Admissions & Diagnosis
Entering Admission

Go to Clinical, then Clinical summary.

Type in the consumer ID number, and press tab.
Click on the Add New button.

<table>
<thead>
<tr>
<th>Admission ID</th>
<th>256383</th>
<th>System of Care</th>
<th>Mental Health (MHCS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Date</td>
<td>06/04/2008</td>
<td>Discharge Date</td>
<td>11/10/2008</td>
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<tr>
<td>Facility</td>
<td>Jail</td>
<td>Program</td>
<td>Adult Outpatient</td>
</tr>
<tr>
<td>Primary Service Provider</td>
<td>NICHOLSON, CHARLES</td>
<td></td>
<td></td>
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<tr>
<td>Number Of Services</td>
<td>0</td>
<td>Last Service Date</td>
<td>N/A</td>
</tr>
<tr>
<td>Admission ID</td>
<td>231077</td>
<td>System of Care</td>
<td>Mental Health (MHCS)</td>
</tr>
</tbody>
</table>

Type in the date, System of Care, Facility Name, Program Name, Primary Service Provider. Click the add button at the top of the screen.
Entering Diagnosis

On the Main Menu Click on Diagnosis.

Click on New.
Type in the date, Time, and select admission. And click Add at the top of the screen.
Click on the blue date.

To enter the Diagnosis go to Clinical, Admissions, and then the diagnosis tab. Click on the DSM-5 button. Share Care will automatically date the diagnosis the day of data entry. You must change it to the date of admission. Click the update button.

On this screen enter the diagnosis given to you by the Clinical Staff.
When you see this screen you have completed the Admission.
ShareCare

Payor Plans
In the **Payor** tab you will click New.

The next screen click on **Payor Plan**.
Scroll down until you see **Medi-Cal ADP**
Click on the blue link.

Your screen now has the insurance plan on the payor screen.
Enter the “Begin Date’ the first day of the month ie 3/01/2010 and the “End Date” the last day of the month ie 03/31/2010.

Type in the consumer’s Social Security number.
Next you MUST click “Use Linked Person As Insured”.

ALWAYS click on the Guarantor “Add” button.

Next click on the “Use Insured SSN”.

3/22/2018
Next you will enter the Begin date for the Assignment Benefits.

Release of Information; use the highlighted statement and Signature Source.

Signature Source; use the highlighted statement.

Your page should look like the one to the right.
Click **ADD**.

Next click **Edit/View**.

Scroll to the bottom of the screen and check the **check box**. A message screen will appear click **OK**.
Entering Private Insurance

In the **Payor** tab you will click New.

The next screen click on **PayorPlan**.
When entering Private Insurance you will follow all of the same steps as for Medicare.

Enter the dates and statements for
Assignment of Benefits
Release of Information
Signature Source
Eligibility Verification

After the Medi-cal payor plan has been imported or manually added, go to the Eligibility tab you will see this screen. Click on Search.

Click on the blue link labeled Payor Plan and choose the type insurance, next click on The blue link labeled Facility and choose the one for your facility. Click ADD. And then click Process.
Common Errors
Common Errors

Names
Share Care verifies the Default name with the State MEDS screen. When you see the name type as “Billing Name (Medi-Cal)” then it is exactly as it is in the State Screen. Unless the consumer has changed their name with Social Security and the State.
If this happens you MUST end date the current Billing Name and enter the new name one day later than the end date of the old name.
Share Care does not allow overlapping dates in the system.
Failure to match the State MEDS screen will cause any service to be rejected until the correction is made.
Address Errors

The address must match the State MEDS screen.

Use address line 1 for the Complete address. Do not use line 2 for Apt or Unit as this will cause an Incomplete address error.

Use the correct zip code, If in doubt check the Postal service web site.

As with the name the old address must have an end date of the day prior to the begin date of the new address.
Address errors
If you open the “History” the end date of the old address is the day prior to the begin date of the new address.

This is necessary in order to enter more than one of the same type of address.

As in this example the “Home” type of address.
In the Demographics section the circled areas MUST be populated.
Identification
In the Identification the Social Security number and the CIN number MUST be the exact match to the State MEDS screen.
Guarantor

If the consumer is the Guarantor in the State MEDS, then click on the “Make Self Guarantor” button.

If someone else is the Guarantor then pick the Relation to from the drop Down menu. Enter their Date of birth and Social Security number.

In the Identification filed of the guarantor area make sure the begin date is the same as or before the admission date.
Payor

The payor must be linked to the guarantor. Click on the “Use Linked Person As Insured” button.

Also the Social Security Number must match the Guarantor.

Make sure the Assignment of Benefits, Release of Information, and Signature Source have the correct date and statement.
Diagnosis

Admission date and the diagnosis date must match.

If the diagnosis is missing or not accepted by Medi-Cal you must contact the Case Manger and obtain the correct diagnosis and then enter it into Share Care.
How to get Medi-Cal PIN from DMH

- ADMHS needs your facility’s PIN in order for you to verify Medi-Cal eligibility via ShareCare and to certify Share of Cost via ShareCare.

- If you do not know your facility’s PIN, send an email from your organization’s director to Carla.Minor@dhcs.ca.gov requesting the PIN for your facility.

- ADMHS recommends that you reference your facility’s address and NPI number.

- Once you retrieve your facility’s PIN, please send it to Dana Fahey via email so it can be added to ShareCare.
SC4132 Services Summary Report

- All UOS that are in ShareCare YTD for FY
- Automatically generated and emailed on the 5th of each month

<table>
<thead>
<tr>
<th>Service Month</th>
<th>Program</th>
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SC3009 DMH Medi-Cal Claim Detail Report

- All UOS that made it on a Medi-Cal claim
- Generated and emailed following the successful submission of a Medi-Cal claim

### Monthly Medi-Cal Claim Report for Facility 1 - Santa Maria Mental Health Services
#### Bill Print Control ID 797
#### JULY 2010

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SC4001A Eligibility Report - Detail

- Displays various eligibilities flagged by consumer in diagnostic format
- Automatically generated and emailed between the 1st and 7th of each month

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Total Unique Consumers for Santa Maria Mental Health Services-Children's Outpatient: 121
## SC4001D Eligibility Report - Brief

- Displays various eligibilities flagged by consumer in summary Y/N format
- Automatically generated and emailed between the 1st and 7th of each month

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Total Unique Consumers for Santa Maria Mental Health Services-Pei-Tay Sm: 13
# SC5005A 182 Day Admission Not Seen - Summary

- Displays all consumers with open admissions who have not been seen in last 30, 60, 90, 120 and 182 days.
- Automatically generated and emailed between the 1st and 3rd of each month

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Santa Maria Mental Health Services-Juvenile Justice (Billable)
**SC6001E Error Edits - Detail**

- Displays various common BSR/Claim errors flagged by consumer in diagnostic format
- Automatically generated and emailed between the 15th and 17th of each month

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<td>314.01</td>
<td>1756</td>
<td>5</td>
<td>10/06/2010</td>
<td></td>
</tr>
</tbody>
</table>

Total Unique Consumers for Santa Maria Mental Health Services-Children’s Outpatient (3): 122
Drug and Alcohol Treatment Access Report (DATAR)

DATARWeb
User Manual

NNA Contract: Document 1K

April-2014
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PART 1: INTRODUCTION

About This Application

The Drug and Alcohol Treatment Access Report (DATAR) is the Department of Health Care Services (DHCS) system to collect data on treatment capacity and waiting lists and is considered a supplement to the California Outcomes Measurement System (CalOMS) client reporting system. DATAR assists in identifying specific categories of individuals awaiting treatment and identifies available treatment facilities for these individuals. The DATARWeb is an application developed by DHCS and can be used by California providers, counties and state staff.

Federal regulations require that each state develop a Capacity Management Program to report alcohol and other drug programs treatment capacity, to ensure the maintenance of the reporting, and to make that information available to the programs. In carrying out this requirement, DHCS established a Waiting List Management Program that includes a unique client identifier to document applicants who are not immediately admitted to a program due to lack of capacity.

The Waiting List Management Program consists of two separate reports, the Waiting List Record (WLR) and DATAR.

Using this application, you will be able to enter DATAR data and submit it directly to DHCS.

About this Document

This user guide provides you with step-by-step instructions on how to use the DATARWeb. The guide provides instruction for Provider, Central Intake Unit, County and DHCS users. The guide is broken into sections by functionality. Note: the functionality you may access is dependent on the type of user and the type of access.

Getting Help

Contact DHCS's Automation Help Desk if you have questions or problems related to DATARWeb.

<table>
<thead>
<tr>
<th>DHCS IT Service Desk</th>
</tr>
</thead>
<tbody>
<tr>
<td>916-440-7000</td>
</tr>
<tr>
<td><a href="mailto:ITServiceDesk@DHCS.ca.gov">ITServiceDesk@DHCS.ca.gov</a></td>
</tr>
<tr>
<td>Monday through Friday</td>
</tr>
<tr>
<td>8:00 AM to 5:00 PM</td>
</tr>
</tbody>
</table>
What is the DATAR?

DATAR has information on the program’s capacity to provide different types of Substance Use Disorder (SUD) treatment to clients and how much of the capacity was utilized that month. If the provider has a waiting list for publicly funded SUD treatment services, DATAR includes summary information about the people on the waiting list. These are the applicants who cannot be admitted due to the facility’s lack of capacity. The monthly DATAR is submitted to DHCS.

Who Must Report?

All SUD treatment providers that receive SUD treatment funding from DHCS are required to submit the one-page DATAR form to DHCS each month. In addition, certified Drug Medi-Cal providers and Licensed Narcotic Treatment Programs (NTP) must report, whether or not they receive public funding.
PART 2: HOW TO USE DATARWEB

Accessing DATARWeb

DATARWeb is a web based system accessed through the DHCS website. To access DATARWeb, please visit the following website:

https://adpapps.dhcs.ca.gov/datar/

You must enter a User ID and Password to access the system. If you do not know your User ID or Password, contact DHCS or your County Administrator.

Once you enter your User Name and Password, the Home page of the application displays when the system is initiated. The Home page is displayed in Figure 1.

Figure 1: DATARWeb Home Page

Note: the options available on this screen are dependent on your user access type.
Navigating DATARWeb

The links on the grey bar on the left hand side of the screen allow you to navigate from function to function. The options available to you are dependent on your user access type. The navigation bar is called out in Figure 2.

![Figure 2: Navigation Links]

The navigation bar displays no matter where you are in the system allowing you to navigate easily from page to page.

Logging Out

To log out of the system, click the Logout link on the menu bar. This brings the user to the Login screen.

Submitting a DATAR Report

Providers and Central Intake Units must submit DATAR reports for each month by the 10th of the following month. For example, for the month of September 2008, the DATAR report must be submitted by the 10th of October 2008.

To submit a DATAR report, follow the steps on the next page.
1. Click the Submit DATAR Form link on the navigation bar. If you are a Provider or Central Intake Unit user, a DATAR Form displays (if you are a County or DHCS user, you must first select the provider or Central Intake Unit, see the section on Selecting a Provider for details).

DATARWeb requires that you submit each form in sequential order. For example, if the last report you submitted was for June, the report month displayed would be July. Note: You may enter data for the current month, but will not be permitted to submit the report until the first day of the following month.

Figure 3 displays the DATARWeb data entry page.

Figure 3: DATARWeb Data Entry Page

2. Enter your DATAR data into the form. Note: you can save your report at any time during your data entry by clicking the Save Work in Progress button.

DATARWeb displays only the types of services the facility is contracted to provide. Below are the abbreviations of each type of service that displays on the DATAR form.
### ABBREVIATION | DESCRIPTION
--- | ---
NRT/R | Outpatient Drug Free (ODF)
MAINT (METH/LAAM) | Outpatient Methadone
NRDX METH | Outpatient Methadone Detoxification (OMD)
NRDX | Outpatient Detoxification Non-Methadone ODX
RDX, NON HOSP | Residential Detoxification
RT/R | Residential Drug Free (RDF)
NR DAY INTSV | Day Care Drug Free (DCDF/DCH)
Other | Hospital Detoxification, Jail Settings, etc.

Enter the following by type of service:

1. **Total Treatment Capacity**: Enter the total treatment capacity at this location by type of service. If a program has two or more types of service, then each entry must reflect the number of "slots" which can be provided in that service type at any given time. If the entries across the line were to be added, the result would be the total program capacity for alcohol and other drug treatment/recovery service at this location.

   *For example, total residential treatment capacity should equal the number of licensed beds. The total treatment capacity for an NTP should equal the number of licensed slots. The total treatment capacity (or utilization) for an outpatient program, (including Daycare Habilitative) should equal the number of unique clients that can be served in the month, based on public funding.*

2a. **Public Treatment Capacity**: Enter the public treatment capacity at this location by type of service.

2b. **Available Public Treatment Openings at End of Month**: Enter, by type of service, the unused public treatment capacity at this location as of the last day of the month (e.g., how many publicly funded "slots" were empty). For outpatient programs, please enter how many more unique clients you could have served, based on current funding.

3. **Number of Days the Program Census/Enrollment Exceeded 90% of Public Treatment Capacity during the Month**: For each service type, enter the number of days during the month that the program's enrollment exceeded 90 percent of its public treatment capacity. For example, if a particular service has 100 public treatment slots available at any given time, and if for 12 days of the report month there were 91 or more clients enrolled in these public treatment slots, then enter "12" in the appropriate service field.
4. Applicants on Waiting List during Month: Enter, by service, the number of applicants that were on the waiting list at any time during the month.

Paper data source: All Waiting List Record (WLR) entries having a check in column 1 "Pub Fund" box, and either a blank or a date within the report month in WLR column 6.

5. Total Number Applicants on Waiting List at End of Month: For each service, enter the number of applicants still active on the waiting list as of the last day of the report month.

Paper data source: All WLR entries having a check in column 1 "Pub Fund" box, and a blank in WLR column 6 on the last day of the report month.

6a. Number of Applicants Admitted to Treatment from Waiting List: Enter the number of clients that were removed from the waiting list during the report month because of admission to treatment either at this program or another program.

Paper data source: All unduplicated WLR entries from column 2 with a check in column 1, "Pub Fund" box; AND a date within the report month in column 6; AND code 1 (admitted to this program) or code 2 (referred to and admitted by another program) in column 9, Reason Removed From Waiting List.

6b. Total Number of Days Spent on Waiting List: For all applicants counted on line 6a, enter the total number of days they were active on the waiting list. The intent of the question is to determine the total days such applicants waited in all months.

Paper data source: For all applicants counted on line 6a; the sum of the number of days entered in column 7.

7a. Number of IDU on Waiting List: Enter, by service, the number of injecting drug user (IDU) applicants that were on the waiting list at any time during the month.

Paper data source: All WLR entries having a check in column 1 "Pub Fund" box; AND a check in column 3 "IDU" box AND either a blank or a date within the report month posted in column 6.

7b. Number of Pregnant Women on Waiting List: Enter, by service, the number of applicants on the waiting list at any time during the month that were pregnant.

Paper data source: All WLR entries having a check in column 1 "Pub Fund" box; AND a check in column 3 "PW" box; AND either a blank or a date within the report month posted in column 6.

7c. Number of Pregnant IDU on Waiting List: Enter the number of pregnant women in 7b, who were also Injecting Drug Users (IDU).

Paper Data Source: This is the same as 7b, but limited to those whose column 3 status also contains a check in the "IDU" (injecting drug user) box.

7d. Number of Medi-Cal Beneficiaries: Enter, by service, the number of applicants on the waiting list at any time during the month who were Medi-Cal beneficiaries, regardless of whether the services requested are covered by Medi-Cal.
Paper data source: All WLR entries having a check in column 1 "Pub Fund" box AND a check in column 3 "Medi-Cal" box AND either a blank or the current month posted in column 6.

7e. Number of CalWORKS Recipients: Enter the number of CalWORKS beneficiaries who were on the waiting list at any time during the report month.

Paper data Source: All WLR entries having an entry in column 1 "Pub Fund" AND an entry in column 3 "CalWORKS" AND either a blank or a date within the report month posted in column 6.

7f. Number of Court/Probation Referrals: Enter the number of Court/Probation Referrals on the waiting list at any time during the report month.

7g. Number of Parole Referrals: Enter the number of Parole Referrals on the waiting list at any time during the report month.

3. If you are ready to submit the report to DHCS, click the Validate and Submit to DHCS button. If you would like to check that your report passes all edits but you are not ready to submit your report to DHCS, click the Validate button. If you are not ready to submit the report to DHCS and would like to save the draft, click the Save Work in Progress button.

4. If you selected Validate and Submit to DHCS, you will receive the message that your form has been saved successfully. Figure 4 displays the confirmation message.

Figure 4: Confirmation Message
5. To print the form you just completed click the **Print Submittal** button. To enter another report, click the **Next Report Period** button. If no other reports are available, the **Next Report Period** button will not display.

### Updating an Existing Report

You may update the last two reports submitted to DHCS. *Note: DHCS users may update any reporting periods for a Provider or Central Intake Unit. If you need to modify a report that is not available to you, call your DHCS representative.*

To update a report that you have already submitted to DHCS, follow the steps below:

1. Click the Correct DATAR Submittals link on the navigation bar. If you are a County or DHCS user, you must first select the provider or Central Intake Unit; see the section on **Selecting a Provider** for details.

2. Select the radio button for the Report Period and click the **Submit** button. The form selected displays and is modifiable.

3. Modify the data as necessary.

4. To submit the updated form, click the **Validate and Submit to DHCS** button. If you are not ready to submit the form, but would like to check the entry for error, click the Validate button. Note: You can not save the document without validating it if the form has already been submitted to DHCS.

### Viewing Historical Reports

You may view and print any report submitted to DHCS for your provider or Central Intake Unit

1. Click the **View Historical Reports** link on the navigation bar. If you are a County or DHCS user, you must first select the provider or Central Intake Unit; see the section on **Selecting a Provider** for details.

2. Select the radio button for the Report Period and click the **Submit** button. The form selected displays but is not modifiable.

3. To print the report, click the Printable Version link at the bottom of the form. The link is displayed in **Figure 5** below.

4. Click the Print button on the upper left hand side of the page.
Generating Reports

Report access is limited by user type. The following table lists each report, what it contains and who may access it.

<table>
<thead>
<tr>
<th>Report</th>
<th>Description</th>
<th>Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statewide Alcohol and Drug Treatment Access</td>
<td>Displays summarized statewide treatment access data for each report month</td>
<td>All Users</td>
</tr>
<tr>
<td>Report</td>
<td></td>
<td></td>
</tr>
<tr>
<td>County Drug and Alcohol Treatment Access</td>
<td>Displays summarized treatment access for a specific county for each report</td>
<td>Providers, Central Intake Units and County users can only access summarized data for their own county. DHCS users can access data for all counties</td>
</tr>
<tr>
<td>Report</td>
<td>month</td>
<td></td>
</tr>
<tr>
<td>Dir Prov Drug and Alcohol Treatment Access</td>
<td>Displays summarized treatment access for all direct providers for each report</td>
<td>Direct providers can only access summarized data for their own provider. DHCS users can access data for all direct providers.</td>
</tr>
<tr>
<td>Report</td>
<td>month</td>
<td></td>
</tr>
<tr>
<td>Statewide Compliance Totals</td>
<td>Provides DHCS users a summary of the number of providers within a each county</td>
<td>DHCS users only</td>
</tr>
<tr>
<td>Report</td>
<td>that are compliant by report month</td>
<td></td>
</tr>
<tr>
<td>State Non-Compliance Report</td>
<td>Provides DHCS users with a list of providers within a each county that are</td>
<td>DHCS users only</td>
</tr>
<tr>
<td>Report</td>
<td>not compliant by report month</td>
<td></td>
</tr>
<tr>
<td>County Non-Compliance Report</td>
<td>Provides DHCS and County users with a list of providers within a specific</td>
<td>County users can only access their county. DHCS users can access any county.</td>
</tr>
<tr>
<td>Report</td>
<td>county that are not compliant by report month</td>
<td></td>
</tr>
<tr>
<td>Dir Prov Non-Compliance Report</td>
<td>Provides DHCS and Direct Provider users with a list of providers that are</td>
<td>Direct providers can only access their own data. DHCS users can access any direct provider.</td>
</tr>
<tr>
<td>Report</td>
<td>not compliant by report month</td>
<td></td>
</tr>
<tr>
<td>Late Notice Letter</td>
<td>Generates late notice letters for providers that are not compliant</td>
<td>DHCS users only</td>
</tr>
</tbody>
</table>

To generate reports follow the steps below:
1. Click the Generate Reports link on the navigation bar.

2. Select the radio button of the report you wish to view or print and click the Submit button.

3. Depending on the report, you may be required to select a report period. If necessary, select the radio button of the month and year you wish to view and click the Submit button. Note: DHCS users may be required to select a County depending on the report type.

4. Once the report is displayed, hover your curser to the bottom of the report. A grey menu bar will appear, and you may print the report by clicking the print icon displayed in Figure 6 below:

   **Figure 6: Print Icon**

   ![Print Icon Image]

**Contacts List**

The Contacts List page displays the county contacts for your provider or Central Intake Unit. *Note: DHCS users may also access the list of DHCS users using the Contacts List.*

To access the contacts list follow the steps below:

1. Click the Contacts List link on the navigation bar. The list of contacts for your county are listed. See Figure 7 for a sample Contact list

2. If you are a DHCS user, you may select the State Users from the list of Counties in the Select County box and click Submit.
Selecting a Provider

If you are a County or DHCS user, you must select the Provider or Central Intake unit before viewing or updating data. The steps differ slightly depending on your access.

**County Users**

County users must select the provider or Central Intake Unit they wish to view or update. To select a provider or Central Intake Unit, follow the steps below:

1. Select the provider in the **Select Provider** box or select a Central Intake Unit from the **Central Intake Unit** box. **Note:** The providers that display in this list are providers that are currently using DATARWeb to submit DATAR records to DHCS and must be assigned to you at the user access level.
2. Click the corresponding **Submit** button.

**DHCS Users**

DHCS users must first select a county then a provider or Central Intake Unit. To select a provider or Central Intake Unit, follow the steps below:

1. Select a county in the **Select County** box or select a direct provider from the Direct Provider box and click the corresponding **Submit** button.
   **Note:** The direct providers that display in this list are direct providers that are currently using DATARWeb to submit DATAR records to DHCS and must be assigned to you at the user access level.
   If you selected a Direct Provider you are done.

2. Select a provider in the **Select Provider** box or select a Central Intake Unit from the **Central Intake Unit**. **Note:** The providers that display in this list are providers that are currently using DATARWeb to submit DATAR records to DHCS and must be assigned to you at the user access level.
3. Click the corresponding **Submit** button
User Administration

The user administration functions allow you to add, update and inactivate users for providers, counties and state users. It also allows you to set and reset passwords for providers, counties and state users. DHCS users can also set and reset the First Report Period for a provider. See Central Intake Unit Administration for this same functionality for Central Intake Units.

County administrators can only add and modify County users and reset passwords for providers within their county. DHCS administrators can add and modify any type of user and reset passwords for any type of user.

Figure 8 displays the User Administration page from an DHCS user perspective.

**Figure 8: User Administration Page**

### Adding a County User

Only an DHCS or County Administrator can add a County User. To add a county user follow the steps outlined below:

1. Select the User Administration link on the navigation bar.
2. Click the Add New County User button.
3. Enter the user’s First and Last name and click the Submit button.
4. When you click submit, DATARWeb checks the list of users for a matching name. If a match occurs, a list of matching names display. If no match occurs, you will see the screen described in Figure 9.

5. If potential matches are found and the user you want to add is not already in the system and you wish to continue to add the user, click the Continue to Add New User button. Figure 9 displays the Add New County User page.

6. If potential matches are found and the user you want to add is already in the system and you wish to confirm or update the user’s information, click the View/Update Existing User button. See Modifying a User for further details.

7. Enter the phone number of the user in the format ###-###-####.

8. Enter an email address for the user.

9. Designate whether or not the user is a primary contact by selecting the appropriate radio button.

10. Enter an effective date on which you wish the access to begin, if it is other than today. A through date is not required unless you wish to limit the access timeframe for the user.
11. Select the access appropriate for the user:
   a. a. View Only – Does not allow the user to update any data but gives them view
      access to provider data for the providers in the list.
   b. b. View and Update – Allows the user to update provider data for the providers
      selected in the list.
   c. c. View and Update and User Set Up – give the user Administrator rights in
      addition to View Update rights.

12. Highlight one or more providers in the Select Provider field and click the right arrow.

13. Click the **Submit** button to add the user.

14. You will receive a confirmation message displaying the User ID of the new user.
    Make note of the user id. You must set the user’s password to allow access to the
    system. See the section on Setting or Resetting Passwords.

### Adding a State User

Only an DHCS Administrator can add a State user. To add a State user, follow the steps outlined
below:

1. Select the User Administration link on the navigation bar.
2. Click the Add New State User button.
3. Enter the users First and Last name and click the Submit button.
4. When you click submit, DATARWeb checks the list of users for a matching name. If a
   match occurs, a list of matching names display. If no match occurs, you will see the
   screen described in Figure 9.
5. If potential matches are found and the user you want to add is not already in the
   system and you wish to continue to add the user, click the **Continue to Add New
   User** button. Figure 9 displays the Add New State User page.
6. If potential matches are found and the user you want to add is already in the system
   and you wish to confirm or update the user’s information, click the **View/Update
   Existing User** button. See Modifying a User for further details.
7. Enter the phone number of the user in the format ###-###-####.
8. Enter an email address for the user.
9. Enter an effective date on which you wish the access to begin, if it is other than today.
   A through date is not required unless you wish to limit the access timeframe for the
   user.
10. Select the access appropriate for the user:
   a. View Only – Does not allow the user to update any data but gives them view access to all provider data
   b. View and Update – Allows the user to update all provider data.
   c. View and Update and User Set Up – give the user Administrator rights in addition to View Update rights.

11. Click the Submit button to add the user.

12. You will receive a confirmation message displaying the User ID of the new user. Make note of the User ID. You must set the users password to allow the access to the system. See the section on Setting or Resetting Passwords.

**Modifying a User**

You may also modify an existing user. County administrators can only modify County users. DHCS administrators can modify any type of user. To modify a user, follow the steps outlined below:

1. Select the User Administration link on the navigation bar.
2. Enter the User ID in the User ID field.
3. Click the View/Update button.
4. Modify the user’s information or access.
5. Click the Submit button.

**Finding a User**

If you can not remember the user id or can not find the user to update, you can use the Find a User function. To locate a user, follow the steps outlined below:

1. Enter a name or a part of a name in the Find User field and click the Find User button. A list of users is displayed.
2. Select the radio button of the user you wish to update and click Submit. The user information is displayed.

**Inactivating a User**

There are two ways to inactivate a user. To permanently inactivate a user id you may user the Inactivate User button. If you wish to inactivate a user temporarily, you may
enter an Authorization Effective Through date on the user’s information page. In this instance, you can then remove the Through date to reactivate the user.

**Temporarily Inactive**

To temporarily inactivate a user, follow the steps below:

1. Select the User Administration link on the navigation bar.
2. Enter the User ID into the User ID field.
3. Click the View/Update button.
4. Add an Authorization Effective Through Date.
5. Click the Submit button.

**Permanently Inactive**

To permanently inactivate a user follow the steps below:

1. Follow the Temporarily Inactive instructions above. THEN:
2. Select the User Administration link on the navigation bar.
3. Enter the User ID into the User ID field.
4. Click the Inactivate User button. Confirm the user name and click the Inactivate User button on the confirmation message

**Central Intake Unit Administration**

While providers are maintained in the Master Provider File, Central Intake Units are added and maintained directly in DATARWeb. Only DHCS users can set up or modify a Central Intake Unit. The Central Intake Unit administration page maintains the facilities first and last report dates as well as the facility’s contact information.

**Figure 10** displays the Central Intake Unit Administration page.
To add a new Central Intake Unit, follow the steps outlined below:

**Adding or Modifying a Central Intake Unit**

1. Select the Central Intake Unit Administration link on the navigation bar.
2. Select a County and click the Submit button.
3. Click the Add New Intake Unit button to add a new facility or select the facility you wish to modify and click the Update Intake Unit button.
4. Enter or modify the Facility Name
5. Enter or modify the First Report Date. Note: If the first report date is changed to a date prior to the existing date, any existing reports in DATARWeb will be deleted allowing the provider to start over from the beginning month. Be sure to print the data for any months submitted BEFORE changing the First Report Date.
   
   If the first report date is changed to a later month, any reports prior to the revised first report date will be deleted.
6. Note the facility code; you must set the facility’s password to allow the access to the system. See the section on Setting or Resetting Passwords.
7. Enter the First and Last Name, phone number and email address of the facility contact.
8. Click the Save button.
**Inactivating a CIU**

To inactivate a facility you must enter a Last Report Date. To set the Last Report Date follow the steps outlined below:

1. Select the Central Intake Unit Administration link on the navigation bar.
2. Select a County and click the **Submit** button.
3. Select the facility you wish to modify and click the **Update Intake Unit** button.
4. Enter a Last Report Date.
5. Click the **Save** button.

**Provider Administration**

Providers are maintained in the Master Provider File (MPF), but to allow a provider access to DATARWeb, the DHCS Administrator must set the First Report Date in DATARWeb. This can be done one of two ways.

1. Individually, by setting the first report date using the steps outlined in section **Setting or Changing the First Report Date**.
2. Multiple, by contacting the System Administrator to add a first report date using the database table. Mass changes to the first report date can only be accomplished by running a script and must be performed by the System Administrator. The script must also set the passwords for all of the providers.

Once the provider is added to the Master Provider File and the first report date is set, the MPF dictates the provider relationship with DATAR. The MPF controls the services available at each provider site and controls the last report month. If a last report month is added to the Master Provider File, DATARWeb will stop allowing entry of DATAR reports after the last report month.

**Setting or Changing the First Report Date**

To activate a provider on DATARWeb, you must first set the First Report Date. This is the first month in which the provider will report DATAR figures.

If the first report date is incorrect because the provider began services earlier or later than the date first entered, you can change the first report date. If the report date is changed to a date prior to the current date, any existing reports in DATARWeb will be deleted allowing the provider to start over from the beginning month. Be sure to print the data for any months submitted BEFORE changing the First Report Date.
If the first report date is changed to a later month, any reports prior to the revised first report date will be deleted.

To set or change the first report date follow the steps below:
1. Select the User Administration link on the navigation bar.
2. Enter the Provider number into the Provider ID field.
3. Click the Add/Update First Report Date button.
4. Enter or change the first report date.
   If the first report date is changed to a date prior to the current date, any existing reports in DATARWeb will be deleted allowing the provider to start over from the beginning month. Be sure to print the data for any months submitted BEFORE changing the First Report Date.
   If the first report date is changed to a later month, any reports prior to the revised first report date will be deleted.
5. Click the Submit button. The system will ask you to confirm your change.
   If you are adding a new provider, you must set the providers password. See the section Set a Provider or Central Intake Unit Password for instructions on how to set a password.

What if a Provider closes?

The MPF controls the last report month. To close a Provider out of DATARWeb, add a Last Report Month to the Master Provider File. DATARWeb will stop allowing entry of DATAR reports after the last report month.

Setting or Resetting Passwords

Users can reset their password by clicking the Change Password link and changing their password. Passwords must be 8 to 13 alphanumeric characters, must be updated upon first logon, and have a 60 day expiration period.

Only a State or County Administrator can set or reset another user’s password. County users can only set and reset passwords for users in their county and providers within their county. DHCS users can set and reset passwords for all users.

Follow the steps outlined below to set a new user’s password or reset an existing password for another user or provider.

Set a Provider or Central Intake Unit Password

To set or reset a Provider or Central Intake Unit password, follow the steps below:
1. Select the User Administration link on the navigation bar.

2. Enter the Provider or Central Intake number into the Provider ID field.

3. Click the Reset Password button.

4. Enter the password in each of the two fields and click Submit. Passwords must be 8 to 13 alphanumeric characters, must be updated upon first logon, and have a 60 day expiration period.

**Set a County or DHCS User Password**

To set or reset a County or DHCS user password, follow the steps below:

1. Select the User Administration link on the navigation bar.

2. Enter the User ID of the DHCS or County user.

3. Click the Reset Password button.

4. Enter the password in each of the two fields and click Submit. Passwords must be 8 to 13 alphanumeric characters, must be updated upon first logon, and have a 60 day expiration period.

**Definitions**

INJECTING DRUG USERS: A person who is administering, or has administered within the past year, drugs by injection.

MEDI-CAL BENEFICIARIES: Those persons who have been found eligible for Medi-Cal benefits by the County Social Services Department. Current eligibility can be proved via the presentation of the card, a sticker from the card with the current month appearing on it, or by accessing the Department of Health Services' Medi-Cal Eligibility Data System (MEDS).

PUBLIC FUNDS: Public funds are those that are allocated to the county drug and alcohol program as well as certain county generated funds. These funds include (but are not necessarily limited to) State General (Perinatal, Parolee programs), federal SATP Block Grant, CSAT discretionary grants, county funds, federal Drug/Medi-Cal, and SB 920, SB 921, and Statham funds.

PUBLIC TREATMENT CAPACITY: The maximum number of clients/participants who could be enrolled for alcohol or drug treatment at any one time, using the public funds available to this treatment provider by federal, state, and/or county government.

REQUEST FOR SERVICES: The WLR information is only recorded for those individuals who would be placed in treatment but weren’t because there wasn’t space in a program. This means that the applicant has met all placement criteria. Since the date an
applicant's name is entered on the WLR in Column 5 is the date of the Request for Service, this date would be the date that the assessment of the client's needs is completed and placement criteria have been met.

SLOT: A "slot" is the capacity to provide treatment services to one individual. Total slots reflect the maximum number of individuals a provider can serve at any one time, given its complement of staffing and other resources. While not all treatment programs use the term "slot", they do have a capacity to treat only a limited number of individuals at one time. Slots should be counted in a manner similar to other capacity reporting mechanisms, such as the National Survey of Substance Abuse Treatment Services (NSSATS) formerly Uniform Facility Data Set (UFDS). Methadone should be reported in terms of licensed slots; for all outpatient services, the capacity is the number of clients a provider can accommodate given available resources; residential services are reported in terms of the available beds. In other words, it is the static capacity that is being reported.

CalWORKs PARTICIPANTS: California Work Opportunity and Responsibility to Kids (CalWORKs) participants who are waiting to receive substance abuse treatment.

TOTAL TREATMENT CAPACITY: The maximum number of clients/participants who could be enrolled for alcohol and other drug treatment at any one time, using all sources of funds (public, Medi-Cal, 3rd party, client fees, etc.) allocated to this treatment unit.
1. PURPOSE/SCOPE

1.1. The Santa Barbara County Department of Behavioral Wellness (hereafter “the Department”) is committed to providing high-quality, evidence-based trainings to care providers. The Department requires the completion of certain trainings to ensure compliance with all relevant laws, regulations, contracts, and guidelines; this includes compliance with the requirements of the Mental Health Plan (MHP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver.¹

2. DEFINITIONS

The following terms are limited to the purposes of this policy:

2.1. MHP staff – any employee or contractor on payroll, or any volunteer, under supervision of the Mental Health Plan (MHP), the program established by the contract between the Department and the California Department of Health Care Services (DHCS) which guides the provision of mental health services to Medi-Cal beneficiaries.

2.2. DMC-ODS staff – any DMC-ODS employee or contractor on payroll, or any volunteer, under the supervision of the DMC-ODS, a substance use disorder (SUD) treatment system.

2.3. CBO staff – any employee, contractor, or volunteer affiliated with a program operated by a Community-Based Organization (CBO) that has a current contract with the Department to provide mental health services, SUD prevention services, or SUD treatment services within the boundaries of Santa Barbara County.

¹ For more information on the DMC-ODS waiver program in Santa Barbara County, please refer to policy ADP-7.006 “Drug Medi-Cal Organized Delivery System (DMC-ODS) Continuum of Care”. A comprehensive implementation plan may also be accessed at this link: http://countyofsb.org/behavioral-wellness/Asset.c/3866.
2.4. **Mental health provider** – any MHP staff or CBO staff who enters documentation, or who has been assigned the right to review and approve documentation of others, using the Clinician’s Gateway electronic health record system.

2.5. **Substance Use Disorder (SUD) provider** – any DMC-ODS staff or CBO staff who enters documentation, or who has been assigned the right to review and approve documentation of others, using the Clinician’s Gateway electronic health record system.

3. **TRAINING DEFINITIONS**

3.1. **Consumer and Family Culture** – a training specified in the Cultural Competence Plan in which consumers, as well as the parents or caretakers of child mental health consumers, describe their personal experiences.

3.2. **Cultural Competence Training** – specified in the Cultural Competence Plan which addresses a cultural issue relevant to mental health and SUD services.
   1. The “Consumer and Family Culture” training does not count as a “Cultural Competence Training.”

3.3. **HIPAA Privacy and Security Training** – a training on the requirements of the Security Rule and Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA), and on any requirements specific to California law which are more restrictive than HIPAA requirements.


3.5. **Code of Conduct Training** – a training which describes and discusses the Compliance Plan and Code of Conduct for the purpose of informing staff of relevant legal and ethical issues and encouraging compliance with legal and ethical standards.

3.6. **Medi-Cal/Drug Medi-Cal Documentation** – a series of two trainings (“Progress Notes” and “Assessment & Plans”) which provide information and ensure compliance regarding Medi-Cal and Drug Medi-Cal documentation standards, as indicated by one or more of the following:
   1. California Code of Regulations (Title 9, Chapter 11, *et al.*; and Title 22);
   2. The contract between the California Department of Health Care Services (DHCS), the MHP and the DMC-ODS;
   3. DHCS Letters and Information Notices;
   4. Results of reviews or audits performed by State and Federal agencies or their contractors;
   5. Information conveyed by or on behalf of State or Federal government agencies related to the interpretation and application of regulations and contracts; or
3.7. **Medicare Documentation** – a training to provide information and ensure compliance with Medicare documentation standards, as indicated by one or more of the following:

1. Code of Federal Regulations;
2. Publications of the Center for Medicare and Medicaid Services (CMS);
3. Publications of the Office of the Inspector General (OIG) of the Department of Health and Human Services (DHHS); or
4. Department policies and procedures.

4. **POLICY**

4.1. It is the policy of the Department to provide necessary administrative and clinical trainings to comply with all relevant laws, regulations, contracts, and guidelines with regard to trainings. It is also the policy of the Department to provide trainings to promote compliance with laws, regulations, contracts, guidelines and Department policies and procedures additionally relevant to staff practices.

5. **MANDATORY TRAININGS for ALL STAFF AND PROVIDERS**

5.1. All MHP staff, DMC-ODS staff, and CBO staff must successfully complete a HIPAA Privacy and Security Training within 30 days of hire or beginning services, and at least once every 12 calendar months. SUD Providers also must complete a 42 CFR training within 30 days of hire or beginning services, and at least once every 12 calendar months.

   1. Whenever a staff member fails to complete the annual HIPAA Privacy and Security Training (and, in the case of SUD providers, 42 CFR training) as required, that staff member will be denied access to all Department electronic health records systems and will be barred from access to any Protected Health Information (PHI) in any format. The individual will be assigned other duties by their supervisor until that individual successfully completes the required training.

5.2. All mental health providers and SUD providers (i.e., MHP, DMC-ODS, and CBO staff providing mental health or SUD treatment services, and those supervising the documentation of these services) must complete a minimum of one training in Medi-Cal/Drug Medi-Cal Documentation during each fiscal year of employment or other service.

   1. In order to meet this requirement, trainings must be provided by the Department, or must be certified by the Department QCM Manager or designee as equivalent to the Department training.

   2. The supervisor of a new mental health provider or SUD provider may permit the individual to enter documentation into Clinician’s Gateway under the following conditions:
a. The supervisor ensures that the individual has been provided with materials and/or training regarding Medi-Cal/Drug Medi-Cal documentation standards prior to beginning documentation; and

b. The supervisor ensures that the individual has been provided with material and/or training regarding Clinician’s Gateway prior to beginning documentation; and

c. Any progress notes entered by the individual must be approved by a designated reviewer to finalize.

3. Whenever a mental health provider or SUD provider fails to complete annual Medi-Cal and/or Drug Medi-Cal Documentation training as required, that provider will be placed on mandatory note review until the individual completes the required training.

4. All new staff, including CBO staff, are encouraged to incorporate initial documentation training and Clinician’s Gateway training into their schedules as early as possible in the employment or volunteering process.

5.3. All MHP staff, DMC-ODS staff, and CBO staff must complete a “Code of Conduct” training within 60 days of hire or beginning services, and at least once during each fiscal year of employment or other service.

5.4. All MHP staff, DMC-ODS staff, and CBO staff must complete a minimum of one training in the “Cultural Competence Training” category during each fiscal year of employment or other service.

5.5. When CBO staff are noncompliant with mandatory training requirements, this noncompliance constitutes a breach of contract and may be reported to the Department’s Chief of Compliance and the Contracts division.

5.6. When MHP staff and DMC-ODS staff are noncompliant with mandatory training requirements, noncompliance will be reflected in the next Employee Performance Review (EPR) for each staff member.

1. The EPR for each supervisory staff member will include the completion of mandatory trainings by supervised staff, including corrective actions where applicable.

6. ADDITIONAL MANDATORY TRAININGS for MHP STAFF and CBO STAFF PROVIDING MENTAL HEALTH SERVICES

6.1. All MHP staff and CBO staff must complete a minimum of one “Consumer and Family Culture” training during each fiscal year of employment or other service.

6.2. Every Medicare provider (any MHP staff or CBO staff who is a mental health provider, who is employed as a Psychiatrist, or who holds a currently valid California license as a Psychiatrist and/or Licensed Clinical Social Worker) must complete a minimum of one training in Medicare documentation during each fiscal year of employment.
1. In order to meet this requirement, trainings must be provided by the MHP, or must be certified by the Department QCM Manager or designee as equivalent to the MHP training.

7. **ADDITIONAL MANDATORY TRAININGS for DMC-ODS STAFF and CBO STAFF**

7.1. All SUD providers (i.e., DMC-ODS staff and CBO staff who provide direct SUD treatment) are required to attend the following SUD-specific trainings at least once per year:
   1. DMC-ODS Continuum of Care
   2. Title 22 Rules and Regulations
   3. ASAM Screening and Multi-Dimensional Assessment
   4. Motivational Interviewing
   5. Cognitive Behavioral Treatment/Counseling

7.2. All SUD providers (i.e., DMC-ODS staff and CBO staff who provide direct SUD treatment) are required to complete a minimum of 18 CEU hours of alcohol and other drug specific clinical training per year.

7.3. All SUD providers who enter data into ShareCare and the California Outcome Measurement Systems (CalOMS) are required to attend scheduled CBO Collaborative meetings.

8. **COMPLIANCE MONITORING**

8.1. Monitoring of staff training completion will be performed by the Department Systems Training Coordinator or designee for MHP staff, by an Alcohol and Drug Program (ADP)-designated staff member for DMC-ODS staff, and by a CBO-designated staff member for each CBO.

8.2. All MHP staff, DMC-ODS staff, and CBO staff will receive a written statement of required trainings, with applicable timelines for completion, at the time of hire or acceptance. All existing staff will be given this written statement at the time of each Employee Performance Review (EPR).

8.3. Each individual responsible for monitoring staff training completion (or their designee) will maintain a log of all individuals covered by these procedures, and the latest date each individual has successfully completed each mandatory training. Completion of a training can be defined as follows:
   1. Face-to-face or video conferenced trainings are completed when the individual has attended the full training and has signed a sign-in sheet at the time of the training.
      a. Staff who arrive at a training more than 5 minutes after the start of the training, or who are absent more than 5 minutes during a training, have not completed the training successfully.
b. Staff who do not sign the appropriate sign-in sheet at the time of the training have not completed the training successfully.

c. Staff who sign the sign-in sheet for another person are in violation of Department standards and will be reported to their direct supervisor to recommend appropriate actions.

2. Online or other electronic trainings are completed when the individual has signed in to the training using the relevant electronic system, has read all training materials, and has achieved a passing score on the test for the training.

   a. Passing scores and number of allowable retries for the training are defined by the electronic training system.

   b. Staff who electronically sign in for another staff, or who obtain answers to tests from another staff, are in violation of Department standards and will be reported to their direct supervisor to recommend appropriate actions.

8.4. An annual summary report showing the mandatory training status of all staff covered by these procedures, including staff names, will be presented to the Department’s Compliance Committee for review as soon as practicable after the end of each fiscal year.

8.5. Supervisory staff are responsible for monitoring all staff under their supervision to ensure timely completion of the requirements above.

   1. “Timely completion” includes ensuring that staff take advantage of training opportunities throughout the fiscal year, so that a disproportionate number of staff do not require completion of trainings during the last quarter of the fiscal year.
REVISION RECORD

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<td>1.1</td>
<td>• Incorporated training procedures for DMC-ODS staff to ensure compliance with the DMC-ODS waiver.</td>
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Culturally and Linguistically Competent Policies
The Department of Behavioral Wellness is committed to the tenets of cultural competency and understands that culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse individuals. All policies and procedures are intended to reflect the integration of diversity and cultural literacy throughout the Department. To the fullest extent possible, information, services and treatments will be provided (in verbal and/or written form) in the individual's preferred language or mode of communication (i.e. assistive devices for blind/deaf)