alameda county behavioral health MENTAL HEALTH & SUBSTANCE USE SERVICES	By: _____ **Karyn L. Tribble, PsyD, LCSW** Behavioral Health Director
POLICY TITLE **Drug Medi-Cal Organized Delivery System (DMC-ODS) of Care Coordination, Continuity of Care, and Transition of Care of Medi-Cal Specialty Mental Health, Substance Use Disorder, and Primary Care Services**	**Policy No: 150-1-3** **Date of Original Approval**: 12/16/19 **Date(s) of Revision(s):**

PURPOSE

This policy outlines the responsibilities of Drug Medi-Cal Organized Delivery System (DMC-ODS), Alameda County Behavioral Health (ACBH) to coordinate Medi-Cal Specialty Mental Health Services (SMHS), Substance Use Disorder Services (SUDS), and Primary Care Services (PCS) for ACBH clients, and to ensure continuity of care.

AUTHORITY

- DHCS-Mental Health Plan Contract
- Title 22, CCR Sections 51303 and 54301
- 42 CFR, part 438.62
- 42 CFR, part 438.10(d)
- Mental Health Substance Use Disorder Information Notice 18-059

SCOPE

All ACBH DMC-ODS county-operated programs in addition to entities, individuals, and programs providing mental health and substance use disorder services under a contract or subcontract with ACBH.

POLICY

I. Under the DMC-ODS Plan, beneficiaries will be assessed and have access to a full continuum of SUD services with an emphasis on engaging the beneficiary in the right care, at the right time, with the right provider, utilizing the principles of the American Society of Addiction Medicine (ASAM) Placement Criteria.

II. Beneficiaries will be linked to all levels of care within the DMC-ODS through the Substance Use Access and Referral Helpline. Additional DMC-ODS access points have been developed for special populations, and include: Center Point's Criminal Justice Case Management Program (AB 109), Drug Court, and Cherry Hill Detox.

III. Referrals to the SUD Access and Referral Helpline may come through a variety of community sources including, specialty mental health treatment providers, managed care plans, emergency rooms, Integrated Behavioral Health (IBH) Coordinators at Federally Qualified Health Centers (FQHC), providers of homeless assistance and outreach, housing resource centers, Child Welfare, and Alameda County Care Connect care managers.

IV. Beneficiary's treatment services shall be coordinated across Levels of Care (LOC); from the initial point of contact, first call or in-person visit, first offered appointment, referral, intake/assessment and determination of medical necessity, treatment planning, transition planning, discharge, and recovery support services. Prior to any changes in the LOC, the SUD service provider shall conduct an Assigned Level of Care (A-LOC) re-assessment. When a change in the LOC is confirmed (and authorized for Residential Treatment and Recovery Residence), the treatment plan must be updated to reflect the change in SUD treatment and frequency of services.

PROCEDURE

I. Beneficiaries shall have an ongoing source of care appropriate to their needs with an SUD provider case manager designated as primarily responsible for coordinating services. Beneficiaries will be informed as to whom to contact, and how to contact, their designated case manager upon initial intake into an SUD treatment program.

II. Activities involving care coordination, including intake, assessment, delegation of care coordination activities, referral, and follow up after referral will be supported by the utilization of the Community Health Record (CHR) when available and appropriate, as permissible via the client's signed release of information.

III. Coordination of services will be furnished to beneficiaries:

A. Between settings of care, including appropriate discharge planning.

B. With the services the beneficiary receives from any other managed care organizations or provider of health services, including primary care, specialty mental health services, and care management / health home services

1. When a beneficiary has not had at least one outpatient primary care appointment for the past 12 months, the SUD treatment provider will coordinate with a primary care provider to schedule an outpatient primary care appointment for the client, within the first two weeks of treatment.

2. If a client's health home is at an FQHC, and the client is determined to be stable and assessed to be at ASAM Level 0.5 Early Intervention, the client can be transitioned to the FQHC IBH provider for ongoing SUD care:

i. When a beneficiary is transitioned to FQHC for ongoing care or referred to FQHC for outpatient medical appointments, the following information needs to be exchanged, contingent upon written beneficiary consent to share the information, between SUD Treatment Provider and FQHCs:

a. Mandatory Discharge Summary including:
i. Psychiatric History
ii. Medical History
iii. Current Medications

iv. Most Recent Laboratory Work
v. Treatment Summary
vi. Social Supports/Strengths/Functional Status
vii. Possible Triggers/Stressors to be aware of such as death anniversaries, unstable housing, etc.

b. Integrated Behavioral Health Care Coordinators (IBHCCs) at the Alameda Health Consortium eight FQHCs may work with the appointed SUD Treatment provider to facilitate appointments at FQHC for clients determined ready for primary care connection.

c. IBHCCs at FQHC can work with SUD Treatment provider to connect a beneficiary with community behavioral health resources if the wait time for the FQ's behavioral health services is too long or if they do not have language capacity.

d. Regular access and communication among FQHC IBH clinician, primary care practitioner, and SUD treatment provider to promote ongoing care coordination and assess progress.

C. With the services the beneficiary receives in fee for service Medicaid.

D. With the services the beneficiary receives from the community and social support providers.

IV. Beneficiaries will access care through the following access points:

A. 24-hour toll free Substance Use Referral and Access Line

B. Walk-ins or referrals directly to Outpatient, Intensive Outpatient, Recovery Support Services, or Opioid Treatment Programs.

C. Walk-ins or referrals to an in-person ASAM screening conducted by Center Point's Criminal Justice Case Management program or Drug Court case management services

D. In-person ASAM screenings and treatment referrals conducted at Cherry Hill Detox for beneficiaries receiving withdrawal management services

V. Initial screenings of each beneficiary's needs shall be conducted upon intake.

A. At every access point in Alameda County, beneficiaries will be triaged for risk and for other needs for assistance to address potential barriers to successful engagement and retention in SUD services and will be advised of the benefits to which they are entitled under the DMC-ODS waiver. Initial screenings will be completed using a universal screening tool based on the ASAM dimensions (ACBH-approved brief ASAM tool) by trained screening staff.

B. Upon screening, the beneficiary will be referred/linked to the appropriate ASAM level of care (LOC) to ensure there are no disruptions in services. Placement considerations include results from the ASAM screening, geographic accessibility, threshold language needs, and the beneficiary's preferences. The beneficiary will be referred to ACBH SUD network providers for an intake appointment for the following services:

1. ASAM 1.0 and 2.1 Outpatient, Intensive Outpatient, and Recovery Support Services
2. ASAM 1.0 and 2.1 Perinatal Outpatient, Intensive Outpatient, and Recovery Support Services
3. ASAM OTP 1.0 Opioid Treatment Programs
4. ASAM 3.2 Residential Withdrawal Management
5. ASAM 3.1, 3.3 or 3.5 - Residential services
6. ASAM 3.1, 3.3 or 3.5 - Perinatal Residential
7. Recovery Residence (adjunct to outpatient, intensive outpatient or recovery support)
8. Medication Assisted Treatment Services

C. Upon screening, the beneficiary will be referred/linked to the appropriate health care and social services, including, but not limited to, primary care, mental health services, and housing resources and services, to ensure there are not disruptions in these services. Placement considerations include results from the ASAM screening, geographic accessibility, threshold language needs, the beneficiary's current service enrollment, and the beneficiary's preferences.

VI. ACBH and its subcontracted providers may share with the California Department of Health Care Services (DHCS) or other managed care organizations or providers of care management serving the beneficiary the results of any identification and assessment of the beneficiary's needs to facilitate effective care coordination, and to prevent duplication of case management activities or other services, with appropriate client Release of Information in place.

VII. Each provider furnishing services to beneficiaries will maintain and share with other treating providers and other relevant services associated with the beneficiary, as appropriate, a beneficiary's health record only in accordance with lawful and professional standards. When appropriate, and with the beneficiary's written permission, this function will be facilitated by the use of the Community Health Record (CHR).

VIII. In the process of coordinating care, each beneficiary's privacy will be protected in accordance with privacy requirements in 45 C.F.R. parts 160 and 164 subparts A and E and 42 CFR Part 2, to the extent that they are applicable.

A. Each beneficiary must have signed a 42 CFR Part 2 compliant Release Of Information for ongoing communication and collaboration with other managed care organizations or provider of health services, including primary care, specialty mental health services, and care management / health home services

IX. For beneficiaries identified through the assessment process as having special health care needs, including co-occurring disorders:

A. At intake, and ongoing throughout SUD treatment, treatment provider will assess to identify any ongoing conditions that may require treatment for co-occurring disorders or additional needs requiring services delivered by other care providers. The assessment will indicate such conditions in the treatment plan and will ensure linkage to the appropriate service providers, including complementary programs specialized in treating the other type of condition.

B. SUD Providers will produce a treatment plan meeting the criteria below for beneficiaries with co-occurring mental health, physical health, or other needs requiring supportive services (e.g. housing, child welfare, probation) determined to need a course of treatment or regular care monitoring. The treatment plan shall be:

1. Developed with beneficiary participation, and in consultation with any providers of care or care management for the beneficiary;

2. Developed by a person trained in person-centered planning using a person-centered process and a plan as defined in 42 CFR §441.301(c)(1);

3. Approved by the County Utilization Management team in a timely manner, when approval is required for residential treatment authorization purposes.

4. Reviewed and revised upon reassessment of functional need, at least every 90 days, or when the beneficiary's circumstances or needs change significantly, or at the request of the beneficiary per 42 CFR §441.301(c)(3);

C. SUD Providers will ensure that beneficiaries who need treatment for co-occurring mental health or physical health needs, and/or who require services to address potential barriers to successful engagement with SUD treatment, have access to services from other qualified providers as appropriate for the beneficiary's condition(s). This access will be facilitated through the SUD Provider's referral to managed care plan, primary care provider, Federally Qualified Health Center, provider of Care Management / Health Home Services, homeless assistance, supportive housing, the ACBH ACCESS line for specialty mental health services, or other agencies. SUD treatment providers will be responsible for coordinating SUD treatment with the other agencies and services to which the beneficiary is referred during the beneficiary's episode of SUD treatment.

X. Intake, Assessment, and Authorization

A. Beneficiaries referred to a residential program will be connected to a contracted Care Navigator provided by the Substance Use Referral & Access Line, Drug Court, or the Criminal Justice Case Management Program.

1. The Care Navigator will maintain at least monthly contact with the beneficiary through the time that he/she is engaged in residential treatment. The primary job of the Care Navigator will be to ensure that the beneficiary successfully connects with and engages in residential treatment; in addition the Care Navigator will ensure that the beneficiary successfully connects with subsequent treatment services recommended post-residential. For a beneficiary who is experiencing homelessness at the time of entry into residential treatment, the Care Navigator will ensure that the beneficiary is assessed for potential housing assistance that may be accessed through a Housing Resource Center (Alameda County's coordinated entry system for homeless assistance).

2. In the event that a beneficiary is placed on a residential waitlist, the Care Navigator will ensure that interim services are provided during the period of time that the beneficiary is waiting for SUD treatment.

B. The residential treatment provider will conduct a comprehensive face to face ASAM assessment within five (5) days of intake appointment at the residential program; the provider will submit a prior authorization request to Utilization Management (UM) on the date of intake, and submit the Initial Medical Necessity Criteria form and final ASAM determination within 5 business days. UM will render an authorization decision within one business day of receipt of this request.

C. Alameda County DMC-ODS outpatient, intensive outpatient and recovery services providers will aim to admit eligible beneficiaries within five (5) business days, but will admit all appropriate beneficiaries no later than ten (10) business days from the date the initial screening was completed. For Opioid Treatment Programs, the DMC-ODS will provide an appointment within three (3) business days from request to appointment.

D. The final LOC determination for placement will be based on the comprehensive assessment, and may override the determination from the initial screening process. In the event that a full comprehensive assessment yields a different LOC, the provider shall be responsible for transitioning the beneficiary to the appropriate level of care, which may include transitioning (and providing or arranging transportation) to another provider facility. For residential cases, the provider may work with the beneficiary's Care Navigator to successfully transition to a new provider.

XI. Re-Assessments

A. Re-assessments provide an opportunity for treatment staff to review and document a beneficiary's progress by comparing the most recent functioning and severity levels to those at intake. All six (6) ASAM dimensions will be reviewed to determine the

beneficiary's current level of functioning and severity. The purpose of the re-assessment will be to determine whether the beneficiary continues to require the current LOC, or whether an alternative LOC may be more appropriate.

1. Treatment staff will conduct re-assessments at the following intervals:

Level of Care (LOC)	Re-Assessment Maximum Timeframe
Residential Withdrawal Management, Level 3.2	5 days
Residential Treatment, Level 3.1, 3.3, 3.5	30 days
Intensive Outpatient, Level 2.1	60 days
Outpatient Treatment, Level 1.0	90 days
Opioid Treatment Programs	90 days
Medication Assisted Treatment	1 year

2. Re-assessments may also occur at times of significant change or could warrant a transfer to a higher or lower level of care. Changes that could warrant such re-assessments may include, but are not limited to:

   i. Achieving Treatment Plan goals
   ii. Inability to achieve treatment plan goals despite amendments to the treatment plan
   iii. Reoccurrence of severe symptoms or new issues that cannot be addressed adequately in the current LOC
   iv. Beneficiary request

XII. Transitioning between Levels of Care and the Role of Care Coordination, including specialized Care Navigators for beneficiaries receiving Residential Services

A. Alameda County contracts with the following agencies to provide care navigation for beneficiaries served in Residential: CenterPoint (Substance Use Access and Referral Line, AB109 Criminal Justice Case Management), and Drug Court case management. Care Navigators from these organizations will provide a specialized form of case management to beneficiaries from the point at which they initiate an ASAM screening that yields a Residential recommendation. The Care Navigator will focus on helping clients effectively engage in Residential Treatment. To do this, the Care Navigator will maintain at least monthly contact (sometimes weekly) with the beneficiary during his/her course of residential treatment; this contact will include communication with the treatment provider. In addition, the Care Navigator will ensure that the beneficiary successfully connects with any recommended subsequent treatment services following the course of treatment in residential.

B. For beneficiaries served in residential treatment, the treatment provider will be responsible for providing service coordination for beneficiaries who have an assigned Care Navigator (from Substance Use Referral and Access Line, Drug Court, or the Criminal Justice Case Management Program). Service coordination is defined as case management services that assist the beneficiary to access needed medical, educational, social, prevocational, vocational, and rehabilitative or other community services. In addition, the residential treatment providers will be responsible for making referrals to other levels of care within the DMC-ODS, and will collaborate with the assigned Care Navigator to ensure that the beneficiary has a smooth transition to the next level of care.

C. Prior to a change in the level of care, all SUD service providers must conduct an A-LOC re-assessment. When a change in level of care is confirmed, the treatment plan must be updated to reflect the change in SUD treatment and frequency of services.

D. For beneficiaries not served in Residential, the primary case management duties (which include care coordination, and service coordination) will be provided by the SUD treatment provider. The primary case manager must collaborate in the transitioning of a beneficiary to a lower or higher level of care.

E. LOC transitions for non-residential providers will occur within five (5) to ten (10) business days. The exception to this will be when an individual requires residential treatment— for this the initial authorization process will be in effect.

F. At program exit, whether due to a change in LOC based on re-assessment, or treatment completion, the SUD treatment provider staff from the existing program will coordinate with the "new" SUD treatment provider in order to help facilitate transfer of care and provide support while the beneficiary engages in the new LOC services. It is expected that the treatment provider's case managers ensure "warm hand-offs" between LOC, which may require collaboration from staff at both SUD programs. This collaboration may include, but is not limited to, communication though emails or phone calls, transportation or other practical supports, and is contingent upon client's written consent to share the information.

G. For beneficiaries exiting the DMC-ODS, i.e. not transitioning to a new SUD program or level of care, to the extent appropriate and based on client consent, the treatment provider should coordinate and communicate with other care providers or care managers serving the beneficiary for the purpose of facilitating a "smooth landing" and to prevent negative outcomes such as victimization, crisis, or homelessness.

XIII. Monitoring Plan For Care Coordination

A. In order to monitor care coordination and continuity of care across the DMC-ODS, ACBH will require all SUD contracted service providers (with the exception of Opioid Treatment Programs, and certain out-of-county providers who serve small amounts of clients as needed) to enter beneficiary records into Clinicians Gateway (CG), the county's centralized electronic health record system (EHR). CG captures beneficiary's SUD treatment services from the initial point of contact, first call and first offered appointment, referral, intake and assessment and determination of medical necessity, treatment planning, progress notes,

transition planning for Recovery Support Services and discharge planning. For purposes of tracking and monitoring care coordination and service coordination, SUD treatment providers authorized to provide case management will be required to use specially developed procedure codes in CG to track time spent performing these case management activities on behalf of beneficiaries. The two case management codes will be as follows:

- **Care Coordination** – Activities associated with providing for seamless transitions of care for beneficiaries in the DMC-ODS system of care without disruption of services.
- **Service Coordination** – Services that assist beneficiaries to access needed medical, mental health, housing, educational, social, prevocational, vocational, rehabilitative or other community services.

B. ACBH contracted SUD treatment providers must ensure that beneficiaries are supported through continuity of care through the provision of individual case management services. The following procedures will take place to monitor care coordination and continuity of care:
   - ACBH SUD operations team – will review CG reports/dashboards to determine whether care coordination and service coordination is occurring, and address deficiencies where they exist. This team will also monitor timely access to intake assessment, residential waitlist and bed capacity, timely treatment plan updates.
   - QA – annual chart audits of all SUD providers will monitor adherence to these procedures in such areas as re-assessment periodicity, thoroughness of assessment including health conditions and co-occurring conditions, adequate provision of or support for linkages to services for needs identified, proper releases of information in place, and evidence of coordination of services as detailed in these procedures.
   - Bi-Weekly operational meetings – will address and identify operational challenges within these procedures. Meetings will include representatives from SUD Operations, Center Point Care Management, Drug Court representative, and Utilization Management
   - Regular Meetings with County's Medi-Cal Managed Care Plans - ACBH coordinates with the managed care plans (Alameda Alliance and Anthem Blue Cross). The health plans will designate an individual to serve as the liaison to ACBH regarding SUD services. The purpose of these meetings will be to review referral, care coordination across systems (managed care plan and SUD Plan), and information exchange protocols and processes.

CONTACT

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DISTRIBUTION

This policy will be distributed to the following:

- ACBH Staff
- ACBH County and Contract Providers

- Public

ISSUANCE AND REVISION HISTORY

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DEFINITIONS

Term	Definition
ACBH	Alameda County Behavioral Health
Alameda County Care Connect	Alameda County's Whole Person Care Program
ASAM	American Society of Addiction Medicine
CHR	Community Health Record
DMC-ODS	Drug Medi-Cal Organized Delivery System
FQHC	Federally Qualified Health Center
IBH	Integrated Behavioral Health
IBHCC	Integrated Behavioral Health Care Coordinators
LOC	Level of Care
PCS	Primary Care Services
SMHS	Specialty Mental Health Services
SUDS	Substance Use Disorder Services