



County of Alameda
Behavioral Health Care Services Department
Substance Use Disorders System of Care

County of Alameda Drug Medi-Cal Organized Delivery System

IMPLEMENTATION PLAN PROPOSAL

July 2016

CONTACT PERSON:
Tom Trabin, PhD, MSM
County Alcohol and Drug and Program Administrator

This proposal is dedicated to David Abramson, who helped launch Alameda County BHCS' effort to develop its organized delivery system for SUD services under the Medi-Cal Waiver. His fingerprints are all over this Proposal. He approached the work with inspired vision, passion, deep knowledge and experience, and a lot of passion and heart. Were it not for his health conditions, he would have loved to join us in seeing the effort through.

Thanks Dave!

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ACRONYM INDEX

AB109	Assembly Bill 109
ACCESS	Acute Crisis Care and Evaluation for System-wide Services
ADAP	Association of Drug and Alcohol Program Administrators
ADP	Alcohol and Drug Program
AOD	Alcohol and Other Drugs
ASAM	American Society of Addiction Medicine
BASN	Bay Area Service Network
BHCS	Behavioral Health Care Services
CAARR	California Association for Addiction Recovery Resources
CADPAAC	County Alcohol and Drug Program Administrators Association
CalOMS	California Outcome Measurement System
CBHDA	County Behavioral Health Directors Association
CBO	Community Based Organizations
CCAPP	California Consortium of Addiction Programs and Professionals
CCP-EC	Community Corrections Partnership - Executive Committee
CDCR	California Department of Corrections & Rehabilitation
CFR	Code of Federal Regulations
DATAR	Drug and Alcohol Treatment Access Report
DHCS	Department of Health Care Services
DMC-ODS	Drug Medi-Cal Organized Delivery System
E.H.R.	Electronic Health Record
EBP	Evidence Based Practice
EQRO	External Quality Review Organization
FFP	Federal Funds Participation
FQHC	Federally Qualified Health Center
GSA	General Services Administration
INSYST	Information System
IOT	Intensive Outpatient Treatment
JGPP	John George Psychiatric Pavilion
LOC	Level of Care
LPHA	Licensed Practitioner of the Healing Arts

MAA	Medical Administrative Activities
MAT	Medication Assisted Treatment
MHSA	Mental Health Services Act
MOU	Memorandum of Understanding
NAMI	National Alliance of Mental Illness
NTP	Narcotic Treatment Program
OIG	Office of the Inspector General
OP	Outpatient Treatment
PATH	Promoting Access to Health
PES	Psychiatric Emergency Services
POCC	Pool of Consumer Champions
PSQ	Problem Severity Questionnaire
QA	Quality Assurance
QI	Quality Improvement
QIC	Quality Improvement Committee
QM	Quality Management
RFP	Request for Proposal
RR	Recovery Residence
RROT	Recovery Residence + Outpatient Treatment
RT	Residential Treatment
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPT	Substance Abuse, Prevention and Treatment
SBIRT	Screening, Brief Intervention, Referral and Treatment
SLEB	Small, Local, and Emerging Businesses
SMI	Serious Mental Illness
STCs	Standard Terms and Conditions
SUD	Substance Use Disorder
TCM	Transitional Care Management
UA	Urine Analysis
UNCOPE PLUS	Used-Neglected-Cut Down-Objected-Preoccupied-Emotional Discomfort

PART I

PLAN QUESTIONS

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

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

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

2. How was community input collected?

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

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

- ☐ Monthly
- ☐ Bi-monthly
- ☐ Quarterly
- ☒ Other method(s) (explain briefly): *As needed. Some entities such as direct care providers may initially need to meet more regularly than monthly, and others such as community parties may need to meet only quarterly*

Review Note: One box must be checked.

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

- ☒ SUD, MH and physical health representatives in our county have been holding regular meetings to discuss other topics prior to waiver discussions
- ☐ There were previously some meetings, but they have increased in frequency or intensity as a result of the Waiver
- ☐ There were no regular meetings previously. Waiver planning has been the catalyst for new planning meetings.
- ☐ There were no regular meetings previously, but they will occur during implementation.
- ☐ There were no regular meetings previously, and none are anticipated.

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

REQUIRED

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

How will these services be provided?

- ☐ All county operated
- ☒ Some county (*physician consultation*) and some contracted (*all others*)
- ☐ All contracted

Optional

- ☒ Additional Medication Assisted Treatment

- ☐ Partial Hospitalization
- ☒ Recovery Residences
- ☐ Other (specify)

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

- ☒ Yes (required)
- ☐ No

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

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

- ☒ Yes (required)
- ☐ No

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

- ☒ Yes (required)
- ☐ No

9. Each county's Quality Improvement Committee will review the following data at minimum on a quarterly basis since external quality review (EQR) site reviews will begin after county implementation. These data elements will be incorporated into the EQRO protocol:

- Number of days to first DMC-ODS service/follow-up appointments at appropriate level of care after referral and assessment
- Existence of a 24/7 telephone access line with prevalent non-English language(s)
- Access to DMC-ODS services with translation services in the prevalent non-English language(s)
- Number, percentage of denied and time period of authorization requests approved or denied

- ☒ Yes (required)
- ☐ No

PART II

PLAN DESCRIPTION (Narrative)

In this part of the plan, the county must describe certain DMC-ODS implementation policies, procedures, and activities.

General Review Notes:

- Keep an electronic copy of your implementation plan description. After DHCS reviews your plan description, you may need to make revisions
- Counties must submit a revised plan to DHCS whenever the county requests to add a new level of service.

NARRATIVE DESCRIPTION

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

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

BHCS conducted extensive collaborative processes, many of which are ongoing, to plan the DMCS-ODS service system. In the following description of that process, the county entities, community parties and other stakeholders are organized according to the categories listed in Part 1, Question 1 of the Implementation Plan template:

A. Within BHCS:

- 1) Beginning in 2009, leaders across BHCS' functional units and systems of care held numerous discussions to envision what an ODS would entail for substance use disorder (SUD) treatment, develop commitment, and begin gradual steps toward implementation.
- 2) BHCS began successful pilots in 2011, initiated by prison reform through the restructuring of Bay Area Services Network (BASN) and the advent of Assembly Bill (AB) 109 for provision of State-funded SUD treatment and recovery services to parolees and probationers living in Alameda County.
- 3) BHCS began department-wide discussions and plans to broaden the ODS to the entire county population several years ago, prompted by increased demand for an ODS referral system from other county stakeholders prompted by the 1115 Waiver Bridge to Health Care Reform and the expanding influence of prison reform. We were involved with our statewide county association [County Alcohol and Drug Program Administrators' Association of California (CADPAAC) and then County Behavioral Health Directors Association of California (CBHDA)] and DHCS in helping to formulate the waiver, and held

internal discussions about its implications for changes we would have to make with the eventual implementation.

In 2015 BHCS established an internal Steering Committee for the DMC Waiver Implementation Plan, and eight Task Forces: Provider Clinical/Business Model Redesign, Fiscal Cost and Revenue Projections, Billing Codes, Quality Management, Recovery Residences, Screening and Referral Center, Training, and Co-occurring Conditions. Beginning in September 2015, each Task Force and the Steering Committee met regularly, on average once a month. Some of the Task Forces will continue to meet on an as-needed basis, providing a useful planning infrastructure for the Waiver implementation.

B. With the contracted network of CBO providers:

- 1) The BHCS Behavioral Health Director, Deputy Director, and Alcohol and Drug Program Administrator meet monthly in a two-hour meeting with the leaders of the contracted CBO providers and BHCS managers of SUD operations. The meetings are well-attended by about 40-50 people, and the discussions are open, lively and engaging. BHCS leadership convey waiver updates and their implications, and providers share both their suggestions and concerns. This meeting has proved to be an excellent forum for preparing a collaboration between BHCS and contracted providers for the waiver implementation.
- 2) BHCS established with providers several ongoing workgroups specific to major treatment modalities (e.g., Residential Treatment, Recovery Residences, Adult Outpatient and Intensive Outpatient, Adolescent Outpatient, and Perinatal). Through these workgroups the attendees can discuss the implications of the waiver implementation in more depth and specifically for their programs. Each of these workgroups met with representatives of BHCS' Provider Clinical/Business Model Redesign Workgroup for detailed discussions of workflow and staffing redesign. The workgroups will continue to meet periodically as new issues arise.

C. With representatives of the SUD providers' association:

The CBO providers have an executive Association of Drug and Alcohol Program Administrators (ADAP) that meets regularly with BHCS executives. The agenda includes DMC Waiver developments and their impact upon the providers' operations, funding and contracts. ADAP provides advocacy and support to Alameda County BHCS (and our County partners) to assist in developing policies and procedures and systemic change aimed at promoting high-quality, accessible, and cost-effective SUD treatment and recovery services to Alameda County residents. ADAP representatives regularly attend our SUD monthly meetings as well as other SUD-related forums, events and trainings.

D. With FQHCs and other physical health care providers:

- 1) In 2011, BHCS began a concerted effort to help the contracted FQHC providers build an integrated behavioral health capacity. This included Screening, Brief Intervention, Referral and Treatment (SBIRT) training for the FQHCs which in turn led to the need for increased coordination between primary care and specialty substance use treatment through the BHCS contracted providers. These efforts required ongoing meetings between BHCS and primary care, the development of materials to streamline referral and coordination efforts, and increased development of BHCS' ODS for SUD.

- 2) As the DMC-ODS Waiver implementation planning began, BHCS met further with the FQHC providers through their association to discuss and refine referral and coordination policies and procedures. These meetings are expected to continue on an ongoing basis throughout the Waiver implementation.
- 3) In July 2016, the BHCS Alcohol and Drug Program Administrator began meeting with the Health Care Services Agency's newly formed Integrated Care Planning Committee. The Committee focuses on improvement of care coordination and, where possible, integration of care systems.

E. With Medi-Cal Managed Care Plans:

In 2011, BHCS began working with the county's Medi-Cal Managed Care Plans to plan care coordination for an anticipated Dual Eligibles pilot that did not come to fruition, the Bridge to Health Care Reform 1115 Waiver, and later for covered patients under the Affordable Care Act. The primary Medi-Cal Managed Care Plan is Alameda Health Alliance and its managed behavioral health care subcontractor Beacon Health Strategies. A smaller plan is Anthem Blue Cross.

The discussions focused on: a) defining criteria for mild, moderate and severe mental health and substance use conditions, 2) determining which payor entities (managed care plans or county) and their respective provider networks would be responsible for which level of each condition based on severity, c) how the network providers for each payor entity would cross refer to each other for those and for physical health conditions, and d) how information would be shared between payor entities and their network providers to facilitate case management and care coordination across various behavioral health and physical health conditions.

The discussions produced important agreements and resulted in an MOU that codified the agreements. BHCS is now arranging meetings with leaders of the Health Care Services Agency to whom we report, to plan further arrangements with the Managed Care Plans that focus on SUDs in more detail. We will then draft amendments to the MOU and propose them to the leaders of the Managed Care Plans for review and discussion. We intend to complete amendments to the existing MOU, vet them with the County Counsel and Managed Care Plans in October, and finalize the amended MOU by December 31, 2016 .

F. With Clients/Client Advocate Groups:

- 1) BHCS, in partnership with community stakeholders, participate in regular occurring county meetings on criminal justice re-entry issues. These meetings include the monthly Joint Re-entry Meeting of county stakeholders and county agency representatives, the monthly Community Advisory Board to the Community Corrections Partnership Executive Committee, and several Town Hall meetings sponsored by the Board of Supervisors. Among the prominent issues put forth by client advocacy groups are access to substance use treatment for the re-entry population. At recent meetings, BHCS has provided information and facilitated discussions about the impact that the DMC ODS Waiver implementation is likely to have on services for the re-entry population.
- 2) BHCS met with National Alliance on Mental Illness (NAMI) members at a regularly scheduled county meeting of NAMI members. The County ADP Administrator presented information to the group about the DMC ODS Waiver, invited input, and led a discussion on how the Waiver implementation might be designed to benefit consumers with co-occurring mental health and substance use disorders.
- 3) BHCS met with the Harm Reduction and Co-Occurring Committee and the Veterans Committee within the Pool of Consumer Champions, a countywide client advocacy group. The County ADP Administrator presented information to the group about the DMC ODC Waiver, invited input, and led a discussion.

G. With the County Executive Office:

The BHCS Director has already spoken with the appropriate representatives in the County Executive Office about the likely need for additional County General Funds and streamlining of processes for hiring additional staff to help resource the efforts necessary to successfully launch our Implementation Plan. More of these meetings are planned in the near future.

H. With County Public Health:

The County ADP Administrator met with the Public Health Department staff—specifically the public health nurses—to overview the substance use treatment system of care and how to refer into it, and to preview our preparations for the DMC-ODS Waiver. The County Alcohol and Drug Program Administrator also met with representatives of a newly emerging FQHC operated by the Alameda County Health Care Service Agency about the waiver and specifically how we might coordinate efforts regarding medication-assisted treatment. The County Alcohol and Drug Program Administrator will participate in future meetings going forward with Public Health and the Health Care Services Agency concerning these coordination issues.

I. With County Social Services:

The County ADP Administrator, members of BHCS' SUD Team, and the Director of BHCS' Children's System of Care met with the leaders of Children and Family Services on several occasions to formulate new policies and procedures for assessments and referrals into BHCS' DMC-ODS under the Waiver. BHCS will arrange more of these meetings, some of which will involve leadership from the Family Drug Court and the county's three Dependency Courts.

J. With Law Enforcement, Court and Probation:

- 1) BHCS established close working relationships with all major departments and offices of law enforcement over a period of many years. This intensified in 2011 when BHCS established a pilot ODS for SUD treatment based upon ASAM Criteria. The pilot focused on persons involved with the criminal justice system and was prompted by the passage of AB109 and by CDCR's restructuring of the BASN Program for Parolees. In 2011, Realignment impacted the BHCS contractual and working relationship with Drug Court, increasing BHCS involvement. After the passage of Proposition 47 in 2014, Drug Court worked with BHCS and other criminal justice agencies to change how it incentivizes treatment, and worked with BHCS to transform its referral procedures to conform to ASAM Criteria. We learned from these pilots and are now expanding them to the general population for the 1115 Drug MediCal Waiver.
- 2) Prompted by prison reform and an increased county responsibility to reduce jail recidivism, our county criminal justice agency counterparts are increasing their referrals of clients to SUD treatment. Accordingly, BHCS is increasing meetings with criminal justice agencies to discuss enhancements to SUD treatment capacity and to innovations for the criminal justice population. The DMC ODS waiver figures prominently in these discussions, both in fiscal considerations and also in new policies, procedures and criteria for how prospective clients are assessed, referred and treated for SUDs.
- 3) BHCS recently launched an innovative Case and Care Management Program for persons re-entering the community from county jail who have a serious mental illness and, in many cases, a co-occurring substance use disorder. The program includes a primary focus on assisting re-entering clients in enrolling in Medi-Cal.

K. With Providers of Recovery Residences:

- 1) In 2011, prompted by AB109 and revisions to BASN, BHCS conducted an RFP for its provider network serving these two funding streams, including Recovery Residences. At that time, BHCS established quality standard requirements for those residences that were included as eligibility criteria for bidding and resulting contracts. It served as an excellent pilot for a capacity expansion through the upcoming DMC ODS Waiver.
- 2) For the DMC ODS Waiver, BHCS engaged the established Recovery Residence providers in meetings to discuss the ongoing implementation of these standards and what might change. As a result of the discussions, decisions were made to continue implementing the standards, to add additional standards, and to increase rates to make the implementations affordable to the providers.

L. With Health Information Technology Stakeholders:

BHCS recently selected Echo Management's ShareCare EHR for its mental health and substance use disorder systems of care. It established multiple workgroups of stakeholders to provide input on the design of the EHR, including a workgroup for SUD providers. BHCS expects the Waiver to increase provider documentation requirements substantially, as well as billing and other data entry requirements. The EHR, if designed well to support these functions, will help the Waiver implementation significantly. The workgroup is expected to meet regularly during the next fiscal year to suggest design elements based upon considerations of workflow. The goals are to support efforts to meet billing and quality assurance requirements, facilitate health information exchange for improved care coordination while respecting privacy and security regulations, and use performance and outcome measures to support quality management and decision support.

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

Review Note: A flowchart may be included

One of the defining characteristics of most persons referred for substance use treatment is their ambivalence about engaging in treatment. We appreciate and respect the courage it takes for many of these persons to enter into a treatment program that might require fundamentally remaking their lives. Consequently, we think it incumbent upon the organized delivery system we are developing to enable easy and timely access to care while these prospective clients are inclined to go. At the same time, we would like those with the most intensive treatment needs to first go through an ASAM-based screening and referral so they are matched to the level of care and treatment modality that best meet their situation. We also would like a good match that best meets their needs to continue as they change, which requires ongoing reassessments, adjustments of treatment plans, and possible transfers to other levels of care and treatment modalities.

Alameda County offers an extensive continuum of care through contracted community-based organizations, which can be complex for a referral source or prospective client to navigate. Screening and referral portals can help insure a best match of level of care and treatment approach customized to the needs of prospective clients. They can also be perceived as barriers to access. In our design of an organized delivery system, we want to provide multiple types of entryways into treatment that provide excellent person-treatment matching when most needed, and direct access when pre-screening seems less important. In either case, the client begins actual treatment with a comprehensive assessment at a treatment site, during which medical necessity is determined and shapes the most appropriate level of care and treatment plan.

This section on Client Flow first depicts in subsections A – C how clients seeking Residential Treatment or Recovery Residence plus Outpatient Treatment access and use treatment services, beginning with screening and referral through one of four portals. In subsection D we depict how clients access and use other types of treatment which do not require initial screening and referral through a portal.

- A. Client Flow for Initial Screening and Referral Process (for a Visual Flow Chart, please see Appendix A-1)
- Adults requesting residential treatment or recovery residence combined with outpatient treatment must first go through an ASAM-based screening and referral process through one of our designated portals. Each portal is staffed with skilled clinicians who are state-certified alcohol and drug counselors, who receive supervision from LPHAs or Certified AOD Counselor - Clinical Supervisors. They are each individually trained in the application of ASAM criteria for effective client-treatment matching. Briefly, these portals are:
- 1) Substance Use Residential Helpline: In operation 24/7, the Helpline is intended for persons seeking or referred for residential treatment or recovery residence combined with SUD outpatient treatment. Callers may be self-referred or may be referred by any of a number of referral sources (e.g., physical health care providers, mental health providers, county ACCESS Center, county Child and Family Services, family member or friend, etc.). Outpatient information and referrals are also provided. Normal operating hours are 8am to 9pm weekdays. For persons calling outside of those hours, the call is transferred to Crisis Support Services of Alameda County (Crisis Support Services) where a trained crisis counselor addresses emergencies immediately, provides helpful information and support around non-emergent requests, and conveys non-urgent messages to the Substance Use Residential Helpline staff, who contact the caller the next business day.
 - 2) AB109 Criminal Justice Care Management: In operation during normal business hours throughout weekdays for clients with realigned AB109 offenses who are referred by Alameda County Probation Department for assessment and referral. The clinicians receive handoffs in person from Probation Officers at their North and South County offices.
 - 3) Cherry Hill Detox: In operation 24/7, with discharge planning services to all levels of substance use treatment and other services.
 - 4) Drug Court: In operation weekdays for persons charged with drug-related crimes willing to engage in treatment as a plea bargain condition at a level of care determined by Court clinical staff.

Through each of these portals, the screening clinician determines the prospective client's coverage eligibility and their situation across the six ASAM Criteria dimensions. Then they determine the best match for the client in level of care and treatment modality. In the case of the Helpline, if the telephonic screening seems insufficient to make a placement decision, then the clinician will make an in-person appointment with the client at either the Helpline's North or South County Office (whichever is most convenient for the client) within a time period not to exceed two business days.

In the BHCS DMC-ODS, prior authorization for a specific level of care is made only for residential treatment

or recovery residence plus outpatient. BHCS will monitor timely access to ensure services are provided within 24 hours or less of the screening and/or assessment. BHCS uses a number of factors to estimate call volume and authorization requests under the new system. We then worked with our contractors to estimate FTEs necessary to be responsive. Each contractor is in the process of hiring staff for the specific activity, and will have that staff hired and trained by the time waiver implementation begins. We will use the monitoring to make adjustments to the process, including the addition of more staff if needed.

When a screening and referral portal clinician, using the ASAM Criteria- based level of care criteria, determines that another level of care is most appropriate, the clinician will refer the client to that level of care without an accompanying authorization.

B. Client Flow for Initial Intake and Assessment with the Treatment Provider

Clients referred into treatment by a screening portal operated by state-certified alcohol and drug counselors, begin their treatment by participating in a comprehensive assessment at the provider site. Our standards for timely access indicate the appointment should be offered for a time within 14 business days of the first screening for non-urgent situations, and within 24 hours for an urgent situation. Treatment providers who receive the referrals begin with a comprehensive assessment to determine the medical necessity and ASAM criteria-based appropriateness of that level of care. If their determination is in agreement with the referring portal, they will proceed to develop a treatment plan with the client and treatment sessions. If they are not in agreement, they will contact the referring portal within in three (3) business days or less, in situations in which the beneficiary LOC is in question, and the client will be referred to the agreed upon level of care.

C. Client Flow for Ongoing Re-Assessments for Extended Authorizations (for a Visual Flow Chart, please see Appendix A-2)

BHCS is committed to a client-centered care approach to treatment. In this approach it is not only the initial match of client to treatment that is important. Providers are expected to conduct reassessments of client progress and make appropriate adjustments to the treatment plan, any time there is a significant change in the client status and/or diagnosis and within the above timeframes by modality. This reassessment will include warm handoff transfers to other levels of care as the client's needs change. To mitigate a sense of disruption, providers were asked to develop and obtain Drug Medi-Cal certification for multiple ASAM levels of care. All residential providers will at a minimum be able to provide ASAM residential levels 3.5 and 3.1. In addition, one provider is able to provide ASAM residential levels 3.5, 3.3 and 3.1. All outpatient providers will be able to provide ASAM levels 1.0 and 2.1.

In addition to providers adopting a proactive, ASAM-based person-centered care approach, care managers from the initiating portals follow the clients who they referred into residential or recovery residence plus outpatient treatment. These care managers will be contracted provider staff for the Residential Helpline, Cherry Hill Detox, and Criminal Justice Care management portals. County staff will serve as care managers for the Drug Court portal. These case managers provide care management with new authorizations to insure the continuation of appropriate level of care matching to the client's needs. The process varies somewhat by screening and referral portal as follows:

1. SUD Residential Helpline: The referring clinician follows up with the client within 25-30 days after treatment is initiated to conduct an onsite in-person reassessment with treatment recommendations conveyed to both the client and the treating provider. The clinician may continue the authorization at that level of care or change it to a different level of care. If care continues under authorization at either the residential or recovery residence plus outpatient level, then the clinician will follow up either onsite in person or by phone with a reassessment

and treatment recommendation 45-50 days after treatment was initiated. If care continues under authorization beyond that follow-up, then the clinician will meet with the person onsite in person 75-80 days after treatment was first initiated. Please see Appendix A-2 for a visual graph of the process. Once clients are referred to other types of treatment, then the new treatment provider takes over the responsibility for further re-assessment and transfers (See Re-Assessment Timeframe Table below)

2. **Cherry Hill Social Model Detox Center:** The Cherry Hill Center sees a high volume of clients who they refer into treatment as part of discharge planning. They are an exception among the screening and referral portals in that they do not follow the clients post-discharge from Cherry Hill. Instead, they hand off that care management responsibility to SUD Residential Helpline clinicians who will come onsite to Cherry Hill twice a week to be introduced to the clients. The helpline is for clients needing residential but all calls will be answered and referred. However, follow-up will only be conducted for those needing residential. Once the handoff is made, the SUD Residential Helpline clinicians will follow up with the clients according to the schedule depicted above. Once clients are referred to other types of treatment, then the new treatment provider takes over the responsibility for further re-assessment and transfers (See Re-Assessment Timeframe Table below)
3. **Criminal Justice Care Management (CJCM):** This service is staffed by the same organization that staffs the SUD Residential Helpline (CenterPoint). They receive referrals only from Probation, and their clients must meet the AB109 criteria for realigned offenses. CJCM clinicians follow the same care management follow-up protocol outlined above for SUD Residential Helpline clinicians with one exception. They will also use that protocol to follow clients they referred to varying levels of outpatient treatment without Recovery Residence. Once clients are referred to other types of treatment, then the new treatment provider takes over the responsibility for further re-assessment and transfers (See Re-Assessment Timeframe Table below)
4. **Drug Court:** Clients report regularly to the Court team about their treatment engagement and progress. The Court Team is a collaboration between clinical staff, the Judge, the Assistant District Attorney, and the Public Defender. **They often take a supportive stance and provide praise when the client makes progress. While the Court Team's clinicians provide care coordination within substance use treatment, the substance use provider is expected to provide case management brokering of services. At the clinician's recommendation, the client may be required to transfer to a more or less intensive treatment program, depending upon progress.** Once clients are referred to other types of treatment, then the new treatment provider takes over the responsibility for further re-assessment and transfers (See Re-Assessment Timeframe Table below)

Re-assessment Timeframe Table	
Level of Care	Reassessment Timeframe Maximum
Residential Detoxification Level 3.2	Five days
Residential Treatment, Levels 3.1, 3.3, 3.5	25-30 days, 45-50 days, 75-80 days
Recovery Residence + _Intensive Outpatient Level 2.1	25-30 days, 45-50 days, 75-80 days
Recovery Residence + _Outpatient Level 1.0	25-30 days, 45-50 days, 75-80 days
Intensive Outpatient Level 2.1	60 days
Outpatient Treatment Level 1.0	90 days

Narcotic Treatment Programs	One year
Recovery Support Services	Six months
Case Management	Evaluate as part of above service modality

D. Other Types of Treatment

Adults seeking or being referred for other levels of care such as detox, outpatient, intensive outpatient, or a narcotic treatment program may contact the treatment program directly. They may be referred by the SUD Residential Helpline if the initial ASAM-based screening determines they need a type of treatment other than Residential. They may be referred by any of the other three portals. Alternatively, they may be self-referred or referred by a physical health care provider, mental health provider, county criminal justice system, county child and family services, or by a family member or friend. Youth seeking or being referred for outpatient, intensive outpatient, or residential treatment may also contact the treatment program directly. In any case, the treatment provider conducts an intake and then a full assessment covering all six ASAM dimensions. The provider then makes a determination regarding medical necessity and whether to admit the person into the program or refer elsewhere. If the provider admits the person into the program, they develop an individualized treatment plan with the new client. The timeline for completing these first steps varies somewhat depending upon the type of treatment as follows:

- a. Residential withdrawal management: The person enters through the Sobering Center and may stay very briefly or as long as 23 hours. During this time, a brief intake and assessment are conducted. Approximately 50% of persons entering the Sobering Center move onto Detox. During the first 24 hours there, a more comprehensive assessment is completed addressing the six ASAM dimensions, and a withdrawal management plan is developed with the client. The plan addresses both withdrawal management considerations, and case management interventions for pre-discharge planning. Clients tend to stay in detox for an average of 4 days.
- b. Outpatient and intensive outpatient treatment: According to Title 22 regulations, the intake, assessment, medical necessity form and treatment plan must all be completed within 30 days.
- c. Narcotic treatment program: By regulation, the intake, assessment, medical necessity form and treatment plan must be completed within 28 days. However, these steps are usually completed much more quickly. The norm is to conduct the intake, begin the assessment, establish medical necessity, and begin dosing at the first visit.

Providers are expected to adopt a person-centered care approach, adjusting treatment to address the changing needs and situation of the client. The adjustments to the treatment plan might entail changes within the same SUD treatment modality or transfers to other treatment modalities. Adjustments may also include referrals to primary or specialty medical care, dental care, and/or mental health care. As the Re-assessment Timeframe Table indicates, re-assessment updates must be entered at least as frequently as: 1) residential detox – 5 days; 2) intensive outpatient treatment – 60 days; 3) outpatient treatment – 90 days; and 4) narcotic treatment program – annually).

3. Beneficiary Notification and Access Line. For the beneficiary toll free access number, what data will be collected (i.e.: measure the number of calls, waiting times, and call abandonment)? How will individuals be able to locate the access number? The access line must be toll-free, functional 24/7, accessible in prevalent non-English languages, and ADA-compliant (TTY).

Review Note: Please note that all written information must be available in the prevalent non-English languages identified by the state in a particular service area. The plan must notify beneficiaries of free oral interpretation services and how to access those services.

Beneficiary notification and access lines will be through the BHCS ACCESS line and through the SUD Residential Helpline. The BHCS ACCESS line is operated by the county through employees who are licensed clinicians. ACCESS is accessible 24 hours a day, 7 days a week through a toll-free number. ACCESS clinicians staff the ACCESS line from 8:30am to 5:00pm on weekdays. Crisis Support Services staff cover the line during the weekday nighttime hours and weekends. While the ACCESS line primarily responds to mental health requests and fulfills the access requirements of the county's mental health plan, it also responds to requests for substance use services with information and referrals. When the Waiver begins for Alameda County, ACCESS will continue to provide this service except for requests for referral into SUD residential treatment or SUD recovery residences. For those requests, they will refer the callers to the SUD Residential Helpline for screening and referral into treatment.

The SUD Residential Helpline will be operated by CenterPoint, a contracted community-based organization. The Helpline will be staffed by SUD certified counselors or other licensed practitioners of the healing arts (LPHA) employed by CenterPoint. The Helpline will be accessible 24 hours a day, 7 days a week through a toll-free number. CenterPoint counselors will staff the Helpline from 8:00 am to 9:00 pm on weekdays. Crisis Support Services will staff the Helpline during the weekday nighttime hours and on weekends. The primary purpose of the Helpline will be to conduct ASAM-based screenings for persons requesting SUD residential treatment or SUD recovery residences combined with SUD outpatient treatment. If callers request other types of treatment, the Helpline counselors will provide the same information and referral services as ACCESS.

Both the ACCESS and Helpline operations will be supported by technology from the Avaya System to track phone call data for management purposes. The data will include number of calls, call wait times, call abandonment rates, and call talk times. Helpline managers will monitor this data regularly to assure that callers are accessing screeners in a timely manner.

The Helpline will also be supported by technology from INSYST and Clinician's Gateway, which BHCS currently uses for its practice management and clinical documentation software. BHCS plans to replace this software in two years with Echo Management's ShareCare, which BHCS selected for its new Electronic Health Record.

ACCESS and Helpline staff will each log calls and collect the following data: Call time and duration, name of caller and of person taking the call, caller request, caller preferred language, utilization of interpreter services (if applicable), and disposition of call.

For those requiring screening, the Helpline staff will also collect the following data: Medi-Cal enrollment status and/or other coverage data if applicable, clinical status on the six ASAM dimensions, and name of provider to whom client was referred.

BHCS will inform potential referrers and the public of the toll-free numbers for ACCESS and the SUD Residential Helpline through various media including but not limited to:

- Alameda County Webpages: Health Care Services Agency, Behavioral Health Care Services

- Email broadcasts to county-contracted providers of physical health care, mental health care and SUD treatment
- Email broadcasts to point persons in other county agencies including criminal justice, child welfare, social services, and housing
- Email broadcasts to point persons in consumer and family advocacy groups such as NAMI and the Pool of Consumer Champions

Language assistance (including ADA-compliant telecommunication TTY for the deaf) will be offered to beneficiaries who have limited English proficiency. BHCS language access/interpretation services are provided by Lionbridge Interpretation Services. BHCS SUD providers are contractually required to conduct services in accordance with the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care Contractor (please refer to Section 8. Availability of Services, Language Capability for County Threshold Languages for more information).

Provider lists and informing materials for beneficiaries will be printed in threshold languages and the provider list will contain cultural and linguistic alternatives and options. Beneficiaries' booklets will be translated in threshold languages. Alternative formats will be developed (e.g. large print, audio discs and braille).

Staffs from the Substance Use Residential Helpline, BHCS ACCESS and Alameda County Crisis Support Services will receive training on interpretation service regulations, utilization of the language line and the test call protocol. During documentation training, staff will be instructed that beneficiaries are to be informed of the right to free language assistance and to document that interpreter services are offered.

BHCS' Cultural Competency Plan will be revised to include cultural competency DMC ODS STCs requirements.

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

Review Note: Include in each description the corresponding American Society of Addiction Medicine (ASAM) level, including opioid treatment programs. Names and descriptions of individual providers are not required in this section; however, a list of all contracted providers will be required within 30 days of the waiver implementation date. This list will be used for billing purposes for the Short Doyle 2 system.

A. Overview of the BHCS Network of Care

BHCS maintains and monitors a network of provider programs who provide a broad continuum of SUD services to address the treatment needs of the Alameda County population. Contracted community-based organizations (CBOs) deliver all the program services through contracts developed by BHCS and approved each year by the County Board of Supervisors. Under the DMC ODS Waiver, BHCS is increasing the number and types of programs that will be DMC certified to serve Medi-Cal beneficiaries, and increasing the capacity of many of these programs to serve more clients. BHCS is also helping network providers increase their capabilities to provide medically necessary, client-centered care based on the ASAM multidimensional assessment criteria. BHCS includes in this approach an expectation that providers connect beneficiaries to

other services than just substance use treatment to meet their physical health, mental health, and ancillary service needs. Whole person care is a guiding principle for service delivery.

Contracted DMC provider facilities and programs are required to maintain DHCS SUD licensure and program certification in addition to DMC certification. Depending upon their position and responsibilities, SUD treatment counseling staff, are required to be licensed, AOD certified or AOD registered to be certified within six months of hire. All contracted providers are required to comply with Federal, State, and local requirements, including BHCS standards and the OIG exclusion list requirements. In addition, BHCS will require that providers be in compliance with any DMC Standard Terms and Conditions (STCs) that were not previously in effect, such as delivery of specified evidence-based practices and other DMC ODS quality standards.

B. Types of services to be incorporated into the DMC-ODS system

See *Appendix D: Alameda County ODS SUD Network of Programs* for a summary table of the service levels we intend to provide by name and, where applicable, ASAM level numbers. Also included are the names of each of the planned program providers for each service level, their DMC certification status, and their contracted treatment capacity.

1) *Early Intervention (ASAM Level 0.5)*

Alameda County has over 30 FQHC program delivery sites, one of which is operated by the county and the others by nonprofit community-based organizations. BHCS used MHSA funding to launch a large, multi-year project that successfully established an integrated behavioral health service capacity within each FQHC site. One of the initial requirements in the contracts with the FQHCs was to obtain and implement training in SBIRT. This project helps serve as a foundation for implementation of SBIRT in the newly forming ODS for the DMC Waiver.

DHCS requires the primary care clinics/FQHCs to conduct an annual State Health Assessment for patients (both youth and adults), included in which at least one item addresses risky alcohol use. Some of the FQHCs ask more extensive screening questions. Patients who are found to be at risk receive SBIRT services from a behavioral health provider who is part of the primary care team. The provider usually begins with administering a 10-item questionnaire called the UNCOPE PLUS, which helps define the severity of the SUD for appropriate placement. The behavioral health provider on the primary care team is expected to be trained in SBIRT and able to make clinical decisions regarding when to provide brief intervention and when to provide referral into specialty treatment. When delivering brief treatment, the primary care behavioral health provider will usually administer the UNCOPE PLUS each month and use the scores to measure and document progress.

2) *Outpatient Services (ASAM Level 1.0)*

BHCS contracts with approximately thirteen CBOs for outpatient treatment services, who provide those services across 26 different programs at separate sites. Of these programs, twelve serve adult men and women, two serve women, one serves men only, one serves women who are pregnant or with young children only, two serve older adults, and nine serve youth (one of which provides co-occurring services). All of the programs are DMC certified or in the process of becoming DMC certified except for two programs serving older adults and five of the programs serving youth that are based in schools. Programs that are not DMC certified will not bill DMC for services. It is anticipated, however, that several of these programs will eventually become DMC certified.

Each outpatient treatment program under the DMC Waiver will provide individual, group, family and collateral sessions, case management services and recovery support services. Each will be billed separately in 15-minute increments.

The county will be asking that each of the organizations operating DMC-certified outpatient programs operate a DMC-certified intensive outpatient program. In the spirit of person-centered care, BHCS wants outpatient and intensive outpatient programs to easily and seamlessly transfer clients to more or less intensive treatment as clients' needs change. Transfer decisions will be made with the client, reflected in the client's treatment plan in advance. A transfer to a different level of care within the same organization will be considered part of the same episode, so the organizational provider will not be required to complete a CalOMS discharge plan form, new CalOMS admission form and new treatment plan form—just an update to the client's previous treatment plan.

3) *Intensive Outpatient Services (ASAM Level 2.1)*

BHCS contracts with four CBOs for intensive outpatient treatment programs and services. The existing thirteen OP CBO's expanded services to include intensive outpatient services. Of these programs, ten serve adult male and females, one serves adult males, one serves adolescents, two serve female only and two are focused around serving women who are pregnant or with young children. When the waiver takes effect, one provider will be providing IOT for youth. We will be monitoring the utilization and need for this service with the idea of possible expansion for youth services if appropriate.

As indicated in the above section on Outpatient Services, most of the CBOs providing outpatient programs that are less intensive will also be asked to provide intensive outpatient treatment when Alameda County is closer to implementation of the DMC Waiver. In the spirit of person-centered care, they will transfer clients readily when an assessment of their situation and condition, based upon ASAM criteria, indicate a different level of treatment is warranted.

Intensive outpatient services are usually delivered as a stand-alone treatment service. However, in some instances a client may participate in intensive outpatient services as a condition for receiving the benefit of a Recovery Residence. In such instances the intensive outpatient treatment must be indicated in an ASAM criteria-based assessment as medically necessary and the most appropriate level of care.

4) *Recovery Residences*

Many of the persons suffering from addictions in Alameda County are homeless, and residential treatment when addictions are unmanaged might in part have been used to address this dilemma even when it is not a medically necessary treatment solution. For the stabilizing, sober living needs of this population, recovery residences are a vital part of the treatment continuum when 24/7 residential treatment is not medically necessary. When stricter length of stay limits on residential treatment are applied through the DMC Waiver, Recovery Residences will become even more critical.

BHCS began contracting for Recovery Residence beds under criminal justice-related benefit plans—first through BASN for parolees funded through the California Department of Corrections and Rehabilitation, and then through California's AB109 prison reform legislation. The benefit designs tied to each funding stream required client beneficiaries of supported Recovery Residences to participate in some form of SUD outpatient treatment every week thereby formally defining the Recovery Residences, combined with outpatient

treatment, as a level of care. BHCS set up a central screening and referral center using ASAM criteria to determine level of care assignments for each client. We used Recovery Residence plus some level of Outpatient Treatment at times as a stepdown to shorten Residential Treatment length of stay, and at other times we used it as an alternative to any Residential Treatment at all.

BHCS plans to expand the criminal justice-related pilot of Recovery Residences connected to outpatient treatment into a county population-wide level of care for the DMC Waiver. To do so, BHCS plans a significant investment to expand our Recovery Residence bed capacity by at least 50 beds. To cover the expense, we plan to use some of our Substance Abuse Prevention and Treatment (SAPT) Block Grant fund allocation that would otherwise have been expended on Residential Treatment expenses that can instead be covered by Drug Medi-Cal under the Waiver. We recognize that we cannot use DMC-related funds for Recovery Residences. We intend to expand the Recovery Residence bed capacity with our current contractors as soon as the DHCS receives notice from SAMHSA approving use of SAPT Block Grant discretionary funds for this purpose. We will release an RFP, probably in FY 17-18, to refresh our network with a start date of July 2018.

BHCS developed initial standards for contracted recovery residence providers several years ago during the AB109 start up. Most of the standards are based upon requirements for certification by the California Association for Addiction Recovery Resources (CAARR), which merged recently with another state association and adopted the new name of the California Consortium of Addiction Programs and Professionals (CCAPP). These standards include the requirements for residents within Recovery Residence to maintain sobriety, engage in random drug testing, and be actively involved in outpatient or intensive outpatient treatment. BHCS used the standards as bidding requirements in a 2013 RFP and then monitored the new contractors for compliance.

In preparation for the Waiver, BHCS met with our four contracted Recovery Residence providers to review what other standards might be added to the basic requirements. As a result, BHCS is adding requirements that the recovery residence house manager be the designated person to oversee client compliance with sobriety, participation in drug testing, and regular participation in treatment. BHCS is standardizing several other best practices for Recovery Residences that will commence with the beginning of the Waiver implementation once approved.

5) *Residential Treatment Services (ASAM Level 3.1 and 3.5)*

BHCS contracts with eight residential treatment facilities that collectively provide approximately 161 beds. There are 76 adult beds in co-ed facilities, 15 in a facility dedicated for men only, 15 for women only, 48 for women who are pregnant or with young children, and approximately seven for youth (not including youth placed by probation/CWS). Residential provider facilities for adults are in process of applying for DMC certification effective when the Alameda County's Waiver proposal is approved. It is anticipated that each residential treatment facility for adults will provide residential treatment ASAM Levels 3.1 and 3.5.

Beneficiaries will be approved for residential treatment through a prior authorization process, which will occur within 24 hours of the initial screening or assessment conducted by one of our entry portals (see Client Flow, section C), based on the results identified by an ASAM criteria-based telephonic screening or in-person assessment through the SUD Residential Helpline or one of the other county-designated screening portals. The length of stay for residential treatment may range from 1 - 90 days, unless a reassessment of medical necessity justifies a one-time services reauthorization for an extension of up to 30 days. Only two non-continuous admissions will be authorized in a one-year period.

There are several exceptions to the residential length of stay limitations. Perinatal women with SUDs will have a length of stay based upon California's pre-waiver DMC benefit for perinatal SUD treatment, which is for pregnancy and up to two months post-partum. Alameda County recognizes that for perinatal women and for some clients re-entering the community from jail or prison, a lengthier stay may be medically necessary. If so, BHCS may extend their stay up to one month longer with DMC funds and if medically necessary for an additional brief period with other funds.

Clients may transfer within a residential treatment facility between ASAM levels 3.5 and 3.1 depending upon changes to their situation and condition. The justification for these transfers must be documented in advance of the transfer in the client's chart along with an update in their treatment plan. The transfer will be regarded as within the same episode, so the provider will not be required to document a CalOMS discharge plan from one level and then a new CalOMS admissions form and treatment plan for the new level of care. Client transfers within levels of residential care will constitute only one admission of the maximum two admissions per year allowed. The one-year period for two non-continuous admissions is effected the first day of the first residential admission.

Residential treatment services includes intake, assessment, treatment planning, individual and group counseling, client education, family therapy, collateral services, crisis intervention services, treatment planning and coordination including level of care coordination. These components are incorporated into a bundled rate. In addition, providers are expected to offer Case Management services, which are unbundled and billed separately. Usually the client will transition from this level of care to an outpatient-based treatment. However, the client may transition to Recovery Support Services directly from Residential Treatment, with the Services provided by trained peers on staff at the Residential Treatment Facility.

For clients in residential treatment, the referring portal staff clinician is responsible for conducting periodic ASAM based re-assessments (See revised Appendix A.2); determining when a transition is appropriate to another level of care; and working collaboratively with the client, the current provider, and the new provider to ensure the transition happens smoothly. We call this *care* management, as differentiated from *case* management. Part of the portals' care management responsibility is also to follow up and make sure the transition has occurred.

In addition to the above, BHCS has provisions in place for coordination with residential 3.7 and 4.0 as well as plans for further developments. Currently the Care Transitions Team at Highland Hospital case manages persons with a high rate of inpatient utilization for a combination of several high risk and chronic medical illnesses—HIV/AIDs, COPD, and Congestive Heart Failure. They learned from careful study and observation that 2/3 of their patients also have SUDs. We developed a close-working collaborative relationship with their staff to support their training in SBIRT and in application of ASAM Criteria, and to readily receive their referrals of patients for substance use treatment. Much of their case management services to address SUDs among their patients occurs while they are hospitalized for their medical conditions.

We are also in conversations with management from a licensed inpatient facility for youth to address co occurring medical, mental health and substance use conditions. Thunder Road is in transition under new management, and we are encouraging them to continue their state license as a specialty inpatient facility for youth that will meet ASAM criteria for residential 3.7 and 4.0.

Prompted by preparations for this Waiver, BHCS is embarking on discussions with several other physician groups working at hospitals in the county to explore how we might collaborate on treatment and referral of patients with SUDs while hospitalized for other medical and/or mental health conditions. These hospitals include John George Psychiatric Pavilion in Hayward and Fremont Hospital in the southernmost part of the county.

6) *Withdrawal Management Services (ASAM Level 3.2-WM)*

BHCS contracts with a social model detox program whose application is in process for DMC certification as an ASAM Level 3.2-WM. The current capacity for Detox Residential is 1,296 (Medi-Cal & Non-Medi-Cal) clients and projected capacity for FY-19/20 is 1,472. Clients first enter through a Sobering Center where they are initially assessed, medically cleared and begin the detox process for a time period not to exceed 24 hours. The staff conducting the initial assessments include trained Emergency Medical Technicians (EMTs) and licensed nurses. They encourage the clients to enter the full detox program in an adjoining building, which more than half the clients decide to do.

The average length of stay in the full detox program is five days. It begins with a more thorough assessment, building upon what was learned about the client in the Sobering Center and expanding to cover all of the ASAM's six dimensions. The resulting care plan covers what will be needed for an effective management of withdrawal symptoms. It also covers whatever is necessary to effect a discharge plan that addresses the client's needs along the ASAM dimensions. Many of the discharge plan preparations are case management functions will be billed separately.

The Emergency Departments in local hospitals meet the criteria of ASAM 3.7 and 4.0, although they are not DMC certified as such. They follow strict protocols for safely detoxing persons who come to them with overdoses or who are otherwise in medical danger related to alcohol or drug use. When they have cleared these persons as medically safe for discharge, they frequently refer them to the Sobering Center. During weekday daytime hours the Sobering Center is staffed to pick up clients at these Emergency Departments and drive them to the Cherry Hill Sobering or Detox facilities. During nights and weekends, the usual arrangement is for the Emergency Departments to arrange the transportation for the clients to Cherry Hill. Emergency Departments are among the most common referral sources for clients to Cherry Hill.

The referral process between Cherry Hill and hospital Emergency Departments is also working well in the reverse direction. When clients not previously screened and medically cleared come to Cherry Hill and are assessed as potentially at medical risk, they are sent to the Emergency Room of the nearest general medical hospital. Cherry Hill has staff and a van to transport them. In case of a medical emergency, staff will call for an ambulance. Cherry Hill will readily accept these clients back once they are medically stabilized and cleared by the Emergency Room of the nearby medical hospital.

The Emergency Department physicians have recently begun meetings with BHCS to develop guidelines for how they can refer clients to SUD treatment who may not need to go to Cherry Hill Detox. BHCS is sharing its SUD Treatment Resource Directory with Emergency Department Physicians, along with information about how to contact our newly launched SUD Residential Helpline, as ways to encourage and streamline referrals. In addition, the California Healthcare Foundation recently initiated a project to encourage these efforts, particularly in cases of opiate addiction.

7) *Narcotic Treatment Program (ASAM Level 1.0)*

Alameda County contracts with seven narcotic treatment program (NTP) organizations with a current

collective capacity of 1,993 contracted treatment slots for methadone maintenance. This capacity is one of the highest per capita of any county in the state of California. In addition to proper and highly regulated dosing protocols, the NTPs are contracted by BHCS to deliver a minimum of 50 minutes of individual counseling per month.

BHCS is committed to the value of Medication-Assisted Treatment (MAT), particularly Methadone, and worked for many years to combat prejudice against clients undergoing treatment through NTPs with Methadone. BHCS requires non-MAT treatment providers to accept clients treated with Methadone and provide them with any medically necessary care. Alameda County plans to add the following required services in NTPs: Buprenorphine, Naloxone, and Disulfiram.

8) *Additional Medication Assisted Treatment (MAT) Services (Optional, ASAM Level 1.0)*

BHCS is planning a major initiative to make buprenorphine more accessible, especially in primary care clinics and also in NTPs. Previously, the county found it challenging to encourage sufficient numbers of primary care physicians to obtain the requisite training and then prescribe buprenorphine. After learning about the barriers, the county is intending to launch a series of new services in calendar year 2017 including:

- a. Buprenorphine Induction Center contracted to Alameda Health System's Highland Hospital conjoining its Pain Management and Functional Restoration Clinic that already prescribes buprenorphine for pain. After dosing stabilization, the Center will provide referrals to clients for maintenance dosing to either primary care or to NTP-based physicians depending upon client needs.
- b. Training to primary care physicians who are prescribing buprenorphine that covers the science and psychosocial aspects of opioid addiction, the science and practical aspects of buprenorphine prescribing, and the practical aspects of guiding and supporting clients through the maintenance phase of buprenorphine treatment.
- c. Case consultation by addictionology-trained physicians and pharmacists, provided to primary care physicians for clients who present particular challenges.

Alameda does not plan on utilizing injectable naltrexone at this time.

9) *Recovery Support Services*

The primary goal of recovery support services, delivered by peers, will be to assist the client in maintaining their recovery. Prior to discharge from the active treatment phase, the client will meet with their primary counselor and recovery support-assigned liaison at the DMC-certified site to review and update the client's treatment plan to ensure that it focuses on the client's transition from the primary treatment phase to Recovery Support services. Transfer and transition services may start up to three months prior to the projected treatment discharge date. The recovery support services will be documented in the client's recovery plan and in the progress notes based upon service contacts. We expect Recovery Support Services to usually follow Outpatient Treatment and therefore be provided by staff in an outpatient program. However, we also expect there will be times when clients move directly from Residential Treatment to Recovery Support Services, and are provided those services by staff from the Residential Treatment facility.

Recovery support services are designed to emphasize the beneficiary's 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. Research shows the highest risk of relapse is through the first three years following the active treatment phase. Recovery support services are expected to average for six months to a year after that phase, but could be provided for longer if deemed medically necessary and the client is motivated to continue.

Recovery support services will be provided by a peer with lived experience recovering from a SUD. The peer may be a LPHA or certified SUD Counselor, but in most cases will not have such license or certification and will be supervised by someone who does. The peer provider will provide any or all of the following service types as needed:

- a. Recovery Monitoring includes recovery coaching and monitoring in person or by telephone or telehealth. In addition, periodic and voluntary urine analysis (UA) testing may be provided.
- b. Substance Abuse Recovery Assistance is ongoing support that includes information and resources for relapse prevention. Smart phone applications may be provided as an adjunct to prior treatment. Recommendations may be made for a return to more active treatment in the case of a relapse or high risk of relapse. The treatment warranted may be primarily for substance use, or may be for a related and co-occurring mental health condition.
- c. Linkages to Other Services including:
 - Life skills, employment services, job training, vocational and education services;
 - Childcare, parent education, child development support services, and family/marriage education;
 - Physical and mental health care;
 - Self-help, faith-based and culturally appropriate support services and/or groups; and
 - Housing assistance, transportation, social services and case management.

10) *Case Management*

Case management services support clients as they move through the DMC ODS continuum of care from the initial engagement and early intervention, through treatment, to recovery support. All beneficiaries are assigned an SUD counselor, who may also act as their case manager in programs that do not have dedicated case manager positions. The client/case manager ratio varies based on a variety of factors, including modality and intensity of need. The case managers are provided by counselors at each DMC-certified program, with the exception of NTPs which negotiated separate rate structures with the state DHCS.

NTP beneficiaries who request residential treatment will receive care management services from the SUD residential help line. Those authorized for residential will also receive more elaborate case management services from the residential program; these will be provided concurrently with NTP services.

The services focus primarily on linking clients to other services including:

- a. Treatment for physical health and mental health conditions;
- b. Life skills, employment service, job training, vocational and education services;
- c. Childcare, parent education, child development support services, and family/marriage education;
- d. Self-help, faith-based and culturally appropriate support services and/or groups; and
- e. Housing assistance and transportation.

Case management at the program level also involves:

- a. Coordinating client care with other types of treatment, and facilitating warm hand-offs to other levels of SUD treatment as necessitated by ASAM criteria;
- b. Assisting the client with other county agencies when necessary such as the courts, probation, child welfare, and social services.

There are three programs in the ODS that do not provide direct treatment but do provide the important case management functions of ASAM-based screening, referrals into treatment, and periodic re-screenings with facilitated transfers to different levels of care when warranted. Because this type of organization cannot become DMC-certified, they will not bill DMC directly under the Waiver and may only bill for TCM or MAA.

The three programs are:

- a. Substance Use Residential Helpline, which under a BHCS contract with CenterPoint operates screening and referral services for the general population seeking SUD residential treatment or recovery residence coupled with SUD outpatient treatment;
- b. Drug Court, which under a MOU with BHCS operates the county's drug court;
- c. Criminal Justice Care Management, which under a BHCS contract with CenterPoint operates assessment and referral services for clients under AB109 status.

11) *Physician Consultation (County Operated)*

BHCS employs a psychiatric consultant with expertise in both psychiatry and addictionology. Among his roles is providing some education and consultation to physicians who work with clients who have physical health and/or mental health conditions that co-occur with their substance use disorders. BHCS also employs a doctor of pharmacy who is beginning to provide some case consultation to primary care physicians who prescribe buprenorphine. BHCS may employ additional medical consultants to physicians who prescribe buprenorphine and other MATs.

C. Challenges and Barriers

1) *Early Intervention:*

- a. We now have behavioral health staff in place in most of the primary care clinics. The biggest challenge is to incentivize primary care physicians to actively screen their patients for problematic alcohol and drug use behaviors, and to refer clients with risky behaviors to the primary care clinic's behavioral health staff.
- b. A second challenge is to enhance the SBIRT skills of behavioral health staff in the primary care clinics. One of the ways we are addressing both of the above challenges is by training primary care staff, which Alameda has been conducting since the 1115 Medi-Cal Bridge to Health Care Reform Waiver started 5 years ago, on how to work effectively and comfortably with clients suffering from substance use conditions, and by providing start-up funding for Integrated Behavioral Health Care Coordinator positions at FQHCs.
- c. Youth are especially vulnerable to developing an addiction. Enhanced funding for early intervention activities through Medi-Cal Fee for Service would be especially helpful for early interventions.

2) *Outpatient and intensive outpatient treatment:*

- a. Programs will have to continue transforming their social model approach and build their infrastructure to address DMC requirements for quality management, documentation and billing. For some programs, a related challenge will be to shift from either a drop-in center orientation or a fixed program-centered orientation to a client-centered and treatment plan-driven orientation. To support these efforts, BHCS will need to provide increased technical assistance and monitoring, and fund more quality management infrastructure.
- b. While most outpatient providers, in their ability to provide intensive outpatient, will have the structural capacity to adjust their treatment intensity according to client needs, there still remains the challenge of doing so in practice.
- c. Alameda County's INSYST system for electronic patient registration, encounter tracking, and billing is based upon "reporting units". A provider must enter a change in a reporting unit if triggered by a transfer from one level of care to another, and the provider must also enter a CalOMS discharge and new admit and treatment plan. For a transfer between levels of outpatient care intensity within the same treatment organization, this degree of "paperwork" is both unnecessary and a serious disincentive to initiating transfers. BHCS is exploring ways to enhance efficiency and minimize any

administrative burden on service providers.

- d. Perinatal IOT was previously underutilized. BHCS **determined multiple reasons for underutilization and is now planning** how to address this issue.

3) *Recovery residences:*

- a. Expanding bed capacity is the single biggest challenge. In no small part, the challenge is finding sufficient new funding. We intend to use some of the funds previously used to cover residential treatment that DMC will now cover. We are expecting a statewide approval from Substance Abuse and Mental Health Services Administration (SAMHSA) to use some of the SAPT Block Grant discretionary funds for this purpose. We will have to find other sources of funds in addition.
- b. Of all the types of populations to serve with increased recovery residences, the most challenging are perinatal women with young children. Part of the challenge is finding suitable residences configured and zoned to accommodate both the women and their children. The more substantial challenge is establishing and carrying out policies and procedures that result in evictions for residents who use drugs. While this may be necessary to preserve the integrity and health of the Recovery Residence, it is extremely problematic for the young children who will be impacted.
- c. By increasing the monitoring responsibilities of the House Managers, BHCS must also increase the bed day rates.

4) *Residential treatment:*

- a. For the first time we will be offering residential treatment as an entitlement. Demand may at times exceed supply, currently resulting in some wait time for admission. **When residential beds are not available, the beneficiary receives interim services in accordance with state and federal requirements that recognize priority populations.** The pressure will be somewhat eased by requiring ASAM-based prior authorizations and shorter lengths of stay. The pressure will be further eased by offering substantially increased bed capacity for Recovery Residences as an alternative. However, we will likely still have to increase our Residential Treatment capacity from time to time, and find the funds to do so.
- b. Residential treatment programs will have to build their infrastructure to address DMC requirements for quality management, documentation and billing. To support these efforts, BHCS will need to determine and fund appropriate rate increases. We will also need to provide increased technical assistance and monitoring.
- c. Residential treatment facilities depend upon a full or nearly full census to cover their substantial fixed costs, and express concern that centralized screening and shortened length of stay may lead to more empty beds.
- d. Each residential treatment provider followed BHCS instructions to become certified in both ASAM levels 3.1 and 3.5 and one provider is certified in 3.1, 3.3 and 3.5, so they could adjust treatment intensity for their clients more readily and seamlessly according to changing client needs. While they now have the structural capability to do so, there remains the challenge of doing so in practice.
- e. Perinatal treatment has allowed lengthier stays. This is supported in part by some earmarked funding through state legislation. It is also supported by directives from the Dependency Courts and Child Welfare. BHCS is negotiating a different approach from these other partners, and from the perinatal treatment providers.
- f. Our co-occurring residential treatment facilities, which are funded by MHSA, are receiving increased pressure from DHCS' compliance unit to refrain from labeling any group sessions as explicitly substance use (e.g. relapse prevention group) and documenting any intervention as primarily focused

upon substance use. We intend to change the facilities from certification under Mental Health Medi-Cal to DMC certification in the hope of receiving more flexible documentation requirements that recognize the necessity for this population to receive treatment that concurrently addresses both mental health and substance use conditions.

5) *Detox (Required, ASAM Level 3.2WM)*

- a. The current model of staffing and workflow must change to meet ASAM Level 3.2WM requirements. These changes include increased documentation (especially treatment plan, discharge plan), increased case management (insuring an effective discharge plan is developed and implemented), and more detailed billing (separating day rate from case management services).
- b. The changes to the current model necessitate a substantially increased staff infrastructure, including LPHAs and increased funding.

6) *Case management:*

- a. This important service is already provided by the basic treatment modalities (e.g. outpatient, intensive outpatient and residential), although not systematically, without funding, without separate billing, and often without separate documentation. Provider programs will need training and technical assistance to be able to deliver the appropriate services to clients and to document and bill appropriately.
- b. The three screening and referral portals are not DMC certified. They will need special training in TCM or MAA billing to maximize FFP. They will need training and monitoring to insure they gather the access data necessary to enable the county to present performance measures to the state DHCS for audits and EQRO visits.

7) *Physician consultation:*

- a. Physician consultation services are currently funded by MHSA and include consultations with many substance use staff besides physicians. We are unclear how much of these activities will be reimbursable under the Waiver because the services are provided through county employees rather than a DMC certified program.
- b. We began providing consultations to primary care physicians by a BHCS-employed pharmacist skilled in addiction medicine. Because he is a Pharm.D. rather than an M.D., we are unclear whether his services will be billable under the Waiver.
- c. We intend to hire an M.D. consultant with expertise in addictionology to also consult to the primary care physicians. However, it is very challenging to find and hire a physician with those qualifications.

8) *Additional MAT:*

- a. We are uncertain what the costs will be of the new opioid treatment induction center we are planning for buprenorphine prescribing.
- b. It will be challenging to recruit sufficient numbers of primary care physicians to obtain training and accept patients for buprenorphine maintenance.

9) *Overall:*

- a. It is challenging in many respects to hire sufficient county staff internal to the BHCS infrastructure to provide the quality, fiscal and contract management we will need to oversee all the new services.
- b. It is challenging to hire and retain qualified staff or contractors to meet the requirements of offering services in the county's identified threshold languages.
- c. We, like many counties, accept some out of county clients, assume other counties accept some of our residents, and assume the result is a fiscal break-even. With the Waiver that will change. We share

the concerns of many other counties that we may end up shouldering considerable expense for out-of-county clients that we will no longer be able to afford.

- d. The MMEF file is an old format that cannot accommodate new data fields now needed to produce expanded reports to support management decision-making.

D. Coordination with Other Counties

BHCS has established strong relationships with surrounding counties' substance use services divisions through meetings at state level associations and Bay Area collaborations. We periodically include in our meetings discussion of how to coordinate care under the Waiver for out of county beneficiaries. BHCS will ensure continuity of treatment for non-county residents by identifying providers in neighboring counties and working with them to establish agreements. For those clients with acute care needs, BHCS will address their immediate SUD treatment needs, including withdrawal management and access to urgent and emergency care, while simultaneously working to support the beneficiary's transition back to providers in their county of residence.

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

- A. How the county will coordinate mental health services for beneficiaries with co-occurring disorders
- Alameda County began a welcoming "no wrong door" initiative eight years ago for treatment of persons with co-occurring disorders. Staff in any treatment program are trained to assess clients initially for both mental health and substance use conditions. Most programs specialize in treatment of one or the other type of condition, but are trained to address both in at least a limited manner. If it appears that a client needs in-depth specialized treatment in both, then the clinician may refer them to one of our co-occurring programs. Alternatively, the client may continue in the program specialized in one type of disorder, and

may be referred to concurrently participate in a complementary program specialized in treating the other type of condition.

BHCS' Acute Crisis Care and Evaluation for System-Wide Services (ACCESS) Center provides centralized call screening and referrals for treatment of both mental health and substance use conditions. The staff of licensed clinicians are updated on service availability throughout the continuum of care. When more in-depth screenings are needed, they refer to the centers that provide those screenings. They include the county's Crisis Response Program for mental health conditions and the SUD Residential Helpline for substance use conditions. Each of those centers is aware of and can refer clients who present complex co-occurring conditions to each other, as necessitated by clients' needs.

Substance use treatment providers seeking to refer a client concurrently to a mental health provider may do so directly with some types of providers, but will usually go through the ACCESS Center. Mental health treatment providers seeking to refer a client concurrently to a substance use treatment provider currently do so directly, although they can consult the ACCESS Center for information and referrals. Once the DMC Waiver begins, mental health providers will have to go through the Substance Use Residential Helpline to refer clients to residential treatment or to recovery residences plus outpatient. Other types of SUD treatment (e.g. sobering center and detox, NTPs, intensive outpatient and outpatient, etc.) will continue to receive direct referrals.

The county's Fairmont Campus includes a Psychiatric Emergency Service (PES) for 5150 assessments and observations for less than 24 hours. It is situated adjacent to John George Psychiatric Pavilion (JGPP) for referrals to inpatient psychiatric services. Close by on the same campus is Cherry Hill Sobering Station for clients needing a safe place to begin withdrawing from alcohol or drugs for less than 24 hours. Cherry Hill also operates a social model detox unit (soon to be DMC-certified as a 3.2 WM withdrawal management facility) in a building adjacent to the Sobering Station. Cherry Hill's Sobering Station and Detox Facility work closely with PES and JGPP to coordinate care for clients presenting urgent or emergent situations with co-occurring disorders.

PES and Cherry Hill both receive co-occurring cases that are cross-referred to one another. When a person is in the midst of an acute crisis episode, it can be difficult to differentiate between a mental health and a substance use disorder as to which is primary. In such diagnostic dilemmas, PES uses the CAGE and/or drug testing as optional components of its screening protocol. PES, Cherry Hill Sobering Station and Cherry Hill Detox Facility and JGPP have meeting at least monthly to address coordination and cross-referral issues. Last year there were approximately 780 referrals from PES to the Sobering Station and the Cherry Hill Detox Facility. In the next year there will be continued focus on the development of strategies to improve throughput from PES as well as increased referrals to the Sobering Station and the Cherry Hill Detox Facility.

Alameda County experiences a high rate of 5150s per capita as compared to other counties, which places pressure on acute and crisis services. We have developed an ambitious new strategy to create regional crisis stabilization services, with use of SB 82 and other funding. We also created new types of conservatorships to provide support to persons with serious mental illness-many of whom have co-occurring substance use disorders-and prevent them from relapsing into crisis that might require acute care. Community based services are available for conserved clients as an alternative to receiving services in an institutional setting. In order to improve coordination between the county's diverse crisis and acute care services, a Division Director of Crisis Services was recently created as a new position, and a person was hired in September 2016 to fill that position. In addition, this past summer BHCS rolled out In-Home Outreach Teams (IHOT) to provide in-home outreach and engagement services to individuals with Serious Mental

Illness--many of whom have co-occurring substance use disorders. IHOT's overarching purpose is to provide successful linkage to natural community supports for people with untreated moderate to severe mental illness and co-occurring substance use conditions. The primary goal is to help them avoid acute care settings as their main way of receiving behavioral health treatment and reduce involvement with the criminal justice system. BHCS contracts with three residential treatment facilities specializing in the treatment of clients with severe co-occurring mental health and substance use disorders. Chrysalis is a 15-bed residential facility for women, Cronin provides 24 residential treatment beds for both men and women, and Bonita House provides eight residential treatment beds for both men and women. In addition, we have one residential facility for youth (Thunder Road) that provides co-occurring treatment under EPSDT. These facilities are each staffed with both licensed mental health clinicians and certified SUD counselors to address both types of disorders effectively. Chrysalis and Cronin are in the process of transitioning their co-occurring programs to meet DMC-certification requirements and Bonita House will continue to bill as a BHCS-certified mental health residential program.

BHCS employs a physician with expertise in both psychiatry and addictionology to provide education, training and consultation to contracted SUD treatment programs. The primary purpose of his work is to enhance the capabilities of substance use providers in our network to address the co-occurring mental health conditions of their clients. He also provides some short-term face-to-face medication evaluation and monitoring for a few clients whose conditions are particularly complex.

There are persons with serious mental illnesses who do not engage easily in group and somewhat confrontation-oriented counseling approaches to SUD treatment. BHCS recently began a pilot program to offer outpatient SUD treatment customized for these clients. The pilot is taking place on the site of one of the intensive case management service teams that provides a range of outpatient services to persons with serious mental illnesses. The SUD counselors attend the regular meetings of the counseling staff as integrated team members. We are learning from this pilot what works best, and intend to then expand the services to more clients.

Alameda County BHCS is known for its mental health recovery orientation and related support of mental health consumer empowerment. One of the many ways in which this is operationalized is through a consumer networking, education and advocacy association called the Pool of Consumer Champions (POCC). The POCC has nearly 1,000 members with lived experience of serious mental illness, many of whom have co-occurring conditions. In recognition of the prevalence of co-occurring substance use conditions among its members, the POCC established a Committee for Harm Reduction and Co-occurring Substance Use Conditions. The County Alcohol and Drug Program Administrator met with them to share ideas about the Waiver.

The mental health-based Adult System of Care providers and the Substance Use System of Care providers each meet monthly. The leaders of each system decided to convene a Quarterly Meeting wherein both sides would join. The meeting includes presentations and discussions on co-occurring themes and is very well-attended.

B. Minimum coordination requirements or goals the county specifies for our providers

The county BHCS expects each SUD provider to conduct a comprehensive assessment with each of their clients that includes a determination of other co-occurring conditions. If there is a determination that a client is experiencing such conditions, the provider is expected to address those conditions as part of the treatment plan or make a suitable referral to an appropriate treatment program that can do so.

If the SUD provider is attempting to address a co-occurring mental health condition for a client and is having

difficulty, the provider is expected to make use of our county-funded training and case consultation service. We employ a psychiatrist to provide guidance to substance use providers on how to identify and treat co-occurring mental health conditions. In situations that require additional mental health consultation or treatment for which the provider is not able to provide the needed treatment, the client is referred to a suitable treatment program that can do so.

C. How the county will monitor these efforts

BHCS will expand its internal QA staff infrastructure to then conduct increased chart audits. The audits will identify assessed need for care coordination with mental health and, where it is relevant, check the chart for evidence that outreach and coordination transpired.

BHCS will provide psychiatric training and consultation regarding how to assess and treat persons with co-occurring mental health and substance use conditions. BHCS will track provider participation in the trainings and in case consultation opportunities.

D. Please briefly describe the county structure for delivering SUD and mental health services. When these structures are separate, how is care coordinated?

Although the county BHCS is administratively integrated for mental health and substance use services, categorical funding streams and their accompanying regulations keep a distinct separation between most mental health and substance use treatment programs. Nevertheless, BHCS has found many creative ways to transcend those separations as described in the response to the first question in this Section #5 on coordination with Mental Health. For coordination across provider systems, we still require client consent to exchange information and we take action to secure electronic exchange of information across our county firewall.

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

A. How the county will coordinate physical health services within the waiver

BHCS will build upon a highly successful project began in 2012 using MHSA funding to develop integrated behavioral health capacity in 30 primary care clinic sites. The project, inspired by the Bridge to Health Care Reform Waiver, leveraged Federal Financial-Participation (FFP) to develop primary care-based services for clients with mild to moderate mental health conditions. The funding helped the county-contracted FQHC primary care clinics to hire behavioral health clinicians and medical assistants (receive consultation and training in the integrated behavioral health IMPACT Model, receive training in several evidence-based practices including SBIRT, and develop measurements of client interventions and outcomes. The project also established guidelines for information exchange and cross-referrals between the FQHCs, BHCS staff, and BHCS contracted providers.

The County Alcohol and Drug Program Administrator participates periodically in meetings of the FQHC teams to inform them about the upcoming Waiver challenges and opportunities, update them on referral procedures to the SUD treatment continuum, and encourage them to provide SBIRT services to their clients within the primary care setting. BHCS intends to continue this process and to expand its own training to FQHC providers in SBIRT.

Another part of the integrated care project established a psychiatric consultation team that provided technical support to primary care physicians prescribing psychotropic medication to clients with mental illnesses. BHCS intends to expand the consultation team to include a physician addictionologist and a doctor of pharmacology expert in addiction medicine. BHCS will soon launch a new initiative to treat opioid addiction with buprenorphine. The initiative will include an Induction Center for the more time-consuming function of stabilizing new clients on proper buprenorphine dosages, and then refer them to FQHCs for maintenance dosing. The consultants will provide support to the primary care physicians through training, education, and case consultation in the hope that they will feel more comfortable treating persons addicted to opioids with buprenorphine and counseling.

BHCS began another project that established behavioral health-based primary care homes, based on a SAMHSA grant called the Promoting Access to Health (PATH) Project. Physicians from several FQHCs were contracted to work within intensive case management teams serving clients with serious mental illnesses, many of whom also have co-occurring SUDs. The integrated care arrangements were highly successful, received national recognition, and are continuing past the grant phase with BHCS funding support.

To maximize the potential of these arrangements, BHCS intends to develop additional protocols for bi-directional communication between FQHCs and specialty SUD treatment programs, and strengthen collaborations between participating FQHC and SUD clinicians. The protocols should balance clients' interest in their own health data privacy and security with their interest in receiving enhanced care through communication between their respective caregivers.

Primary care is not the only physical health service with which BHCS is seeking coordination between physical health and substance use treatment services. We know that SUDs contribute significantly and tragically to

chronic and life-ending medical conditions that are costly to treat. BHCS has begun collaborations with various specialty medical programs:

- 1) We will be establishing a buprenorphine induction center to treat opioid addictions through a contract with Alameda Health System's Pain Management and Functional Restoration Clinic that already prescribes buprenorphine for pain management.
- 2) We began in 2013 what has become an ongoing collaboration with Alameda Health Systems' Care Transitions Team, which provides case management to persons with multiple chronic medical conditions. The lead manager of that program discovered that nearly two thirds of the clients have SUDs contributing to their medical condition. Since the collaboration began, the Transitions Team received extensive training in SBIRT and in ASAM screening and referrals.

In 2016 we began dialogues with Emergency Department physician leaders and managers to explore how referrals to specialty SUD providers can be more easily facilitated.

- B. Minimum coordination requirements or goals the county specifies for providers, and how the county will monitor for their implementation

All SUD providers are by regulation required to assess new clients for physical exam needs, and make a referral when a recent one has not occurred. Even when a routine physical exam is not necessary, most SUD clients have multiple physical problems resulting from their addiction that warrant a referral for medical treatment. The county QA Unit will periodically conduct random chart audits to determine if providers are making referrals to primary and/or specialty medical and dental care.

Most people with addictions treated by the county systems of care had no coverage prior to the Affordable Care Act. Now that they are eligible, providers are expected to motivate and support their clients in becoming Medi-Cal enrolled and in connecting with a primary care clinic convenient to their residence. BHCS will closely monitor the extent to which each provider does this by regularly analyzing data on the percent of each provider's clients who are eligible for and enrolled in Medi-Cal.

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

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

- A. Comprehensive substance use, physical, and mental health screening;

All SUD providers conduct comprehensive assessments. However, we would like them to use a standardized tool to increase the quality of the assessment uniformly across all provider organizations. We would like the tool

to be electronic to streamline the process and produce a narrative summary with treatment plan recommendations. We think we have found suitable assessment software, but need to hire additional staff for this and other looming projects. Many of our providers are not yet using an EHR so will need our assistance in shifting to an electronic assessment tool.

We would also like to develop a way of incentivizing and monitoring the types of actions that providers take when the assessment indicates the need for referral to and coordination with physical health care and/or mental health care.

- B. Beneficiary engagement and participation in an integrated care program as needed; and
 - C. Shared development of care plans by the beneficiary, caregivers and all providers
- Our BHCS department, the broader Health Care Services Agency under which we are positioned, our FQHC and Health Plan partners all see the value of more intensive care coordination. This is especially the case for those few clients with multiple co-occurring illnesses who utilize intensive and costly services. For these highest utilizers of diverse care systems, we would like to have ways of identifying them and providing intensive case coordination to improve their health. Towards this end, we have applied for a Whole Person Care grant. Without the extra support from the grant, it is very challenging to launch a meaningful program to work with the highest utilizers across many diverse systems of care. It will require substantial additional staff to arrange the data-sharing agreements, care coordination and case management.

Several years ago, BHCS used MHSA funds and the 1115 Bridge to Health Care Reform Waiver to launch a project integrating behavioral health care into primary care settings across 27 FQHC sites. It is highly successful but challenging to sustain, particularly with regards to SBIRT and Motivational Interviewing. Staff turnover at the FQHCs require continual training of new staff in the SBIRT processes and the integrated care model. Most substance use counselors in California are state-certified as such, but not licensed in a category (e.g. MD, psychologist, or social worker) that HRSA recognizes as qualified to bill Medi-Cal. Consequently, staffing these functions at the FQHC sites becomes a fiscal reimbursement issue.

- D. Collaborative Treatment Planning with Managed Care
- We will launch a major project in this area as part of our Whole Person Care grant proposal if it is awarded to us. In such case, we will have additional funding and impetus to collaborate with our county Health Care Services Agency and county Health Plans. At this point, we are awaiting word from the granting agency.
- E. Shared development of care plans by the beneficiary, caregivers and all providers;
- This idea is fraught with daunting challenges. Most of all, privacy and security of patient data makes it difficult to launch such a project. Also challenging is how to logistically share information from caregivers who use distinctly different software systems. To make it worthwhile to undergo the effort to surmount these challenges, the project would target only the highest utilizers. We have targeted such a group for our Whole Person Care proposal. If we proceed, we could benefit from learning how others approached this set of challenges successfully.
- F. Care coordination and effective communication among providers; navigation support for patients and caregivers; facilitation and tracking of referrals between systems;
- Providers face mixed incentives for whether and how much to actively coordinate with other providers, provide navigation support for patients and caregivers, and facilitate and track referrals between systems. They are motivated to do so by their professional ethics and mission to help their clients, but it takes more time that

many of them do not have. The Waiver will help significantly by reimbursing for case management.

For the county, the challenge is to encourage this activity and be prepared to take on the extra cost in match funding when providers do it.

G. Facilitation and tracking of referrals between systems

We would be useful to eventually program fields in our new EHR software to record referrals in a manner lending itself to quantitative reports for trend analyses. This will be a few years away, as we first have many more basic steps to complete in first configuring and implementing the software.

8. Availability of Services. Pursuant to 42CFR 438.206, the pilot County must ensure availability and accessibility of adequate number and types of providers of medically necessary services. At minimum, the County must maintain and monitor a network of providers that is supported by written agreements for subcontractors and that is sufficient to provide adequate access to all services covered under this contract. In establishing and monitoring the network, describe how the County will consider the following:

- A. The anticipated number of Medi-Cal clients
- B. The expected utilization of services by service type
- C. The numbers and types of providers required to furnish the contracted Medi-Cal Services
- D. A demonstration of how the current network of providers compares to the expected utilization by service type
- E. Hours of operation of providers
- F. Language capability for the county threshold languages
- G. Specified access standards and timeliness requirements, including number of days to first face-to-face visit after initial contact and first DMC-ODS treatment service, timeliness of services for urgent conditions and access afterhours care, and frequency of follow-up appointments in accordance with individualized treatment plans.
- H. The geographic location of providers and Medi-Cal beneficiaries, considering distance, travel time, transportation and access for beneficiaries with disabilities.
- I. How will the county address service gaps, including access to MAT services?
- J. As an appendix document, please include a list of network providers indicating if they provide MAT, their current patient load, their total DMC-ODS patient capacity, and the populations they treat (i.e., adolescent, adult, perinatal).

A. Anticipated Number of Medi-Cal Clients

For fiscal year 15-16, the latest year for which BHCS has full data, Alameda County had 357,826 Medi-Cal beneficiaries age 12 and above, according to BHCS Decision Support data systems. In FY 16-17, BHCS anticipates the number of beneficiaries who will qualify for an alcohol or drug diagnosis to be 28,665 adults and 3,663 youth assuming a local SUD prevalence rate¹ of 9.2% for adults and 7.35% for youth aged 12-17. This projection also assumes a 1% annual rate of county population growth based on the County Level Economic Forecast for Alameda County.² Given current estimated local penetration rates in the county's

¹ Based on 200% FPL estimated prevalence rates for adults and youth aged 12-17 in Alameda County, Source: California Behavioral Health Prevalence Estimates, Estimates of Need for Behavioral Health Services Alameda County – Alcohol or Drug Diagnosis All Ages, pg. 48-49

² California County Level Forecast 2015-2040. California Economic Forecast (2015) prepared for the Economic Analysis Branch Office of State Planning, California Department of Transportation.

current SUD system of care, BHCS anticipates serving a total of 5,335 unduplicated adults and 156 unduplicated youth Medi-Cal beneficiaries during the first year of the DMC-ODS waiver, FY 16-17. Please see *Table 1: Estimated Medi-Cal Beneficiaries (18+ years) Needing and Accessing Substance Use Treatment* and *Table 2: Estimated Medi-Cal Beneficiaries (12-17) Needing and Accessing Substance Use Treatment*.

Table 1: Estimated* Adult Medi-Cal Beneficiaries (18+ years) Needing and Accessing Substance Use Treatment

	Total Medi-Cal Beneficiaries (18+)	Estimated Substance Use Prevalence**	Estimated Beneficiaries Needing SUD Treatment	Estimated Penetration Rate	Estimated Medi-Cal Beneficiaries Accessing SUD Treatment
FY 15-16	308,488	9.20%	28,381	18.61%	5,281
FY 16-17	311,573	9.20%	28,665	18.61%	5,335
FY 17-18	314,689	9.20%	28,951	20.61%	5,967
FY 18-19	317,835	9.20%	29,241	20.61%	6,027
FY 19-20	321,014	9.20%	29,533	20.61%	6,087

* For FY 16-17 – FY 19-20, assumes 1% population growth between 2015-2020, per CA DOT Alameda County Economic Forecast

** Based on 200% FPL rate for adults in Alameda County, California Behavioral Health Prevalence Estimates, Estimates of Need for Behavioral Health Services Alameda County – Alcohol or Drug Diagnosis All Ages, pg. 49

Table 2: Estimated* Youth Medi-Cal Beneficiaries (12-17 years) Needing and Accessing Substance Use Treatment

	Total Medi-Cal Beneficiaries (12-17)	Estimated Substance Use Prevalence	Estimated Beneficiaries Needing SUD Treatment	Estimated Penetration Rate	Estimated Medi-Cal Beneficiaries Accessing SUD Treatment
FY 15-16	49,338	7.35%	3,626	4.27%	155
FY 16-17	49,831	7.35%	3,663	4.27%	156
FY 17-18	50,330	7.35%	3,699	6.27%	232
FY 18-19	50,833	7.35%	3,736	6.27%	234
FY 19-20	51,341	7.35%	3,774	6.27%	237

* For FY 16-17 – FY 19-20, assumes 1% population growth between 2015-2020, per CA DOT Alameda County Economic Forecast

** Based on 200% FPL rate for youth 12-17 in Alameda County, California Behavioral Health Prevalence Estimates, Estimates of Need for Behavioral Health Services Alameda County – Alcohol or Drug Diagnosis All Ages, pg. 48

B. The expected utilization of services by service type

1) *Net Growth in Clients Served*

The number of Medi-Cal beneficiaries served with SUD treatment increased in FY 14-15 by 10% over the previous fiscal year as a result of two likely factors: the growth in Medi-Cal Expansion population, which started in January 2014 and continued into fiscal year 15-16, and the growth in the opioid epidemic with resulting increases in demand for the county's narcotic treatment programs. The opioid epidemic

accounts for anticipated net growth in the SUD service population over the next four years, with annual expansion of NTP clients over the next three years, and stabilizing in 19-20. A second source of assumed net growth in SUD services is the forecasted growth in county population, 1% annual year-over-year growth through FY 19-20.

Table 3: Actual & Projected Unique Medi-Cal Beneficiaries served within ODS SUD Services					
	FY 15-16	FY 16-17	FY 17-18	FY 18-19	FY 19-20
	Actual	Projected			
Adult Outpatient	1,680	1,782	1,889	1,908	1,927
Adolescent Outpatient	160	178	233	236	238
Intensive Outpatient (IOT)	0	350	407	472	548
Perinatal IOP	48	100	121	122	124
NTP Maintenance	2,375	2,639	2,932	3,109	3,140
Residential	466	494	599	665	672
Perinatal Residential	100	106	129	143	144
Detox Residential	755	801	849	900	909
Sobering Station	1,278	1,420	1,577	1,753	1,770
Recovery Residence	24	75	125	150	150
*Total Unique Clients:	5,437	5,491	6,199	6,261	6,324

* Numbers do not add to total as clients are served in multiple modalities. Unique clients served assumes 1% annual growth, and utilization based on penetration rates in Tables 1 and 2

A modest amount of growth is expected in the adolescent population served as the county embarks upon efforts to strengthen its adolescent SUD network capacity, including the addition of adolescent IOT services once the waiver starts, improved outreach efforts in schools including expansion of DMC services into several school sites, and consolidation of poorly performing programs with stronger more experienced SUD providers. The goal is to increase the current penetration rate among Medi-Cal beneficiaries aged 12-17 in need of SUD services to at least 6.27%.

2) Improved Access to Enhanced Services

As a result of the waiver Medi-Cal beneficiaries will be connected to more appropriate levels of care through access to a broader range of treatment options, including new modalities such as IOT, Recovery Residence, and additional MAT services. For service modalities that do not yet exist, such as IOT, BHCS assumes that in the first year of the approved waiver approximately 350 clients will receive IOT services either as a “step-up” from outpatient or “step-down” from residential. As providers become more experienced with IOT, utilization will increase by about 15% annually over the 3 years following its initial implementation in 16-17.

BHCS also predicts an increase in residential utilization following the first year of waiver implementation, with the greatest growth occurring in years two and three of the waiver. Currently, the median length of stay in residential SUD programs is approximately 7 weeks because of the large amount of clients who drop out within 1-2 weeks. As appropriate treatment alternatives to residential become available, clients in need of residential will be better matched to this resource. The assumption is that median length of stay will align closer to 10-12 weeks as a result of the improved match between client need and resource.

- C. The numbers and types of providers required to furnish the contracted Medi-Cal Services
BHCS currently contracts with 23 CBOs to serve clients in 15,305 admissions across nine existing SUD modalities. For a full list of BHCS SUD providers with current contract capacity, please refer to *Appendix D Alameda County ODS SUD Network of Programs*. While the present system adequately serves the current population, it is expected that some additional capacity will be needed in the short term. Table 4 below represents the total projected clients served (including Medi-Cal and non-Medi-Cal beneficiaries) across the ODS SUD system. It is intended to indicate for which service modalities the county anticipates a need for capacity expansion. The greatest need for short term capacity expansion in FY 16-17 will be in the service modalities of NTP, Perinatal IOT, and Recovery Residence. Short term augmentations to existing contracts will provide the additional capacity needed in these modalities.

Table 4: TOTAL (Medi-Cal & Non-Medi-Cal) Actual & Projected Clients served within ODS SUD Services

	FY 15-16	FY 16-17	FY 17-18	FY 18-19	FY 19-20
	Actual	Projected			
Adult Outpatient	2,519	2,629	2,745	2,773	2,800
Adolescent Outpatient	375	402	460	464	469
Intensive Outpatient (IOT)	0	350	407	472	548
Perinatal IOT	62	114	135	137	138
NTP Maintenance	2,753	2,976	3,272	3,453	3,488
Residential	618	648	754	822	830
Perinatal Residential	126	132	155	170	171
Detox Residential	1,296	1,347	1,401	1,458	1,472
Sobering Station	2,216	2,367	2,534	2,719	2,746
Recovery Residence	34	85	135	160	160
*Total Unique Clients:	7,844	7,922	8,654	8,741	8,828

* Numbers do not add to total as clients are served in multiple modalities. Unique clients served assumes 1% annual growth, and utilization based on penetration rates in Tables 1 and 2

- D. Demonstration of how the current network of providers compares to the expected utilization by service type
Medi-Cal service penetration rates are expected to increase in FY 17-18 as a result of enhanced access to appropriate services brought about by waiver system changes. BHCS anticipates greater capacity investments will be needed in residential and perinatal residential bed capacity in the third and fourth years of the waiver. BHCS will monitor service utilization trends carefully, and add additional capacity through contract augmentation in these modalities as actual utilization patterns necessitate.

For IOT, BHCS expects to utilize existing DMC outpatient program capacity to provide these services. Currently BHCS has some underutilized capacity in outpatient programs; BHCS anticipates using some of this extra capacity in outpatient programs to provide 350 clients with an average of 10 weeks of IOT services. Further investments in IOT capacity expansion will be made in accordance with actual need as determined by service utilization for this new modality.

- E. Hours of operation of providers

Please refer to *Appendix D: Alameda County BHCS Network of ODS Programs* comprehensive list of all SUD-ODS providers, including their hours of operation.

F. Language capability for the county threshold languages

Threshold languages in Alameda County include Spanish, Mandarin, Cantonese, Farsi & Vietnamese. BHCS will be adding Korean and Tagalog in the next few months. BHCS SUD providers are contractually required to conduct services in accordance with the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care Contractor. These standards include:

- a. Offering 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.
- b. Informing all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
- c. Ensuring the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
- d. Providing easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area

On a yearly basis providers must complete and submit an electronic survey regarding their implementation of CLAS standards.

BHCS forms and grievance materials are also translated into the threshold languages by a translation service. BHCS language access/interpretation services are with Lionbridge Interpretation Services. This is the company ACBHCS contacts when we have a consumer grievance and the beneficiary's primary language is one other than English. Translation services are available in: English, Spanish, Chinese Traditional (Mandarin), Simplified Chinese (Cantonese), Farsi & Vietnamese. BHCS will be adding Korean and Tagalog in the next few months.

G. Specified access standards and timeliness requirements, including number of days to first face-to-face visit after initial contact and first DMC-ODS treatment service, timeliness of services for urgent conditions and access afterhours care, and frequency of follow-up appointments in accordance with individualized treatment plans.

BHCS and DMC-ODS providers are committed to timely access to services. The following specific access and timeliness standards will be incorporated into the Quality Improvement Plan and provider contracts, as applicable:

- First face-to-face DMC ODS treatment service: Within 14 business days after initial client contact to first outpatient or intensive outpatient visit for intake and assessment. By year three of the plan implementation, the goal is to reduce the timeliness standard to within 10 business days after the initial contact.
- Services for urgent conditions: Within 24 hours of the request. The Sobering Station and associated detoxification services are available 24/7.
- Emergent conditions: Response and access to services for emergent conditions will be immediate with referral to an appropriate acute or crisis facility and when necessary direct contact with a first responders (e.g., police, 911, welfare check, etc.).
- Access to after-hours care: Beneficiaries will have access to a 24/7 toll-free phone number. The Substance Use Residential Helpline will be operational Monday - Friday from 8 am - 9 pm. In addition, Alameda County Crisis Support Services will provide after-hours coverage for the 24/7 toll-freephone number and the Substance Use Residential Helpline weekdays, evenings and holidays. Refer to Section 9, Access to Services, for additional information on access standards and timeliness requirements.

The frequency of follow-up appointments in accordance with individualized treatment plans will be based on client need and progress or lack of treatment progress. If the client relapsed during treatment or transferred to a “higher level” of care (e.g., outpatient ASAM Level 1.0 to intensive outpatient ASAM Level 2.1), the provider will increase the frequency of follow-up appointments to support revisions of the treatment plan goals and objectives.

- H. The geographic location of providers and Medi-Cal beneficiaries, considering distance, travel time, transportation and access for beneficiaries with disabilities. **Alameda County is divided into four geographic regions: North, Central, South, and East. Although Medi-Cal beneficiaries live throughout the County, the northern and central parts of the County are where the highest concentrations of beneficiaries (age 12 and above) reside, with 47% (168,807) in the north and 26% (91,563) in the central region. Consequently, the bulk of SUD service sites are located in the principal cities of these regions such as Oakland and Berkeley in the north and Hayward in the central county. Smaller but sizable parts of the Medi-Cal population also live in the southern part of the county, 16% (56,566), and the eastern part, 6% (20,847)³. All regions are currently served by outpatient service providers, and will have access to IOT services under the waiver. For modalities such as residential and NTP, beneficiaries from the eastern parts of the county who rely on public transportation take bus and BART rapid transit connections to service sites in Hayward, Fremont, and Oakland. See *Appendix E: Geographical Map of SUD-ODS Providers*.**

Table 5 below represents the number of program sites across the four county regions by treatment modality. When interpreting this table, it is important to keep in mind the wide variation in treatment capacity available at different sites. For example, one adult outpatient program in central county, Second Chance Hayward, is contracted to serve 925 unique clients per year. By contrast school-based adolescent outpatient programs serve smaller amounts of clients (e.g. less than 20) at various middle school and high school sites.

Alameda County has a number of disabled-accessible public transit options, including Bay Area Rapid Transit (BART), AC Transit, Wheels-Livermore Amador Valley Transit Authority, Union City Transit, and East Bay Paratransit. The majority of Medi-Cal beneficiaries live less than one hour’s travel time to SUD treatment services. However, for those clients living in the eastern parts of the county who are limited to public transportation, the travel may take longer to reach two types of services—Perinatal IOT and NTP. Although we have not had complaints, we began conducting a needs assessment for these two types of treatment services in the eastern part of the county. We determined very minimal need for either service in that region, partly because it is less populated and partly because it is a wealthier area in which most of the residents have cars. Nevertheless, we began discussions with the Perinatal outpatient provider most geographically proximate to the eastern region of the county, exploring whether we might contract with them to provide van transportation to new clients from the eastern region when needed. Also, we are beginning to increase our Recovery Residence capacity in general and for perinatal women with SUDs. This will help to address any emerging need for perinatal IOT among residents in eastern county, as perinatal women undergoing IOT for SUD are often in situations requiring concurrent drug-free housing.

Regarding NTPs, we began discussions with several of our contracted providers who all expressed an interest in setting up a satellite program in the eastern region if there is sufficient client demand for such services. We have little evidence of that demand. Nevertheless, we are exploring how we might arrange

for a satellite program and may have to do so through an RFP. In such case, we would be able to set up a satellite in the eastern region of the county during the third year of the Waiver. In the meantime, our county Health Care Services Agency established a policy, effective in February 2017, that each FQHC must have at least two primary care physicians waived to prescribe buprenorphine. In the eastern region of the county we have Axis Community Health Services as the FQHC that will provide these services. BHCS has already helped establish for that FQHC the capacity to provide ancillary behavioral health services integrated into the primary care team. BHCS also provides psychiatric consultations on demand to the primary care physicians and the behavioral health clinicians for their work with patients whose behavioral health conditions may prove challenging to treat.

With regard to disability access at SUD providers' sites, BHCS requires contracted providers to serve clients with disabilities in compliance with all federal SAPTBG requirements and regulations. BHCS Program Contract Managers monitor access to services and reasonable accommodation for people with disabilities as part of their annual SAPT site visit contract monitoring process.

³ Approximately 5% of Medi-Cal beneficiaries reside out-of-county, or have a residence unknown in the BHCS data system.

Table 5: Expected SUD Program Sites Across County Regions by Modality (FY16-17)												
County Region	Adult Outpatient	Adolescent Outpatient	IOT General	IOT Adolescent	IOT Perinatal	NTP	Additional MAT	Residential General	Residential Perinatal	Residential Detox	Sobering Station	Recovery Residential
North: Alameda, Albany, Berkeley, Emeryville, Oakland	12	9	6	0	2	6	1	4	3	0	0	3
Central: Castro Valley, Hayward, San Leandro, San Lorenzo	1	3	1	0	0	2	0	1	1	1	1	1
South: Fremont, Newark, Union City	2	3	2	0	0	0	0	1	0	0	0	1
East: Dublin, Livermore, Pleasanton	2	1	1	1	0	0	0	0	0	0	0	0

- I. How will the county address service gaps, including access to MAT services?
The largest anticipated service gap is anticipated to be in the Recovery Residence modality. BHCS plans to fund a significant expansion of recovery residences by leveraging SAPT block grant funds that would have otherwise been expended upon residential treatment prior to the waiver. As mentioned above in Section 6, BHCS plans to launch a new initiative to treat opioid addiction in non-NTP settings. After brief treatment at a buprenorphine induction clinic, opioid-addicted clients will be referred to FQHCs across the county for maintenance dosing. This will allow opioid-addicted clients to be served closer to home in their communities. An additional identified service gap exists for youth IOT services. To fill this gap, BHCS will explore adding IOT as a service modality to most of the DMC certified youth outpatient programs so that IOT is available in all regions of the County.
- J. Refer to Appendix D, Alameda County BHCS Network of ODS Programs.

9. Access to Services. In accordance with 42 CFR 438.206, describe how the County will assure the following:

- A. Meet and require providers to meet standards for timely access to care and services, taking into account the urgency of need for services.
- B. Require subcontracted providers to 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 patients.
- C. Make services available to beneficiaries 24 hours a day, 7 days a week, when medically necessary.
- D. Establish mechanisms to ensure that network providers comply with the timely access requirements.
- E. Monitor network providers regularly to determine compliance with timely access requirements.
- F. Take corrective action if there is a failure to comply with timely access requirements.

A. Access system design

As indicated earlier in this Plan, BHCS designed a hybrid model for access to services. Those in Cherry Hill Detox, Alameda County Drug Court, or the AB109 Criminal Justice Care Management Center will be screened and referred into the appropriate ASAM level of care. Those people referred by other sources or self-referred for residential treatment must go through the SUD Residential Helpline, whose clinical staff will screen and refer into the appropriate ASAM level of care. All others seeking some other type of treatment (e.g. ASAM 1.0 outpatient or NTP, ASAM 2.1 Intensive Outpatient, and ASAM 3.2WM detox) may choose to access that treatment directly. They will be assessed at the treatment site where a determination will be made regarding medical necessity and appropriate level of care.

The hybrid model was designed after careful consideration of several tradeoffs. The SUD Residential Helpline with ASAM-driven screenings will improve client-treatment matching, but can also be experienced by some as a barrier to access. We decided to offer screenings to whomever from the general public might want them, but require the screenings only for those requesting residential treatment or a recovery residence plus outpatient treatment. Those are the treatment modalities for which we will require prior authorization. For others not referred for those treatment modalities, we also are permitting direct access to an intake without prior screening.

During several of the monthly meetings with the full group of contracted SUD providers, the County Alcohol and Drug Program Administrator explained to them the managed care responsibilities for access to services and how the county and all providers will be held accountable. He explained the data collection requirements necessary to measure the time from first call to first offered appointment and to first actual appointment. Providers of treatment other than residential or recovery residence plus outpatient agreed to the responsibility of collecting data on the date/time pre-clients first call, the date/time of first offered appointment, and the date/time of the first actual appointment. In the interest of ambivalent pre-clients seeking to access services quickly, providers opted to take this responsibility rather than have a completely centralized screening and referral center for all pre-clients seeking any type of treatment.

BHCS is designing the technologies and procedures to enable electronic collection, consolidation, storage, analysis and reporting of the data so it results in meaningful information on timeliness measures. Substance Use Residential Helpline and other three Screening Portals will all use Clinicians' Gateway, which is an electronic record system that links easily into BHCS' client management system called INSYST. BHCS worked with the software developer and the providers of the Substance Use Residential Helpline and three Screening

Portals to design a reconfiguration of the software to accommodate ASAM criteria-based screening and a logging of timeliness-related data.

BHCS intends to gradually implement Clinicians' Gateway throughout the SUD provider network over a two-year period. In the interim, we are designing technology interfaces and procedures for the treatment providers to regularly transmit to BHCS their timeliness-related data. We are also expecting the residential treatment providers and the recovery residence providers to electronically update their bed census data for the Substance Use Residential Helpline and other Screening Portals, so that client referrals can be made with real-time information about accessibility of services.

B. Standards for timely access

A primary principle underlying BHCS' DMC ODS is to provide timely access to medically necessary quality care. BHCS' Helpline, Screening Portal, or Provider directly contacted by a pre-client will refer the person with a need that is:

- 1) Emergent – within 2 hours to an appropriate acute care or crisis facility. In addition, Crisis Support Services provides coverage weekday evenings and weekends for information, crisis counseling, coverage ~~including~~ information, referral, or when necessary direct contact with first responders (e.g., police or 911 for safety check).
- 2) Urgent – for an intake within 24 hours to the Cherry Hill Sobering Station, or in some instances to residential treatment or another appropriate provider. The Sobering Station and associated Detox Center services are available 24/7.
- 3) Routine/non-urgent – for an intake within 15 business days to an outpatient or intensive outpatient treatment provider or other appropriate provider as indicated by ASAM criteria.

C. Hours of operation

All providers in the BHCS network maintain hours of operation that do not differentiate between Medi-Cal and non-Medi-Cal covered persons. Please see *Appendix D: Alameda County BHCS Network of ODS Programs* for a listing of the hours of operations for each provider serving Drug Medi-Cal clients. During the first year of the Waiver, BHCS will review hours of operation and make changes that best meet the needs of the Medi-Cal beneficiaries.

As stated earlier (Client Flow Section), BHCS offers several screening portals so that access is facilitated in a timely manner

- 1) Substance Use Residential Helpline: In operation 24/7, required for persons seeking or referred for residential treatment and not screened through any of the other three Portals, and optional for others seeking information or referral to non-residential treatment. The Helpline staff are available 8:00am to 9:00pm weekdays. After hours calls are handled through Alameda Crisis Support Services weekday evenings and weekends.
- 2) Cherry Hill Detox: In operation 24/7, with discharge planning services to all levels of substance use treatment and other services.
- 3) AB 109 Criminal Justice Care Management: In operation weekdays during normal business hours for clients with realigned AB 109 offenses referred by Probation for assessment and referral into all levels of substance use treatment.
- 4) Drug Court: In operation weekdays during normal business hours, the Court clinicians assess clients and make referral recommendations into all levels of substance use treatment and other services.

- 5) ACCESS: In operation 24/7 as an information and referral portal to most substance use treatment modalities, with call transfers to the SUD Residential Helpline for screening and referral to residential treatment. The ACCESS staff are available 8:30am to 5:00pm weekdays. After hours calls are handled through Alameda Crisis Support Services weekday evenings and weekends.

D. Ensuring compliance with timeliness standards

To ensure that providers comply with timeliness expectations, BHCS' QA office will review the regulation(s) with providers and develop monitoring tools to ensure compliance. Primary among the monitoring tools will be a regular management review of timeliness data collected from Helpline, Screening Portal and Provider logs. In addition, a test call protocol will be developed and training offered prior to implementation of the protocol. It is planned that performance measure results will be reviewed by the Quality Improvement Committee (QIC).

Providers that have difficulty meeting timeliness expectation will initially be provided with feedback, technical assistance, and clear expectations. If performance doesn't improve, the provider will be required to submit a corrective action plan. Additional training will be offered, test call frequency will be increased, and test call results will be reviewed with the provider. Providers who are not able to show progress within a reasonable period of time towards timeliness expectations will be held accountable and face additional actions including suspension and/or termination of their contract with BHCS.

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

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

The Training Unit of BHCS provides training activities and access to technical assistance for the evidence-based practices (EBPs) identified under the DMC-ODS Pilot including Motivational Interviewing, Screening, Brief Intervention and Referral to Treatment (SBIRT), Cognitive-Behavioral Therapy, Motivational Enhancement Therapy (relapse prevention), Seeking Safety, and ASAM Criteria. The Training Unit also provides an extensive array of other trainings, including psycho-education for Post-Traumatic Stress Disorder and Addiction, Trauma-Informed Care, and CLAS.

- A. Required trainings in Evidence Based Practices (EBP) for providers of SUD Services: Each SUD treatment program will be required to select two of the EBPs required in the DMC-ODS STCs. They will be expected to meet the requirement by requiring that each of their counselors engage in extensive training in at least one of the two selected EBPs. In addition, all staff who conduct screenings and assessments are required to complete training in the use of ASAM Criteria for making decisions regarding treatment placement. BHCS will offer the required trainings and will monitor enrollment and participation.
- B. Optional trainings in EBPs and other Best Practices for Providers of SUD Services: The following table is a list of EBP workshops provided to SUD counselors and to a range of other clinical and non-clinical staff in Alameda County agencies and contracted community-based organizations who provide care to clients with SUDs. Also included in the table are several trainings under development, which are planned for piloting in FY16-17.

EBP Topic	Target Audiences	Frequency	Comments
Motivational Interviewing (MI)	SUD counselors, MH clinicians, and BH staff in primary care settings	Offered on an ongoing basis; minimum annually with numerous sessions	We have trained extensively on MI in Alameda County and will continue to do so in the future.
Screening, Brief Intervention and Referral to Treatment (SBIRT)	BH and medical staff in primary care settings and MH staff	Offered on an ongoing basis in conjunction with MI training above; minimum annually with numerous sessions	We have trained more than 300 staff on SBIRT in Alameda County and will continue to offer more sessions in the future.
Cognitive-Behavioral Therapy (CBT)	SUD counselors, MH clinicians, and BH staff in primary care settings	Offered on an ongoing basis; minimum annually	CBT is offered with distinct specializations, for example, CBT for psychosis; CBT for addictive behavior, etc.
Motivational Enhancement Therapy (relapse prevention)	SUD counselors, MH clinicians, and BH staff in primary care settings	Offered on an ongoing basis; minimum annually	MET will be offered extensively to SUD Provider Staff beginning in Autumn 2016.
Seeking Safety	SUD counselors, MH clinicians, and BH staff in primary care settings	Offered on an ongoing basis; minimum annually with numerous sessions	We have trained more than 300 staff on Seeking Safety and will continue to offer sessions in the future.
Psycho-Education for Post-Traumatic Stress Disorder & Addiction (Trauma Informed System)	SUD counselors, MH clinicians, and BH staff in primary care settings	Offered on an ongoing basis; minimum annually with numerous sessions	We are part of a regional TIS network and will offer training on PTSD/trauma recovery in the future.

C. Other training and technical assistance (TA) for SUD Providers and others:

<i>Training/TA Topic</i>	<i>Target Audiences</i>	<i>Frequency</i>	<i>Comments</i>
ASAM Criteria Training	SUD counselors, MH clinicians, BH staff integrated into primary care, probation and parole officers, child welfare workers	Offered annually	We have trained extensively on the ASAM criteria in Alameda County with hundreds of staff trained.
Buprenorphine Training	Psychiatric and primary care staff	Offered occasionally	This includes continuing medical education (CME) credits for physicians

<i>Training/TA Topic</i>	<i>Target Audiences</i>	<i>Frequency</i>	<i>Comments</i>
Etiology and neurobiology of mental illnesses, and their co-occurring treatment through both medication and counseling.	SUD Treatment Provider Staff	Offered annually	This is an annual three part training series with BHCS “resident psychiatrist” Dr. Rob Lee.
Documentation Training and Technical Assistance	SUD Treatment Provider Staff	Offered on an ongoing basis	We have QA and SUD Team staff who provide this TA on an ongoing basis to our SUD providers.
Data Collection and Entry	SUD Treatment Provider Staff	Offered on an ongoing basis	We have Provider Relations, QA and SUD Team staff who provide this TA on an ongoing basis, and IS consulting staff will soon be added to assist in implementing BHCS’ new EHR.
General Billing and MA Billing Training/TA	SUD Treatment Provider Staff	TBA	This training is in development.
CLAS Training	SUD Treatment Provider Staff	To be offered on an annual basis	This training is in development.
Human Trafficking	SUD Treatment Provider Staff	TBA	This training is in development.
CFR42	SUD Treatment Provider Staff	TBA	This training is in development.
Title 22 Training	SUD Treatment Provider Staff	TBA	This training is in development.
Other specialized EBP topics as determined by SUD System of Care Director/others	SUD Treatment Provider Staff	To be determined	Training staff meet with the County ADP Administrator and SUD provider representatives annually to determine new EBP topics to be addressed.

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

- A. Alameda County will need assistance from state DHCS with regular updates on policy and regulatory changes, and how to implement them at the county and provider levels.
- B. Alameda County would like to request state assistance and leadership to facilitate a process for inter-county billing and payment of DMC-ODS services rendered to non-county residents. This is of particular concern regarding Medi-Cal residents in counties that did not opt into the DMC-ODS Waiver.

- C. We would appreciate it if the state DHCS would reformat the MMEF file to accommodate more data fields for information we need to successfully manage the Waiver responsibilities.

12. Quality Assurance. Describe the County's Quality Management and Quality Improvement programs. This includes a description of the Quality Improvement (QI) Committee (or integration of DMC-ODS responsibilities into the existing MHP QI Committee). The monitoring of accessibility of services outlined in the Quality Improvement Plan will at a minimum include:

- Timeliness of first initial contact to face-to-face appointment
- Frequency of follow-up appointments in accordance with individualized treatment plans
- Timeliness of services of the first dose of NTP services
- Access to after-hours care
- Responsiveness of the beneficiary access line
- Strategies to reduce avoidable hospitalizations
- Coordination of physical and mental health services with waiver services at the provider level
- Assessment of the beneficiaries' experiences, including complaints, grievances and appeals
- Telephone access line and services in the prevalent non-English languages

Review Note: Plans must also include how beneficiary complaints data shall be collected, categorized and assessed for monitoring Grievances and Appeals. At a minimum, plans shall specify:

- How to submit a grievance, appeal, and state fair hearing
- The timeframe for resolution of appeals (including expedited appeal)
- The content of an appeal resolution
- Record Keeping
- Continuation of Benefits
- Requirements of state fair hearings

A. The Quality Management Program

The Quality Management Program provides a vehicle for BHCS management to meet DHCS and CMS quality improvement standards and ensure beneficiaries rights and protections by monitoring compliance to access, authorization, care coordination, cultural competency, and informing requirements. BHCS management conducts ongoing quality assurance activities, including data collection, reporting and analysis, contract monitoring, on-going utilization review, and use of information for the purposes of continuous quality improvement. BHCS quality management is staffed by a team of clinicians who are dedicated to monitoring the BHCS system of care and how well they are serving client needs.

B. The Quality Improvement Plan

The BHCS Quality Improvement Plan is a comprehensive document that serves as a guideline for annual QI activities. BHCS acknowledges regulatory limitations of full integration of DMC ODS responsibilities into the existing QI Plan. The DMC ODS Quality Improvement Work Plan in combination with the Mental Health Quality Improvement Work Plan will include, not limited to: monitoring client satisfaction; timeliness review of the residential authorization process; updating policies and procedures to improve clinical practices and reduce audit disallowance; improving training participation, documentation and quality of care; implementing, assessing, and reporting on performance improvement measures; monitoring of DMC ODS

accessibility of service requirements; and compliance to utilization of Evidence Based Practices. The QI Plan and year-end report are reviewed and approved by the BHCS Executive Leadership Team.

C. Quality Improvement Committee

The Quality Improvement Committee (QIC) is an integral component of the BHCS Quality Improvement Program. The Director of Quality Management leads the committee and QM staff members provide support with meeting agendas, follow-up minutes, etc. The membership of the QIC is representative of BHCS and community stakeholders including county executive leadership, mental health, SUD, clinical, information systems and fiscal staff, consumers and family members, advocates (Patients' Rights and the Pool of Consumer Champions), Community Based Organizations (mental health, co-occurring, SUD care providers), and invited guests (e.g. Alameda Alliance for Health System and Primary Care Providers).

See Appendix F: QIC Member Roster.

The current core group of QIC SUD stakeholders will be expanded to include additional SUD providers.

The QIC meets monthly to: recommend policy decisions; review and evaluate the results of QI activities; institute needed QI actions; and ensure follow-up of QI processes. The QIC monitors grievances for system wide trends and strategically plans for necessary quality improvement activities. Currently the QIC receives annual SAPT audit reports from the County Alcohol and Drug Administrator. The QIC role will expand to receive and analyze DMC ODS performance reports and monitor compliance to the data requirements of the DMC ODS STC's. The QIC will form an SUD Sub-Committee to further the integration of DMC ODS into the QI Plan.

D. Monitoring of Accessibility of Services

The Quality Improvement Plan will at a minimum, monitor the following accessibility of services requirements:

1) *Timeliness of First Initial Contact to Face-to-Face Appointment*

Responsiveness begins with answering the phone. The SUD Residential Helpline will use the Avaya software system to monitor the number of calls, call wait time, and call abandonments rate. Helpline managers will use the daily reports to assess for logjams and take appropriate action when needed. The residential treatment and recovery residence providers will electronically transmit their bed census data to the Helpline and other screening portals at least weekly, with further real-time updates as the census changes. Consequently, client referrals can be made with real-time information that will facilitate easier and more effective referral processes.

As stated in Section 9, Access to Services, BHCS is designing the technologies and procedures to enable electronic collection, storage, analysis and reporting data so it results in meaningful information on timeliness measures. The Helpline and Screening Portals will all use Clinicians Gateway, which is an electronic record system that links into the BHCS' client management system call INSYST. BHCS worked with the software developer and developer and the providers of the Helpline and Screening Portals to design a reconfiguration of the software to accommodate ASAM criteria-based screening and the entry of timeliness-related data.

BHCS intends to gradually implement Clinicians' Gateway throughout the SUD provider network over a two-year period so that all providers will be able to enter timeliness-of-access data. We expect all the SUD

providers will be using Clinicians' Gateway and producing timeliness of access data by the second year of the Waiver.

For this requirement, BHCS will monitor timeliness for routine (non-urgent), urgent, and emergency requests for services. The timeliness requirement was explained and discussed during monthly meetings with SUD providers. Managed care responsibilities for service access and related accountability for data collection and reporting requirements were discussed. Data elements to be collected include: the date/time of pre-client first call, the date/time of first offered appointment, and the date/time of first actual appointment.

2) Frequency of Follow-up Appointments in accordance with the individualized treatment plans

The frequency of follow-up appointments will be based on client need and progress or lack of treatment progress. If the client has a relapse during treatment to a higher level of care, frequency of follow-ups appointments will be increased to achieve timely revised and medically necessary treatment plan goals and objectives.

After screening and the ASAM Level of Care (LOC) assessment has occurred, and within 14 business days from the initial contact, the beneficiary will receive their first DMC ODS treatment service. If the admission is into RT or RROT, then care management services will be provided for possible changes to LOC for approximately five hours per client delivered intermittently throughout the course of the treatment episode. Periodic reassessment of the client's LOC ASAM assessment and transition planning from LOC to another LOC will be conducted by one of the designated screeners/referrers (e.g. SUD Residential Helpline, Drug Court or Criminal Justice Care Management) with oversight by the BHCS QA Unit for quality management.

When a referred client does not show up for their scheduled intake appointment, the SUD provider will reach out to the client to document the reason for the no show. There is no specific wait time for being rescheduled. The SUD treatment provider will follow-up with the client by telephone within three business days of the missed appointment. The client may reschedule at any time and will be given the first available appointment.

3) Timeliness of the First Dose of Medication Assisted Treatment within the NTP

Staff within the NTPs will enter the time when the client first requested an appointment, the time of the first offered appointment, and the time of the first medication dose. Clients seeking NTP services usually have their first treatment visit on the same day they requested treatment. The requirement is to receive NTP services within three business days of the initial request.

4) Access to After Hours Care

Beneficiaries will have access to a 24/7 toll-free phone number. The Substance Use Residential Helpline will be operational Monday – Friday from 8 am – 9 pm. The 24/7 toll-free phone number is transferred to Alameda County Crisis Support Services for coverages on weekday evenings and weekends for information, crisis counseling coverage including information, referral, or when necessary direct contact with first responders. Alameda County Crisis Support Services will submit an electronic call log daily to the Substance Use Residential Helpline for next business day follow-up on routine/non urgent requests for services. Cherry Hill's Sobering Station and Cherry Hill Detox are available for urgent care 24/7.

To ensure that providers comply with timeliness expectations, BHCS' QA office will develop monitoring tools and review the results with staff from the Substance Use Residential Helpline, Screening Portals and Alameda County Crisis Support Services. Primary among the monitoring tools will be a regular management review of the timeliness data collected from the Helpline, Screening Portals and Provider logs. In addition, a test call protocol will be developed and training offered prior to implementation of the protocol. It is planned that

performance measure results will be reviewed by the QIC.

5) *Responsiveness of the Beneficiary Access Line*

BHCS will review the standards with CBOs and develop monitoring tools to ensure compliance. There will be regular QIC review of timeliness data collected from the Substance Use Residential Helpline, Screening Portals and SUD Provider (e. g. Outpatient, Insensitive Outpatient, Residential,etc.) Logs. Prior to implementation, the test call protocol will be developed and training offered to the Helpline and Screening Portals Staffs and SUD Providers. Data from the test calls will be analyzed for trends and reported to the QIC.

6) *Strategies to Reduce Avoidable Hospitalizations*

A primary principle of BHCS' DMC ODS is to provide timely access to quality medically necessary care in the most appropriate and cost-effective treatment setting. BHCS will utilize strategies to reduce or avoid unnecessary emergency room encounters and has initiated dialogues with Emergency Department physicians to explore how referrals to SUD providers can be more easily facilitated. The Alameda Health Systems Care Transitions Team provides intensive case management to clients with multiple chronic medical conditions, many of whom also have co –occurring substance use disorders. The Team has had extensive training in SBIRT and ASAM screening and provides proactive alternatives to unnecessary ED encounters. In-Home Outreach Teams provide case management to persons who frequently utilize crisis and acute services, and the county is investing in several regionally-based crisis residential facilities for those who need short-term support for stabilization. The county also recently created several types of Conservatorships.

Increased outreach and case management services are planned to identify and facilitate care coordination and referral for high utilizers of acute and crisis services. Plans were developed for health information sharing across systems of care to identify high utilizers across diverse systems of care and opportunities to provide support through increased health information exchange, intensive case management and other types of interventions. Some of these plans will require considerable additional resources, and the county is awaiting word on its grant application through the Whole Person Care Initiative.

To improve coordination of care and reduce avoidable hospitalizations, stakeholder meetings with mental health providers, physical health care providers, BHCS ACCESS Center, Physicians, FQHCs and SUD Providers have been taking place since 2011. In addition to SBIRT and ASAM trainings, providers, physicians and access to care services will receive cross training to inform each profession of the needs and nuances of beneficiaries affected by substance use. Relationships among care providers will improve in efficiency of services and transition to appropriate treatment services based on medical necessity. Cherry Hill Detox Facility and Sobering Station has an established relationship with local hospital(s) and currently assists beneficiaries with transportation from and in some instances to the hospital. The MOU with the MCOs will strengthen relationships among care providers.

7) *Coordination of Physical and Mental Health Services with Waiver Services at the Provider Level*

BHCS has many projects and initiatives for treatment of persons with co-occurring disorders. For program information on these initiatives please refer to Section 5 – Coordination with Mental Health and Section 6 – Coordination with Physical Health.

BHCS will expand its internal QA staff infrastructure to better monitor the coordination of care between physical and mental health services with waiver services at the provider level. BHCS will amend the Mental Health Quality Improvement Work Plan by January 31, 2017 to address the expanded QA responsibilities for monitoring DMCODS requirements. The Mental Health Quality Improvement Workplan will be renamed the Behavioral Health Quality Improvement Workplan.

Dedicated QA staff will conduct increased chart audits of SUD treatment providers. Audits will identify assessed need for care coordination and where relevant, check the chart for evidence that outreach and coordination transpired. In addition, QA staff will periodically conduct random chart audits to determine if providers are making referrals to primary care and/or specialty medical and dental care.

QA staff will monitor complaints and grievances focusing on possible patterns or trends that indicate beneficiary care coordination needs are or are not being met.

BHCS will provide psychiatric training and consultation regarding how to assess and treat persons with co-occurring mental health and substance use conditions. BHCS will track provider participation in the trainings and case consultation opportunities.

The MOU with BHCS and the county's Medi-Cal Managed Care Plans is another vehicle to monitor care coordination. The MOU will include a data sharing agreement to facilitate care coordination and address PHI privacy and security concerns (42 C.F.R. 2.11; 45 C.F.R. 160.103, 164.504(e)).

8) Assessment of the Beneficiaries' Experiences, Including Complaints, Grievances and Appeals

BHCS and its providers take appropriate action to quickly resolve concerns expressed by clients. The QA Program has an established Beneficiary Grievance and Appeal Process which complies with regulatory guidelines (42 CFR 438) for both mental health and SUD operations. There is an established record keeping procedure where beneficiary complaints data are collected, categorized and assessed for monitoring grievances and appeals.

Grievance informing materials are translated into the following threshold languages: Spanish, Traditional Chinese (Mandarin), Simplified Chinese (Cantonese), Farsi and Vietnamese. BHCS will be adding Korean and Tagalog capabilities in the next few months. There are dedicated mental health staff responsible for the grievance and appeal process, and findings are reported out to the QIC annually to analyze performance reports, monitor compliance and recommend quality improvement strategies and actions. Informing materials are required to be posted at provider sites and postings are monitored during site visits. Similar grievance and appeal processes and informing materials will apply to substance use services once the county formally opts into the Waiver.

Providers will receive training on the grievance and appeal process; informing materials will be posted at provider sites, and at time of initial service inquiry, clients will be informed of the appeal process, their right to file a grievance and how to file a grievance. Client Right's Advocates are available to assist. Providers will be contractually required to comply with the grievance and appeal process requirements and will be monitored on a regular basis.

The client has the right to bring up concerns related to the contractor's performance of duties, including the delivery of SUD treatment services either by calling the contractor or BHCS to provide the information orally, or in writing. For assistance, the client can call the BHCS 1-800 number. Within sixty (60) days after the receipt of the grievance a BHCS representative will notify the affected parties of a decision on the grievance. The time frame may be extended 14 calendar days if the client requests an extension or if BHCS feels that there is a need for additional information and that the delay is for the benefit of the client.

Clients have the right to appeal any adverse decision made to the client's SUD treatment that modifies or denies requested services and/or a reduction, suspension, or termination of a previously authorized service. The Contract Service Provider approves SUD treatment services based on client eligibility and medical necessity. The client can call the BHCS 1-800 number for assistance and information for filing an appeal. However, an appeal must be submitted in writing, from the client, to BHCS. If the client's initial report was verbal, the date of the verbal

report shall be considered the filing date. Generally, BHCS has 45 calendar days of receipt of the appeal to provide a decision on the appeal and this time frame may be extended up to 14 calendar days. The decision about the SUD services may be described in a Notice of Action (NOA) letter sent or given to the client personally.

The Notice of Action (NOA) process requires client notification in writing, by the Contractor or BHCS, for any adverse decision to their SUD treatment. The NOA must include information about their right to appeal and the State Fair Hearing process. Generally, clients can continue receiving treatment services for short periods of time while the client is in the appeal process.

The client's benefits will continue while an appeal is in process if all of the following conditions are met:

- a) The appeal was filed on or before the later of the following: within 10 days of the Contractor mailing the notice of action; or the intended effective date of the Contractor's proposed action with or without a NOA;
- b) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- c) The services were ordered by an authorized provider;
- d) The authorization period has not expired; and
- e) The client requests an extension of benefits.

An expedited appeal process will be used when the Contractor determines or the client and/or the client's provider certifies that following the timeframe for an appeal as established would seriously jeopardize the client's life, health, or ability to attain, maintain, or regain maximum function.

Once the county's appeal process is exhausted, beneficiaries have the right to a State Fair Hearing through an independent review conducted by the California Department of Social Services. Information, contact numbers and the form for the request of a State Fair Hearing is included with each Notice of Action (NOA); the request must be submitted within 90 days of the postmark date or day that the NOA was received. To keep the same services, a hearing must be requested within ten (10) days from the date the NOA was mailed or personally given to the beneficiary or before the effective date of the change in services.

The client's benefits will continue while an appeal is pending until one of the following occurs:

- a) The client withdraws the appeal;
- b) The client does not request a State Fair Hearing with continuation of benefits within 10 days from the date the contractor mails an adverse appeal decision;
- c) A state Fair Hearing decision adverse to the client is made; or
- d) The service authorization expires or authorization limits are met.

See Appendix G: Grievance and Appeals Process and Forms: Grievance & Appeals Process & Request procedure; Grievance & Appeals Request form; Grievance & Appeal Call form; Beneficiary Problem Resolution Process and Input by Person Accepting and Managing Grievance Process.

9) *Telephone Access Line and Services in the Prevalent Non-English Languages*

Language assistance will be offered to individuals who have limited English proficiency. BHCS language access/ interpretation services are with Lionbridge Interpretation Services. BHCS SUD providers are contractually required to conduct services in accordance with the National Standards for Culturally and Linguistically Appropriate Services (CLAS). Also, on a yearly basis providers, including the SUD Residential Helpline staff, must complete and submit an electronic survey regarding implementation of CLAS standards.

Substance Use Residential Helpline, access portals and SUD provider staff will receive orientation on this requirement. A test call protocol will be developed, staff trained on the protocol and test calls initiated on a regular basis. Access logs will be reviewed to ensure test calls are documented. Test call performance outcomes will be shared with staff and re-training provided as necessary. The QIC will review performance

outcomes.

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

Upon approval of the BHCS-submitted Waiver Implementation Plan, BHCS will be requiring each substance use treatment provider to certify that direct service staff are trained in at least two of the above EBPs either by attending BHCS sponsored training activities or through their own resources. BHCS will monitor provider compliance with this requirement through chart audits, training sign-in sheets, regular provider meetings, and compliance site visits.

The BHCS QA staff will define the criteria for monitoring and conducting periodic chart audits to determine if at least two of the identified EBPs are being deployed. It is notoriously challenging for researchers to identify meaningful measures of fidelity to EBPs. The QA staff will review specific interventions that are fidelity hallmarks of each EBP and choose a limited few for each that can be used by QA auditors in their review of treatment plans and related progress notes. The QA auditors will convey their findings to the provider and to the appropriate Network Office Program Contract Managers. The Program Contract Manager will connect with the provider if there is a pronounced trend of notable deficiencies over time, and would then work with BHCS QA to develop a corrective action plan with the provider for correcting those deficiencies. Beginning in Fiscal Year 2017 - 18, an EBP contract requirement will be included into the substance use treatment provider contracts.

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

The county is not implementing a regional model.

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

Review Note: The following elements in the MOU should be implemented at the point of care to ensure clinical integration between DMC-ODS and managed care providers:

- Comprehensive substance use, physical, and mental health screening, including ASAM Level 0.5 SBIRT services;
- Beneficiary engagement and participation in an integrated care program as needed;
- Shared development of care plans by the beneficiary, caregivers and all providers;
- Collaborative treatment planning with managed care;
- Delineation of case management responsibilities;
- A process for resolving disputes between the county and the Medi-Cal managed care plan that includes a means for beneficiaries to receive medically necessary services while the dispute is being resolved;
- Availability of clinical consultation, including consultation on medications;
- Care coordination and effective communication among providers including procedures for exchanges of medical information;
- Navigation support for patients and caregivers; and
- Facilitation and tracking of referrals

Alameda County is a two-plan county for Medi-Cal managed care. Alameda Alliance for Health and Anthem Blue Cross of California are the two primary Medi-Cal Managed Care Plans in the county.

Alameda County's Health Care Service Agency (HCSA) developed an MOU for BHCS with each of the two health plans several years ago for the Bridge to Health Care Reform 1115 Waiver. The MOU addressed such areas as: a) defining criteria for mild, moderate and severe mental health and substance use conditions, 2) determining which payor entities (managed care plans or county) and their respective provider networks would be responsible for which severity level of each condition, c) how the network providers for each payor entity would cross refer to each other for those and for physical health conditions, and d) how information would be shared between BHCS and the Managed Care Plans and between their respective network providers to facilitate case management and care coordination across various behavioral health and physical health conditions.

BHCS is arranging meetings to address refinements to the MOU that will support the coordination of service delivery and related health information exchange specific to the role of the DMC ODS within the larger Alameda County health care system for Medi-Cal beneficiaries. The meetings have begun with leaders of HCSA. These will be followed by meetings with leaders of the Health Plans and with review by our county counsel. BHCS intends to

incorporate new agreements as amendments into the existing MOUs by December 31, 2016. The MOU will contain all of the elements listed in the DMC ODS application.

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

BHCS intends to implement a Telepsychiatry and Telepharmacy service if awarded the Whole Person Care Grant. We expect to receive notice of this grant award on or about October 23, 2016. If awarded, we would plan to begin implementation six months after notice of the award. The telehealth system selected by BHCS will provide DMC-ODS providers access to psychiatric and pharmacy consultation services which will include: 1) medication management; 2) patient and provider education; and 3) assistance with assessment/diagnosis of patients with Co-Occurring mental health disorders. The BHCS telehealth system will be HIPAA compliant and able to meet the highest level of confidentiality necessary to safeguard the protected health information (PHI) of consumers. BHCS will also have a signed HIPAA Business Associate Agreement with the selected telehealth technology provider.

In addition, BHCS is considering the use of telehealth services in a pilot project during the second year of the DMC ODS implementation. The pilot being considered would use smart phone-based app functionality that would be given to clients towards the end of their initial treatment phase as they transition into a maintenance phase using recovery support services. The treatment program counselors would first work with the clients to identify the geographic locations of highest risk to them for relapse, such as local bars at which they used to drink or parks they used to frequent for scoring drugs. The counselors would also work with the clients to identify self-directed messages most likely to work as counters to fantasies of using alcohol or drugs. The smart phone would be custom programmed to alert the client when the GPS indicates proximity to places the client identified as risk areas, and would also be programmed to prompt the client to reflect on messages the client identified as potentially effective in countering fantasies of using alcohol or drugs. The smart phone messages would also include an offer to connect the client with the Recovery Support Peer Specialist to whom they were assigned for maintenance phase support. This type of app has been the subject of increasing research that supports its effectiveness in preventing relapse as an adjunct to treatment.

Several other telehealth possibilities are also being considered, but nothing is yet decided. No telehealth implementations are planned for the first year of the Waiver.

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

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

The General Services Agency (GSA) is the designated County agency that oversees procurement policy and procedure. In compliance with GSA and the Board of Supervisors (BOS), GSA has delegated authority to conduct procurement for the direct human services to HCSA/BHCS.

BHCS complies with the Alameda County policies and procedures for the selection and retention of service providers as described in the County of Alameda Contracting and Procedures Manual: Goods and Services. Alameda County has a policy of encouraging contract awards to Small, Local and Emerging Businesses (SLEB). Local organizations (regardless of size) receive five percent preference points.

BHCS administers competitive Request for Interest and/or Request for Proposal process under the direction of the BHCS Director. The main stages of the competitive process are:

1. Development of procurement of request and approval of funding by BHCS executive.
2. RFP Development
3. RFP release
4. Bidders' Conferences (x2 required in different locations in the County)
5. Publish Addendum(a)
6. Bid submission
7. County Selection Committee Training (includes panelists confidentiality and conflict of interest statements)
8. Evaluation of written proposal by County Selection Committee (CSC aka evaluation panel)
9. Oral interviews (at the discretion of the CSC)
10. Award/notification letters sent to all bidders
11. Formal bid protest/appeal process in two stages:
 - a. Bid protest to BHCS Director
 - b. Appeal to County Auditor
12. Contract development/negotiation
13. Presentation of the Department's recommendation to the BOS for approval

BHCS intends to launch a RFP process for the DMC network in FY 17-18. The usual contract term is 12 months with the possibility of renewal.

Alameda County prides itself on the establishment of fair and competitive services procurement and contracting procedures and commitment made to following those procedures. In the event that bidders wish to protest the bid process or appeal the recommendation to award a contract, the County has a formal appeals process. This is documented in the Procurement Manual and in Alameda County's standard RFP forms that bidders complete and submit to the County when proposing services to perform.

If an existing contract provider does not receive an award for a county contract for DMC-ODS services at any time through the selective provider contracting process, the county and the provider shall work together and develop a plan to transition the care of existing clients to selected DMC-ODS service providers. Our foremost consideration is that there is no disruption of treatment services, that sharing of protected treatment information between providers occurs within 4-6 weeks and in adherence with all confidentiality requirements, that client notification is timely and that they are actively involved in the transition of care. This process entails coordinated efforts from BHCS, the providers and the client that includes: initial client notification of change, referral options, release of information and initial contact with the new provider. Designated QA staff, Program Contract Manager, and Operational Lead are responsible for facilitating and monitoring timely transition of client services.

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

Alameda County is among the counties with the most per capita NTPs providing methadone. With the advent of state regulations permitting and guiding the prescription of buprenorphine for opiate addictions, we expect an upsurge in utilization for this service. The county intends to fold this into a broader organized delivery system for buprenorphine that includes the following components:

A county-run buprenorphine Induction Center will be established used as a hub. The center will refer its clients after stabilization to a FQHC or a NTP, depending upon the client's need for structure and additional counseling services. The Induction Center will be located in Highland Hospital near its Pain Clinic that already prescribes buprenorphine for pain. The hospital is centrally located in Oakland. A small task force led by the BHCS Medical Directors' Office and the County Alcohol and Drug Program Administrator will formulate specifications and costs for the proposed Induction Center.

A joint task force, led by the BHCS Medical Director and comprised of selected BHCS leadership staff, medical staff at the county's Health Care Services Agency, medical staff from the Alameda Health System and the Alameda Health Consortium, will develop the referral criteria for buprenorphine stabilization. Dr. David Mee Lee who consults to the County will help advise us from the ASAM perspective.

BHCS and the FQHC organizations will jointly promote training of at least two primary care physicians at each FQHC organization in buprenorphine prescribing. Already three FQHCs won a HRSA grant to begin this training and service delivery. To further this initiative, BHCS plans to hire at least one addictionology consultant to provide clinical consultation to the primary care physicians and their staff at the FQHCs. These consultations are intended to ease primary care physician concerns about addressing complications that may arise with patients taking buprenorphine.

The county will negotiate contracts with the NTPs interested in providing buprenorphine during FY17-18, with calculations of slot needs based in part on the assumption that many clients will prefer to obtain buprenorphine through their FQHC primary care physicians.

Alameda does not plan on utilizing long-acting injectable naltrexone.

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

All authorizations for Residential Treatment (RT) and for Recovery Residence when combined with Outpatient Treatment will be administered by the county-designated portals that were described in Section 2 of this Implementation Plan. These portals are: Substance Use Residential Helpline, AB109 Criminal Justice Case Management, Cherry Hill Detox Center, and Alameda County Drug Court. The portal staff are comprised of experienced and certified SUD counselors trained in the use of ASAM criteria.

When a screening and referral are conducted, the relevant data will be entered by the portal staff member into the county EHR system software called Clinician’s Gateway. The data includes a pre-intake client identifier number that will link to the client number once an intake is conducted by the provider. The entry data will prompt an automated electronic authorization form, the contents of which will be sent to the provider and communicated to the client within 24 hours of the screening or assessment.

The portals may determine using ASAM Criteria that a caller needs a level of care other than RT. In such cases the portal counselor will refer the client accordingly. If the level of care recommended is Recovery Residence plus IOT or Outpatient (RROT), then an authorization for that combined level of services will be generated. If the referral is to any other level (e.g. outpatient with Recovery Residence, NTP, Detox) then the referral will be made without an accompanying authorization.

Initial authorizations for RT or RROT will be for a duration of no longer than 45 days. Portal staff will go to the site of the client’s treatment between 25 to 30 days after the client is admitted into treatment to conduct an updated screening. Using ASAM criteria, the staff member will make a determination of whether to authorize an additional length of stay at that level or to initiate a transfer to a different level of care. If a second authorization is made, then the staff member will conduct an updated screening by phone or in person 45 to 50 days after the initial admission (approximately 25 days after the first screening update). If there is a third authorization, which would be for a maximum 30-day extension, then the subsequent assessment contact would be in-person 75 to 80 days after the initial admission.

Of the four portals, only three will conduct follow-up care management re-screenings and help initiate transfers. The exception is Cherry Hill Detox, which will only conduct the initial screening, referral and authorization. Counseling staff who operate the Substance Use Residential Helpline will be onsite at Cherry Hill Detox twice weekly to meet with clients referred by Cherry Hill into RR or RROT, receive a warm handoff, and assume the later responsibilities of follow-up, re-screening and care management.

Quality management of these managed care authorization processes will be administered in part by the BHCS Quality Assurance Unit through periodic chart audits of the Portals. They will review the charts with attention to whether the screening data supports the ASAM ratings on each of the six dimensions, and whether those ratings support the level of care referral that was made.

Quality management will also be administered through review of performance data. Because the initial screening data and the later intake data will be linked through BHCS’ INSYST and Clinician’s Gateway database, critical performance data reports will be easier to generate. The reports will include time from first request to the time of first authorization, number of requests for RT for which authorizations were made to RT or another level of

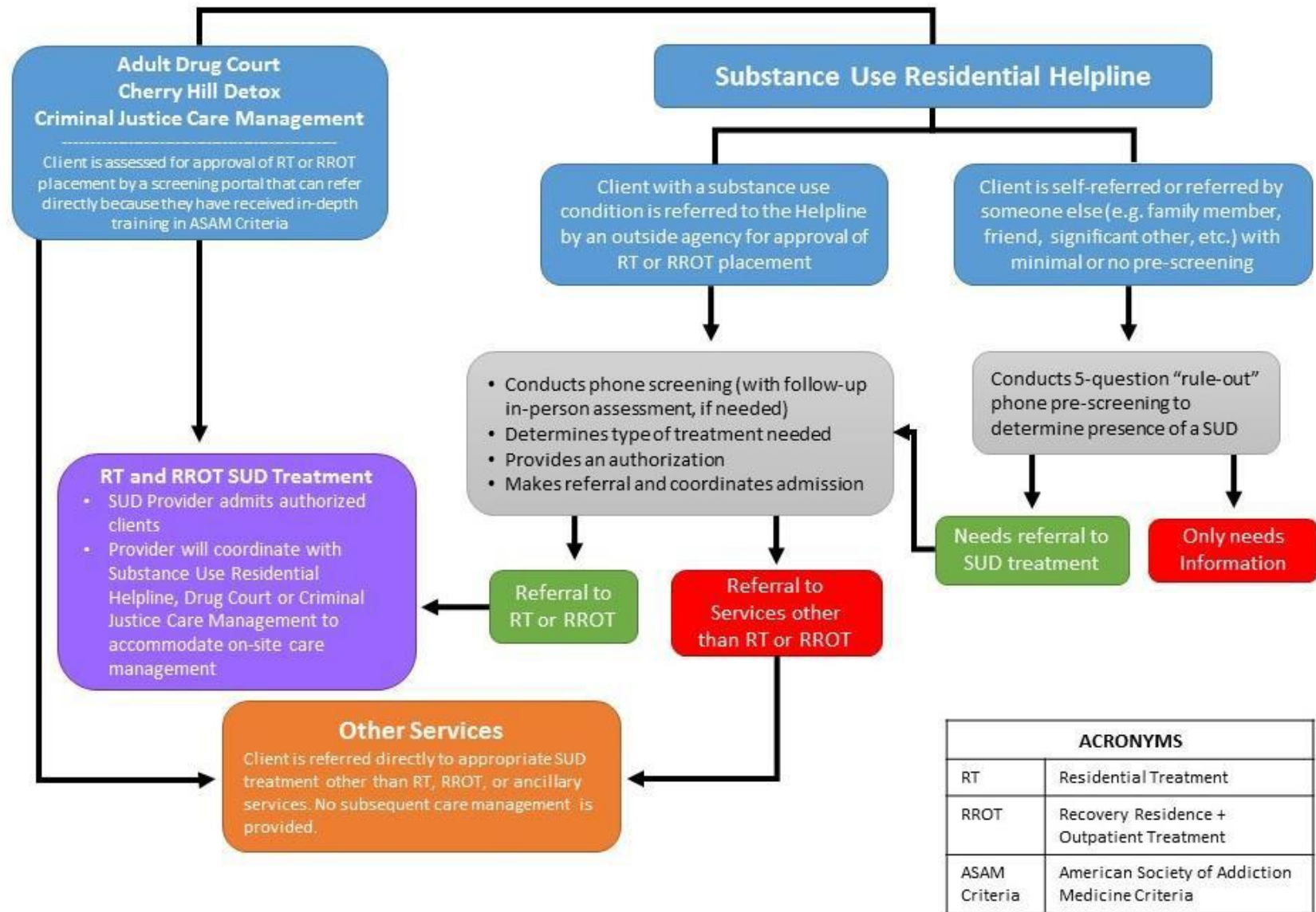
care, and number of initial authorizations for which a subsequent authorization for an extended stay or a transfer were made.

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

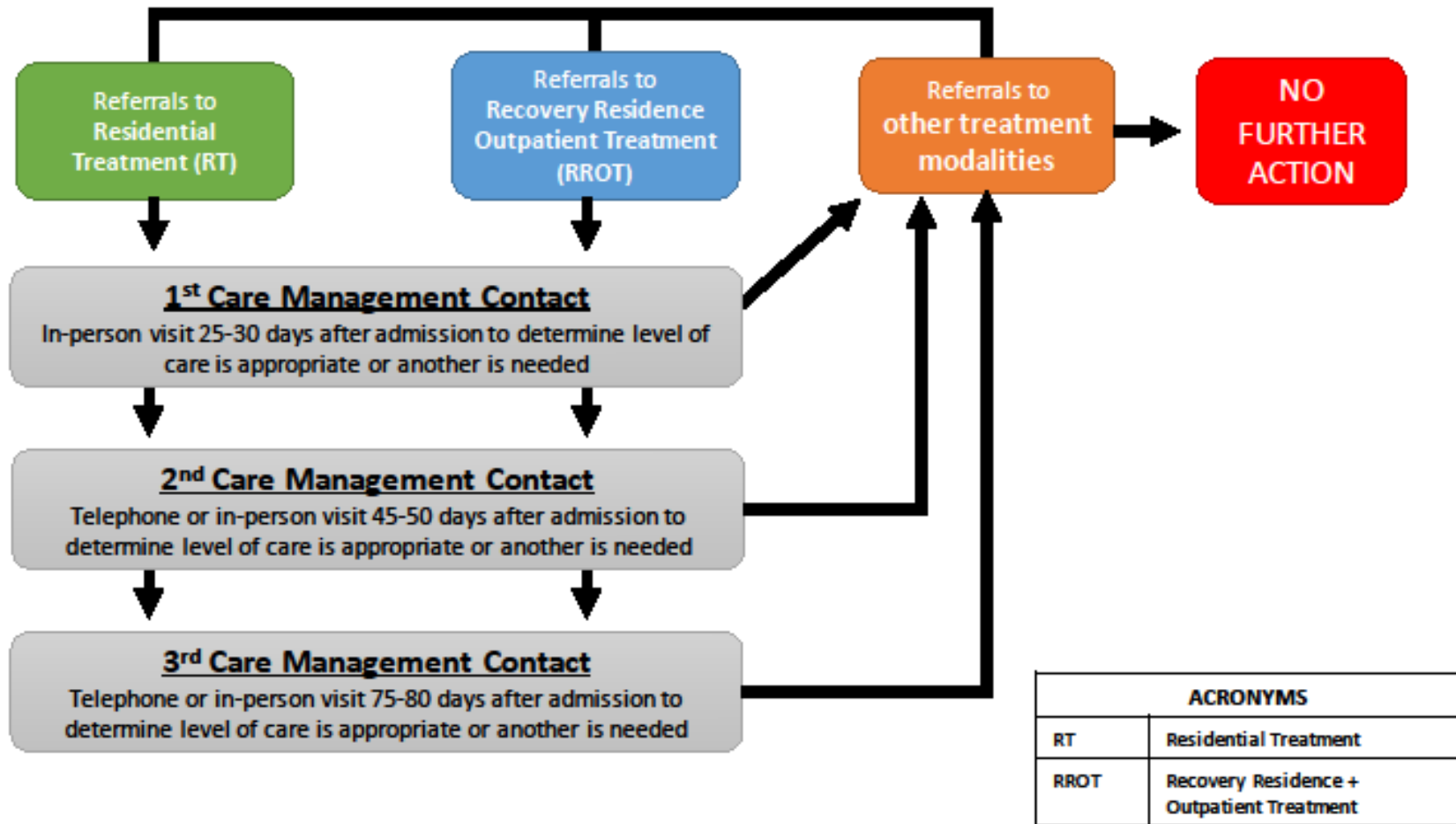
Review Note: This question only applies to counties participating in the one-year provisional program and only needs to be completed by these counties.

The County is able to meet all mandatory requirements and will not utilize the one-year provisional period.

Appendix A.1 | Screening and Referral Flow Chart for Substance Use Disorder Residential Treatment and Recovery Residence + Outpatient Treatment



Appendix A.2 | Care Management Flow Chart for Substance Use Disorder Residential Treatment and Recovery Residence + Outpatient Treatment



Appendix B | Alameda County ODS SUD Network of Programs

Adult Outpatient & Intensive Outpatient ASAM 1.0 & 2.1

Provider Name	Program Name	DMC Number	Service Modality	Service Population	Capacity Beds/Slots	Capacity Unique Clients Year	Days/Hours of Operation Treatment	MAT
Alameda County Highland General Hospital	Highland Substance Abuse Treatment Program	0109	Outpatient, IOT Pending	Adult	48-54	72	M-F 9:00 am-5:00 pm	
Alameda Family Services	Alameda Family Services	0168	Outpatient	Adult	20	50	M-T 9:00 am-8:00 pm F 9:00 am-5:00 pm	
Axis Community Health, Inc.	Axis Community Health, Inc.	8121	Outpatient, IOT Pending	Adult	80	75	M-F 1:00 pm-9:00 pm	
Bi-Bett; EORC	East Oakland Recovery Center	01AD	Outpatient, IOT Pending	Adult	40	30 DMC 80 non-DMC	M-F 8:00 am-9:00 pm; S-S 1:00 pm-9:00 pm	
Bi-Bett; EORC AB109	East Oakland Recovery Center	01AD	Outpatient, IOT Pending	Adult	7	29	M-F 8:00 am-9:00 pm; S-S 1:00 pm-9:00 pm	
La Familia Counseling Service	La Familia/Family Services Center	Pending	Outpatient, IOT Pending	Male	60	205	M, W, Th, F 8:30 am-8:00 pm, T 8:30 am-7:00 pm, Sat 9:00 am-6:00 pm	
La Familia Mujeres Family Services	Mujeres con Esperanza Outpatient	Pending	Outpatient	Female	34	120	M-F 9:00 am-6:00 pm	
Options Recovery Services/Allston	Options Recovery Services	0120	Outpatient, Intensive Outpatient	Adult			M-F 8:30 am-7:00 pm	
Options Recovery Services/Berkeley	Options Recovery Services/Berkeley	0120	Outpatient, IOT Pending	Adult	120	370	M-F 8:30 am-7:00 pm	
Options Recovery Services/Berkeley/AB109	Options Recovery Services/Berkeley/AB109	0120	Outpatient, IOT Pending	Adult	6	40	M-F 8:30 am-7:00 pm	
Options Recovery Services/Oakland	Options Oakland Drug Free Outpatient Program	01AJ	Outpatient, IOT Pending	Adult	50	160	M-F 8:30 am-7:00 pm	
Second Chance, Inc.	Second Chance Hayward Recovery Center/AB109	01AB	Outpatient, IOT Pending	Adult			M-F 12:00 pm-10:00 pm; Weekend Support Groups Sat at 6:00 pm and 8:00 pm	
Second Chance, Inc.	Second Chance Tri-Cities Center/AB109	0179	Outpatient, IOT Pending	Adult	6.5	21	M-F 12:00 pm-10:00 pm; Weekend Support Groups Sat at 6:00 pm and 8:00 pm	
Second Chance, Inc.	Second Chance Tri-Cities Center	0180	Outpatient, IOT Pending	Adult	400	825	M-F 12:00 pm-10:00 pm; 24/7 hotline	
Second Chance, Inc.	Second Chance Hayward Recovery Center	0025	Outpatient, IOT Pending	Adult	425	925	M, T, Th, F 12:00 pm-8:00 pm; W 4:00 pm-8:00 pm; emergency shelter and hotline 24/7	

Second Chance, Inc.	Second Chance, Inc. Women's Phoenix Center	0180	Outpatient, IOT Pending	Female	50	160	M-F 9:30 am-1:00 pm; F 10:00 am-1:00 pm; 24/7 hotline	
Senior Support Program of the Tri Valley	Senior Support Program of the Tri-Valley for Seniors Only	Not DMC Certified	Outpatient	Senior	15	30	M-F 8:00 am-4:00 pm	
St. Mary's Center	Recovery 55	Not DMC	Outpatient	Senior	55	80	M-F 9:00 am-12:00 pm and 1:00 pm-5:00 pm	
The West Oakland Health Council/Community Recovery Center-East	The Community Recovery Center East	0172	Outpatient	Adult	120	300	M-S 8:00 am-8:00 pm	
The West Oakland Health Council/Community Recovery Center-West	The Community Recovery Center West	8122	Outpatient	Adult	120	300	M-S 8:00 am-8:00 pm	

Perinatal Outpatient and Intensive Outpatient ASAM 1.0 & 2.1

Provider Name	Program Name	DMC Number	Service Modality	Service Population	Capacity Beds/Slots	Capacity Unique ClientsYear	Days/Hours of Operation Treatment	MAT
Alameda County Medical Center- Highland	Highland Perinatal Outpatient	0109	Perinatal Intensive Outpatient	Perinatal	12-15	18	M-F 9:00 am-5:00 pm	
La Familia Counseling Service	La Familia Women's Enhancement Perinatal	Pending	Perinatal Intensive Outpatient	Perinatal	24	85	M-F 9:00 am-6:00 pm	
The West Oakland Health Council	Intensive Outpatient Perinatal Treatment	0171	Perinatal Intensive Outpatient	Perinatal	8	45	M-F 8:30 am-5:00 pm	

Adolescent Outpatient & Intensive Outpatient ASAM 1.0 & 2.1

Provider Name	Program Name	DMC Number	Service Modality	Service Population	Capacity Beds/Slots	Capacity Unique ClientsYear	Days/Hours of Operation Treatment	MAT
Adolescent Treatment Centers, Inc.	Thunder Road Community Outpatient Services	Not DMC Certified	Outpatient, Co- occurring Mental Health and SUD	Adolescent	21	21	M-F 5:00 pm-8:00 pm; Saturday by Appointment	
Alameda Family Services-Adolescent	Alameda Family Services	0168	Outpatient Youth	Adolescent	10	33	M-T 9:00 am-8:00 pm F 9:00 am-5:00 pm	
Axis Community Health, Inc.	Axis Community Health Drug and Alcohol Program	0185	Outpatient, IOT Pending	Adolescent			M-F 11:00 am-7:30 pm	
City of Fremont, Youth and Family Services	City of Fremont, Youth and Family Services	Not DMC Certified	Outpatient	Adolescent	24	55	M-F 8:00 am-5:00 pm; evening by appointments; Saturday 9:00 am-1:00 pm for crises appointments	
Community Health for Asian Americans	Community Health for Asian Americans	Not DMC Certified	Outpatient	Adolescent	20	40	M-F 9:00 am-5:00 pm	

Horizon Services, Inc.	Project Eden/Outpatient Treatment	0178	Outpatient Youth	Adolescent	19	70	M-F 9:00 am-5:00 pm with some evening and weekend availability	
La Familia Counseling Service	La Familia/Projecto Primavera	Not DMC Certified	Outpatient Youth	Adolescent	30	85	9:00 am-7:00 pm (clinic); M-Th-F 9:00 am-1:30 pm, T 9:00 am-3:00 pm (schools)	
New Bridge Foundation, Inc./Aspire	New Bridge Foundation, Inc.	Not DMC Certified	Outpatient	Adolescent	TBD	158	M-F 8:30 am-4:30 pm	
The West Oakland Health Council/Community Recovery Center-East	Adolescent Substance Use Disorder (SUD) Outpatient Treatment	0172	Outpatient	Adolescent	15	30		

Narcotic Treatment Programs/Methadone Maintenance: ASAM OTP 1.0

Provider Name	Program Name	DMC Number	Service Modality	Service Population	Capacity Beds/Slots	Capacity Unique Clients Year	Days/Hours of Operation Treatment	MAT
BAART	Bay Area Addiction Research and Treatment		Methadone Maintenance	Adult	30.85	32	M. T. W. F. 6:00 am-1:00 pm; Th 6:00 am-1:00 pm; SS Holiday 7:00 am – 10:30 am	Yes
Berkeley Addiction Treatment Services	Berkeley Addiction Treatment Services	0181	Methadone Maintenance	Adult	153	153	M-F 5:30 am-11:45 am; S-S 5:30 am-9:00 am; County Holidays 7:00 am-9:00 am	Yes
Berkeley Addiction Treatment Services	Berkeley Addiction Treatment Services	0181	Methadone Maintenance	Perinatal	2	2	M-F 5:30 am-11:45 am; S-S 5:30 am-9:00 am; County Holidays 7:00 am-9:00 am	Yes
Humanistic Alternatives to Addiction Research and Treatment, Inc.	H.A.A.R.T./Oakland	0167	Methadone Maintenance	Perinatal	5	10	M-F 6:00 am-1:00 pm; S-S 7:30 am-10:00 am	Yes
Humanistic Alternatives to Addiction Research and Treatment, Inc.	H.A.A.R.T./Hayward	8104	Methadone Maintenance	Adult	275	455	M-F 5:45 am-1:00 pm; S-S 7:30 am-9:30 am	Yes
Lifeline Treatment Services, Inc.	Lifeline Treatment Services, Inc.	01AI	Methadone Maintenance	Adult	327	327	M-F 6:00 am-1:30 pm; S, S and holidays 8:00 am-11:15 am	Yes
Successful Alternatives for Addiction and Counseling Services, Inc./MedMark/SAACS	MedMark Treatment Centers Hayward	8108	Methadone Maintenance	Adult	209	209	M-F 5:00 am-1:30 pm; Weekends and Holidays 8:00 am-10:30 am	Yes
The West Oakland Health Council/Options for Recovery	West Oakland Health Council Methadone Maintenance	0171	Methadone Maintenance	Adult	100	100	M-F 7:15 am-4:15 pm; SS Holiday 7:15 am-11:15 am	Yes

Residential Treatment: ASAM 3.1, 3.3 & 3.5

Provider Name	Program Name	DMC Number	Service Modality	Service Population	Capacity Beds/Slots	Capacity Unique Clients Year	Days/Hours of Operation Treatment	MAT
Adolescent Treatment Centers, Inc.	Thunder Road	Not DMC Certified	Residential Treatment Co-Occurring MHS/SUD	Adolescent		40	24/7	
C.U.R.A., INC	C.U.R.A., INC/Residential Treatment	Pending	Residential Treatment	Adult	24	72	24/7	
C.U.R.A., INC	C.U.R.A., INC/Residential Treatment/AB109	Pending	Residential Treatment	Adult	3.66	11	24/7	
Horizon Services, Inc.	Chrysalis	Pending	Residential Treatment Co-Occurring MHS/SUD	Female	15	60	24/7	
Horizon Services, Inc.	Cronin House	Pending	Residential Treatment Co-Occurring MHS/SUD	Adult	30	200-243	24/7	
La Familia Counseling Service	La Familia/El Chante	Pending	Residential Treatment	Adult	15	50	24/7	
New Bridge Foundation, Inc.	New Bridge Foundation, Inc.	Pending	Residential Treatment	Adult	23	80	24/7	
New Bridge Foundation, Inc./AB109	New Bridge Foundation, Inc.	Pending	Residential Treatment	Adult	2-3 slots	20	24/7	

Perinatal Residential Treatment: ASAM 3.1, 3.3 & 3.5

Provider Name	Program Name	DMC Number	Service Modality	Service Population	Capacity Beds/Slots	Capacity Unique Clients Year	Days/Hours of Operation Treatment	MAT
Bi-Bett	Orchid Women's Recovery Center	Pending	Perinatal Residential Treatment	Female, Perinatal	12	41 Adult 4 Children (Perinatal); 1 Adult 2 Children (AB109 Perinatal; 3 Adult (AB109 Non-Perinatal)	24/7	
East Bay Community Recovery Project	Project Pride	Pending	Perinatal Residential Treatment	Female, Perinatal	20	25	24/7	
Magnolia Women's Recovery Program, Inc.	Magnolia Women's Recovery Program-Hayward	01AF	Perinatal Residential Treatment	Perinatal	6 adults, 6 infants	26 adults, 26 infants	24/7	

Magnolia Women's Recovery Program, Inc.	Magnolia Women's Recovery Program- Oakland	01AF	Perinatal Residential Treatment	Perinatal	10 adults, 10 children	20 adults, 20 children	24/7	
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Detox/Clinically Managed Residential: ASAM 3.2-WM

Provider Name	Program Name	DMC Number	Service Modality	Service Population	Capacity Beds/Slots	Capacity Unique Clients Year	Days/Hours of Operation Treatment	MAT
Horizon Services Inc. - Cherry Hill	Horizon Cherry Hill Detox	Pending	Detox Clinically Managed Residential	Adult	25	2025	24/7	

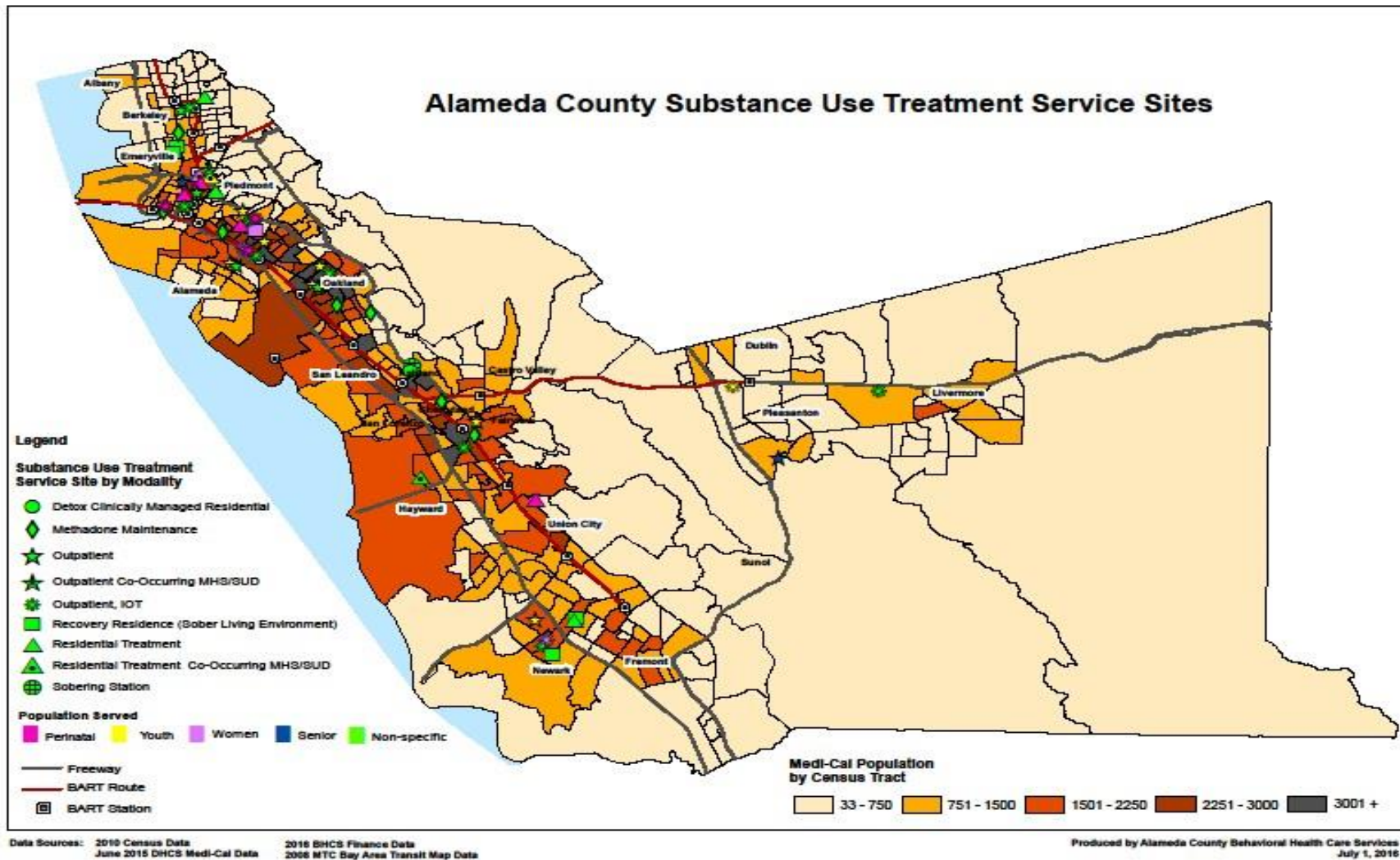
Sobering Station: ASAM 2-WM

Provider Name	Program Name	DMC Number	Service Modality	Service Population	Capacity Beds/Slots	Capacity Unique Clients Year	Days/Hours of Operation Treatment	MAT
Horizon Services Inc.- Cherry Hill	Horizon Cherry Hill Detox (Detox & Sobering Station)	Pending	Sobering Station	Adult	17 average daily		24/7	

Residential Recovery/Sober Living Environment

Provider Name	Program Name	DMC Number	Service Modality	Service Population	Capacity Beds/Slots	Capacity Unique Clients Year	Days/Hours of Operation Treatment	MAT
Bi-Bett	Bi-Bett Women's Sober Living- Oakland	N/A	RR SLE	Female	1.6	3	24/7	
C.U.R.A., INC.	C.U.R.A., INC./Transitional Living/Drug Court	N/A	RR SLE	Adult	4-5	15	24/7	
Options Recovery Services	Options Recovery Services, Inc. (Stanford Ave. Oakland)	N/A	RR SLE	Adult	1.6	5	24/7	
Options Recovery Services	Options Recovery Services, Inc. (59th St Oakland)	N/A	RR SLE	Adult	4	11	24/7	
Second Chance, Inc.	Second Chance, Inc.	N/A	RR SLE	Adult	2.7	10-15	24/7	

Appendix C | Geographical Map of SUD-ODS Providers



Appendix D | Quality Improvement Committee Members

INTERNAL (BHCS) Quality Improvement Committee Members	
NAME	ROLE / ORGANIZATION
1. Rudy Arrieta	Director, Quality Management
2. Khatera Aslami	Consumer Empowerment Manager
3. Radawn Alcorn	Acting Director, Transition Age Youth System-of-Care & Crisis Response Program
4. Fiona Branagh	Director, Network Office
5. Karen Capece	Associate Authorizations Manager
6. Aaron Chapman	Medical Director
7. Ken Coelho	Decision Support – Adult System of Care
8. Natalie Courson	IS Systems Manager
9. Gigi Crowder	Ethnic Services Manager
10. John Engstrom	Manager, Decision Support
11. Donna Fone	QA Administrator, Quality Assurance Unit
12. Tracy Hazelton	Prevention Coordinator
13. Mary Hogden	BHCS Consumer Empowerment Team – POCC Coordinator
14. Alex Jackson	Director, Special Projects, Quality Management
15. Manuel Jimenez	Behavioral Health Director
16. Sharon Loveseth	Program Analyst, Quality Assurance/Substance Use Programs
17. Jennifer Mullane	Program Specialist, Adult SOC
18. Marie Murray	Utilization Management Director
19. Jeff Rackmil	Director, Children’s Services
20. Barbara Saler	ACCESS Program Manager
21. Lillian Schaechner	Director, Older Adult Services
22. Henning Schulz	Critical Care Manager
23. Tom Trabin	Alcohol and Drug Program Administrator
24. Karyn Tribble	Deputy Director
25. Linda Truong	Executive Assistant, Quality Management
26. James Wagner	Director, Adult Services
27. Rosa Warder	Family Empowerment Manager
28. Jaleah Winn	BHCS Consumer Empowerment Team

EXTERNAL Quality Improvement Committee Members	
NAME	ROLE / ORGANIZATION
1. Michelle Alansalon	Quality Assurance Manager, Lincoln Child Center
2. Beverly Bergman	Family Advocate, Mental Health Association
3. Jennifer Cardenas	Quality Improvement Director SENECA FAMILY OF AGENCIES
4. Jasmine Casil	Quality Assurance Manager, SENECA FAMILY OF AGENCIES

EXTERNAL Quality Improvement Committee Members	
NAME	ROLE / ORGANIZATION
5. De Juana Champion	Family to Family – NAMI
6. Haydee Cuza	Executive Director, PEERS
7. Bree Desmond	Quality Manager/Data Analyst, Fred Finch Youth Center
8. Michele Dragovich	Behavioral Health Quality Improvement Manager, Native American Health Center
9. David Farrell	Vice President, Telecare
10. Alane Friedrich	Mental Health Board
11. Kelley Gin	Director of Clinical Services, West Coast Children’s Clinic
12. Tom Gorham	Executive Director, Options Recovery Services
13. Sandy Hobson	QA Assistant Director, Seneca
14. Courtney Jones	Chief Administrative Officer, Seneca
15. Annie Kim	Director, Family Education and Resource Center
16. Janet King	Native American Health Services
17. Shareen Leland	Program Director, New Bridge Foundation
18. Michelle Mateo	Chair, Steering Committee, Pool of Consumer Champions
19. Andrea Makunje	Clinical Operations/QA Manager, Family Paths, Inc.
20. Megan Maley	Clinical Documentation Integrity Specialist, UCSF Benioff Children's Hospital Oakland
21. Wendy McVey	QAC, Bonita House
22. Sherri Millick	NAMI
23. Brian Newton	Manager, Data and Reporting Systems , HUME Center
24. Scotty Scott	Director, Reaching Across, Alameda County Network of Mental Health Clients
25. Carol Silverman	Evaluation Director, Telecare
26. Dana Smith	Quality Improvement Director, Telecare
27. Francesca Tenenbaum	Director, Patient’s Rights Advocates, Mental Health Association
28. Michelle Thomas	Associate Director, PEERS
29. Rebecca Tortorelli	Medical Records Manager, Fred Finch Youth Center

Appendix E | Grievance and Appeals Process and Request Forms

Grievance and Appeals Process & Request Form

If you have a concern or problem or are not satisfied with your mental health services, the Mental Health Plan (MHP) wants to be sure your concerns are resolved simply and quickly. You or your representative may file a Grievance or Appeal, orally or in writing, with your provider, or with the Consumer Assistance office at 1(800) 779-0787. Please use the attached Grievance and Appeal Request Form to file a Grievance or to request an Appeal. You will not be subject to discrimination or any other penalty for filing a Grievance or Appeal.

Grievance is defined as an expression of unhappiness about anything regarding your specialty mental health services that are not one of the problems covered by the Appeal and State Fair Hearing processes described below. Examples of grievances might be as follows: the quality of care of services provided, aspects of interpersonal relationships – such as rudeness of an employee, etc. Steps to file a Grievance:

- File a Grievance orally or in writing. Oral grievances do not have to be followed up in writing. You may authorize another person to act on your behalf.
- You will receive a written acknowledge of receipt of your Grievance.
- The MHP has 60 days after the receipt of your Grievance to review it and notify you or your representative in writing about the decision.
- Timeframes may be extended by you up to 14 calendar days if you request an extension, or if the MHP feels that there is a need for additional information and that the delay is for your benefit.
- You may file a Grievance at any time.

An Appeal is a request for a review of a decision that was made by the MHP or your provider that modifies or denies a requested specialty mental health service (SMHS) and/or a reduction, suspension, or termination of a previously authorized service. The decision made by the MHP about your specialty mental health services may be described in a Notice of Action (NOA) letter sent or given personally to you. You will not always get a NOA. Steps to file an Appeal:

- File an Appeal in person, on the phone or in writing within 90 days of the date of a NOA. If you file the Appeal in person or by telephone, you must follow it up with a signed written Appeal. If you did not receive a NOA, there is no deadline for filing; so you may file at any time. You may authorize another person to act on your behalf.
- Upon request, your benefits will continue while the Appeal is pending IF you file the Appeal within 10 days from the date the NOA was mailed or given to you.
- You will receive a written acknowledge of receipt of your Appeal.
- The MHP has 45 days after the receipt of your Appeal to review it and notify you or your representative in writing about the decision.
- Timeframes may be extended by you up to 14 calendar days if you request an extension, or if the MHP feels that there is a need for additional information and that the delay is for your benefit.

An Expedited Appeal can be requested if you think waiting 45 days will jeopardize your life, health, or ability to attain, maintain or regain maximum function. If the MHP agrees that your appeal meets the requirements for an Expedited

Appeal, the MHP will resolve it within 3 working days after the Expedited Appeal is received. Steps to file an Expedited Appeal:

- File an Appeal in person, on the phone or in writing within 90 days of the date of a Notice of Action (NOA). Verbal and in person requests for Expedited Appeals do not have to be put in writing. You may authorize another person to act on your behalf.
- Upon request, your benefits will continue while the Expedited Appeal is pending IF you file the Appeal within 10 days from the date the NOA was mailed or given to you.
- You will receive a written acknowledgement of receipt of your Expedited Appeal.
- The MHP has 3 days after the receipt of your Expedited Appeal to review it and notify you or your representative in writing about the decision.
- Timeframes may be extended by you up to 14 calendar days if you request an extension, or if the MHP feels that there is a need for additional information and that the delay is for your benefit.
- If the MHP decides that your appeal does not qualify for an Expedited Appeal, they will notify you right away verbally and in writing within 2 calendar days. Your appeal will then follow the Standard Appeal process.

You have a right to a State Fair Hearing, an independent review conducted by the California Department of Social Services, if you have completed the MHP's Grievance and/or Appeals process and the problem is not resolved to your satisfaction. A request for a State Fair Hearing is included with each Notice of Action (NOA); you must submit the request within 90 days of the postmark date or the day that the MHP personally gave you the NOA. You may request a fair hearing whether or not you have received a NOA. To keep your same services while waiting for a hearing, you must request the hearing within ten (10) days from the date the NOA was mailed or personally given to you or before the effective date of the change in service, whichever is later. You may also request a State Fair Hearing by calling 1(800) 952-5253, sending a fax to (916) 651-5210 or (916) 651-2789, or writing to:

Department of Social Services/State Hearings Division

P.O. Box 944243, Mail Station 9-17-37

Sacramento, CA 94244-2430.

For more detailed information on the Grievance or Appeals process, please ask your provider for a copy of *Guide to Medi-Cal Mental Health Services*. For questions or assistance with filling out forms, you may ask your provider or call:

Consumer Assistance 1 (800) 779-0787

Grievance or Appeal Request

This form is used to file a Grievance or to request an Appeal. If you need assistance in completing this form, you can request help from your provider or by calling Consumer Assistance at (800) 779-0787 or Patient's Rights at (510) 835-2505. **A signed *Authorization for Release of Confidential Information* needs to be submitted along with this form.** The Grievance or Appeal Request can be submitted to your provider (MD, case manager, clinician, the Program Supervisor, etc.) or mailed directly to Consumer Assistance at: 2000 Embarcadero Cove, Suite 400, Oakland, CA 94606. **Please fill out both sides of this form.**

I wish to file: (choose one) Grievance ☐ Appeal ☐

☐ Check here if you are requesting that your Appeal be processed through the Expedited Appeals Process (*see requirements for an Expedited Appeal*)

Your address and phone number are important. We need this information to contact you about the outcome of your Grievance or Appeal. **PLEASE PRINT:**

Your Name: _____

Your Address: _____

Your Daytime Phone: _____ Date of Birth: _____

May we leave a message at the above #? Yes ☐ No ☐

Current Provider: _____

If Applicable, Person Representing You: _____

Their Address: _____

Their Daytime Phone: _____

Please answer the following questions. Attach additional pages if needed.

What is the problem? _____

What have you done to try to resolve the problem? _____

What would you like the solution to be? _____

Consumer (or Consumer's Representative) Signature

Date

***You will not be subject to discrimination or any other penalty for filing a
Grievance or Appeal. Your confidentiality will be protected at all times in accordance with
State and Federal law. You may request a State Fair Hearing following the completion of
the Grievance and/or Appeals Process.***

GRIEVANCE/APPEAL CALL FORM

Date: Click here to enter a date.	Staff:	Live Call: Office Visit:	Email: Voice Mail:	Resolution by: Click here to enter a date.
CALLER: Beneficiary: Yes_ /No_____		Family: (Name/Relationship)	Advocate/Other:	Provider:
Beneficiary's Name:		Medi-Cal Beneficiary	Transferred to PRA Date:	Transferred to QA Date:
Address:		Birthdate:		
		Medi-Cal #:		
Phone:		Social Security #:		
Provider Agency:		Grievance Category: Choose an item. <input type="checkbox"/> Access: <input type="checkbox"/> Quality of Care: <input type="checkbox"/> Change of Provider: <input type="checkbox"/> Confidentiality: <input type="checkbox"/> Other: Housing Issue	Written Grievance: Choose an item.	
			Date Acknowledgement Letter Sent:	
Issue:	Date of Resolution: Resolution:		Release Form Received:	
Actions: I mailed out the grievance packet to the consumer, and a notice to the provider.				
<ul style="list-style-type: none"> Initial Letter Sent Resolved Within 60 days: Extension Request by Client/Complainant (14 day) Resolution Letter Sent to Provider? Click here to enter a date. 				

