



SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

Drug Medi-Cal Organized Delivery System Implementation Plan

Santa Barbara County
Department of Behavioral Wellness
Alcohol and Drug Programs
countyofsb.org/behavioral-wellness
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PART I PLAN QUESTIONS

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

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

- County Behavioral Health Agency**
- County Substance Use Disorder (SUD) 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**
- Federal 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 (RR))**
- Health Information technology stakeholders**
- Other (specify) _____**

- 2. How was community input collected?**

- Community meetings**
- County advisory groups**
- Focus groups**
- Other method(s) (explain briefly) Survey Monkey, County Wide**



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:** Monthly meetings will include County Alcohol and Drug Program (ADP) network providers, members of the Drug Medi-Cal Organized Delivery System (DMC ODS) Implementation Work Group, including the Santa Barbara County (SBC) Public Health Department (PHD) and the Department of Social Service (DSS), Probation and internal Behavioral Wellness (BeWell) staff. We anticipate two (2) separate meetings per month, one for ADP providers and one for internal work group. Ad hoc committees or sub committees may be established as needed to address specific issues that may arise. DMC ODS information is also provided at monthly Community Based Organization (CBO) meetings with the BeWell Director and the BeWell Commission.

4. Prior to any meetings to discuss development of this implementation plan, did representatives from 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.**



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



9. What services will be available to DMC ODS clients upon year one implementation under this county plan?

REQUIRED

- Withdrawal (W/D) Management (minimum one level)**
- Residential Services (minimum one level)**
- Intensive Outpatient**
- Outpatient**
- Opioid (Narcotic) Treatment Programs**
- Recovery Services**
- Case Management**
- Physician Consultation**

How will these required services be provided?

- All County operated**
- Some County and some contracted**
- All contracted.**

OPTIONAL

- Additional Medication Assisted Treatment (MAT)**
- Partial Hospitalization**
- Recovery Residences**
- Other (specify) _____**

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

- Yes (required)**
- No Plan to establish by:**

We currently have a twenty four (24) hour Access screening Line (AL) that uses an American Society of Addiction Medicine (ASAM) screening tool. The phone number is (888) 868-1649.

11. 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**



12. The county will comply with all quarterly reporting requirements as contained in the Standard Terms and Conditions (STCs).

- Yes (required)**
 No

13. Each county's Quality Improvement Committee (QIC) will review the following data at a 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 External Quality Review Organization (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

1. Collaborative Process.

Describe the collaborative process used to plan DMC 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.

Santa Barbara (SB) is a collaborative county. The Department of Behavioral Wellness (BeWell), partner agencies and community providers have worked closely together to reach consensus in establishing and sustaining programs for many years. The Department of Behavioral Wellness Alcohol and Drug Program (ADP) has an exemplary record of successful collaboration with ADP treatment providers and internal partner agencies, especially the SBC Probation and Department of Social Services (DSS), in developing programs that are satisfactory to all parties and ensure the best client care and public safety.

BeWell is an integrated Mental Health (MH) and Substance Abuse Disorders (SUD) prevention and treatment department. BeWell is now collaborating with the Santa Barbara County Public Health Department (SBC PHD) to integrate limited SUD services into the primary care setting. Specifically, BeWell and the PHD have worked together to integrate Screening, Brief Intervention and Referral to Treatment (SBIRT) into selected PHD clinics. PHD and BeWell staff triages clients who appear to have SUD/MH or Co-Occurring Disorder (COD) issues and then refer these clients to appropriate services. The Drug Medi-Cal Organized System of Delivery (DMC ODS) planning process has expedited this collaboration. BeWell organized an internal County ODS Planning work group consisting of staff from BeWell, PHD, DSS and Probation. These departments are connected to the majority of our county's Substance abuse treatment centers. This group met twice to review the DMC ODS STCs and identify service gaps that the DMC ODS needed to address. A consensus was reached with the design of the plan. This planning group will reconvene again once the plan has been approved.

Concurrently, BeWell organized formal stakeholder meetings and other community meetings throughout each region of the County – SB City area, Lompoc, and Santa Maria. A broad range of stakeholders and community groups attended including SUD prevention and treatment providers, primary care and managed health plans, National Alliance on Mental Illness (NAMI), local school district staff, law enforcement personnel, sober living environments, hospital staff and individual community members. All meetings were three (3) hours long each, and consisted of two parts, a basic power point overview of the DMC ODS followed by a general discussion on how community members might envision a transformed system of SUD care. Total stakeholder participation was 294.

During the meeting, two questions were posed:

- 1. *Where do you see service gaps?***
- 2. *How would you improve the SUD system of care?***

We recognized that certain stakeholders might not have been able to attend the community stakeholder meetings, so we also developed a survey which was distributed throughout the County posing the same two questions above and received valuable feedback from 68 respondents. During the past two years we have also presented and discussed the DMC ODS in regularly scheduled meetings with providers, CBOs, the ADP Advisory Board, the MH Commission, Core Committees (CC), therapeutic justice meetings, SB Board of Supervisors (BOS) and County Executive Officer (CEO), and in meetings with educational institutions as well as other groups. We have been educating our community and soliciting suggestions as well as concerns regarding the gaps in our system and asking stakeholders what they would like to see from the DMC ODS. As such, the department has received a wealth of information and suggestions on how to organize a delivery system that is complete yet realistic. We combined this input with California Outcomes Measurement Service (CalOMS) and other data sources to create a data driven DMC ODS plan that is agreeable to all parties.

The ODS stakeholder process has generated optimism as well as concern. Community members are pleased that our SUD system of care will be expanded and enhanced, but question the potential costs and necessary supports required to do so. The following SBC DMC-ODS Implementation Plan is a system transformation that will require a significant investment in clinical and administrative infrastructure. In order to obtain positive outcomes, BeWell anticipates significant costs establishing a transformed and integrated system of care which includes hiring and maintaining a qualified workforce, providing on-going training and technical assistance to internal and CBO staff, ensuring fidelity to Evidence Based Practices (EBP), and meeting EQRO demands. Therefore, it is important that the DMC reimbursement rates be adequate to meet the costs of not only building a quality system of care, but also providing parity consistent with federal law. To be successful, this investment will need to be sustained through both adequate administrative allowances and reasonable reimbursement rates.

SBC stakeholders and BeWell also share the concerns of other counties that the current state rules and regulations for reimbursement are at times inflexible and constrain new treatment paradigms. We agree with Santa Clara County's concerns that:



The current rules for reimbursement and reporting act as a constraint to the full development of a good and modern behavioral health delivery system...Current regulations are based on an acute model of care for SUDs, with clear points of entry and exit...Regulations will need to become more flexible to accommodate a person oriented treatment approach (Santa Clara DMC ODS Implementation Plan, pp 6-7).

In short, the BeWell DMC-ODS Implementation Plan will pivot on healthcare integration that will require a significant investment in infrastructure development and flexibility with the current reimbursement rules and regulations.

New DMC ODS reimbursement rates for DMC must cover costs of evidence based system transformation. SBC BeWell is committed to expanding these important services and recognizes the long term benefits to the individual and community on implementing the DMC-ODS.

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, the professional qualifications of individuals who will conduct ASAM criteria interviews and assessments, 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 and who is providing the case management services. Also describe if there will be timelines established for the movement between one level of care to another. Please describe how you plan to ensure successful care transitions for high-utilizers or individuals at risk of unsuccessful transitions.

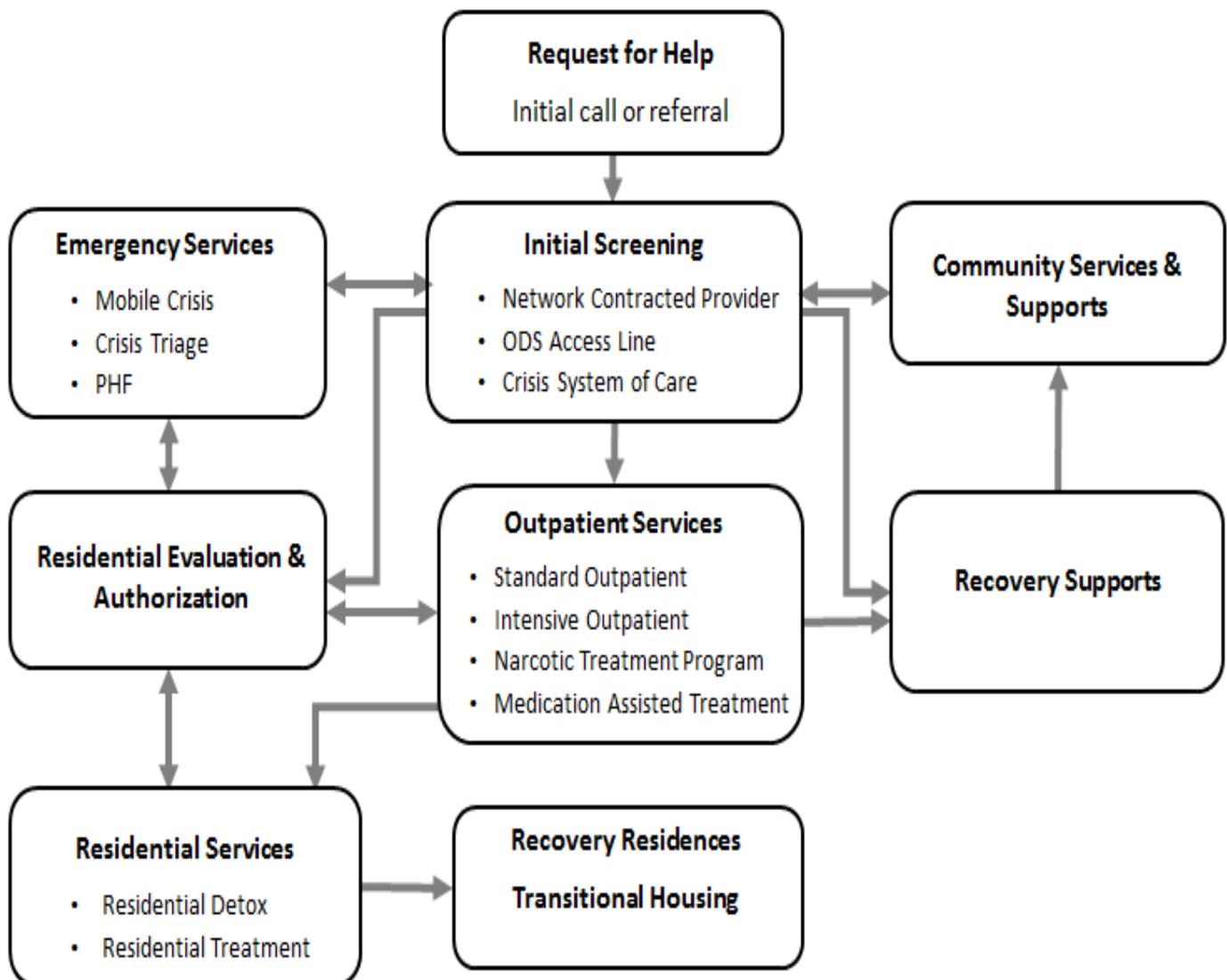
There will be no wrong door to access treatment services in SB. Anyone inquiring about treatment services – the individual who needs to access services or the family/significant other of the individual – will be screened and/or given educational and referral information depending on their individual needs. SBC believes that family and social supports are vital in the successful recovery of every individual suffering from SUD. Therefore, as allowed by federal law, involving families and significant others throughout the client engagement and treatment will be instrumental in the recovery process.

Requesting Services (Referral)

There will be three (3) points of entry into the ODS system:

- 1) Calls into the Beneficiary Access Line
- 2) Calls or walk-ins into a SUD contracted provider/CBO;
- 3) Referrals from our Crisis Stabilization Units (CSU) and crisis services.

The following is a basic flowchart of client movement through the SB DMC-ODS system of care.



Providing quick and direct service access for DMC-ODS eligible clients will be paramount. SBC recognizes that providing clients and/ or their significant others with numerous contacts that may lead to more contacts can create barriers to treatment. Having every referral go through the Access Line for example, is inappropriate and delays client care. Though having multiple points of entry will require more resources for quality control and quality management, doing so will ensure appropriate assessment, referral and linkages to indicated treatment services and levels on a timelier manner. Simply put, the less clients are “bounced around”, the greater the engagement and treatment success. Therefore, every door will be open and every handoff as warm as possible to smooth the client’s path to treatment engagement.

These points of entry are broad and will be able to capture and include clients from anywhere in the Santa Barbara communities. Other service providers such as PCPs and community social workers will be able to refer clients to anyone of these points of entry for quick and easy access to DMC-ODS services. Of course, part of the SB DMC-ODS process will be educating all potential referral sources – the entire SB population – about the entry points and available services within the plan. From press releases to meeting announcements, website information to private correspondence, the DMC-ODS will be advertised throughout the county for “no wrong door” easy access.

County BeWell ADP already provides this access in many instances. ADP staff provides client care by receiving direct calls from clients and significant others and providing screening, assessment and direct referrals over the phone or in person. The ODS will institutionalize, expand and build on current departmental ~~practices~~.

Initial Service Assessment Screening

All individuals expressing interest in entering our system of care will be screened and triaged for safety, risk and the caller desired service. Every caller or potential client will be met “where they are” and welcomed into an integrated system, regardless of whether the client actually enters the system. The Access Line and all treatment services will accommodate and be available English and Spanish, the prevalent or threshold non-English language in Santa Barbara. Access Line staff are and will be full trained and proficient in TTY and other language translation services.

The Access Line will be staffed by Licensed Practitioners of the Healing Arts (LPHA) or LPHA interns who will be versed in SUD issues, including differential diagnoses. The Access Line will consist of an integrated screening team and use an integrated screening tool that includes ASAM risk levels. If it is clear that the caller and/or family member has SUD issues or has been referred for SUD treatment, the ASAM criteria will be the focus of the screening. If the caller presents with MH or Severe Persistent Mental Illness (SPMI) issues and high risk, then screening for safety and risk will be paramount.

It is expected that most callers who are not referred for SUD treatment specifically will present with complex, co-occurring conditions. Therefore, it is anticipated that the ASAM criteria will be used in the majority of cases and calls. MH and SUD issues often coexist, so “whole person” screening will be emphasized. Finally, each caller will also be screened for any immediate physical needs, and referrals/collaboration with primary care will be made. The Access team will also possess differential diagnosis skills and use Motivational Interviewing (MI) and the ASAM screening tool to assist in identifying and engaging clients.

Clients who contact the treatment system directly through local service providers will be screened using the same ASAM tool that is used at the Access team. Each contracted provider will be required to have co-occurring capabilities per ASAM standards. Direct service staff will be certified or registered as an alcohol and other drug (AOD) counselor as recognized by the Department of Health Care Services (DHCS), Title 9 California Code of Regulations (CCR) requirements.

Although every effort will be made to employ certified AOD counselors for all direct services, the lack of available qualified staff may require hiring a large number of registered counselors. All registered SUD counselors will be intensely supervised by certified and or licensed staff and will be qualified to provide direct services per state regulations.

All SUD practitioners will be trained and proficient with ASAM theory and practice, administration of the ASAM screening tool and capable of providing a basic differential diagnosis of MH and SUD disorders. Providers will also be able to refer or link clients to the appropriate level of care level of care and ancillary services accurately and swiftly. The County CSUs will be another entry portal and will also administer the same ASAM tool.

Once screened, the beneficiary will be referred to the appropriate ASAM level of care. Matching each client to the appropriate treatment provider can be just as important as matching the client to the appropriate level of care. Therefore, each referral will be grounded in each client’s preferences and cultural experience including geographic location, language preferences, transportation and other client centered values and concerns.

All screening staff will have the ability to refer beneficiaries to the following services available for client referrals:

- Outpatient and Intensive Outpatient Treatment (IOT) services
- Narcotic Treatment Program (NTP) services
- Outpatient W/D or Detoxification services
- MAT services
- Residential Treatment Referral to QCM
- SUD Case Management services
- Recovery Support Services

Residential referrals will be made to QCM staff. (Please see below). Clients with both substance abuse disorders and severe mental illness may be referred to both specialty mental and DMC services for example methadone treatment and outpatient mental health services. As an integrated department, these services will be coordinated with appropriate consent from individual clients.

Intake Assessment and Medical Necessity Determination (Assessment, Placement Authorization)

Once ASAM screening is complete and SUD treatment appears to be indicated, the client will be referred to an appropriate treatment provider for a full biopsychosocial assessment. As mentioned earlier, all contracted direct service staff will be registered or certified AOD counselors with co-occurring capabilities, and able to provide a basic differential diagnosis. A standardized Multidimensional ASAM Assessment will be

administered. Medical necessity will be established through the use of the ASAM Multidimensional Assessment. All Title 22 CCR regulations will be followed in determining medical necessity.

The ASAM screening and assessment should be aligned to proceed with the appropriate level of care placement, however, sometimes screenings and assessments are not in sync. Initial ASAM screenings and referral may yield different results than the comprehensive ASAM Assessment. In such cases, the provider must work with the client to ensure proper treatment placement and referral to the appropriate level or system of care.

Our internal Quality Care Management (QCM) and case management services (see below, Care Coordination and Quality Management) will be used to ensure that client receives the appropriate level of care at the appropriate treatment provider. In the event that a client does not meet the established medical necessity, the client will be referred to secondary prevention services, (ASAM Treatment Level 0.5, Early Intervention).

Residential Evaluation

Once an individual screening indicates the need for residential services, an authorization request will be sent to our QCM team for approval. An evaluation appointment will be offered within twenty four (24) hours of the initial call and may be provided face-to-face or by telephone, and may be provided anywhere in the community. Authorization may or may not require ASAM/Addiction Severity Index (ASI) level assessment for residential placement. Regardless, whichever point of entry, all residential authorizations must be made by a LPHA on the QCM team. QCM will monitor all residential authorizations and QCM staff may also be included in the authorization process from the beginning.

Once residential services have been authorized, it is expected that treatment services will begin within twenty four (24) hours.

Every effort will be made to place authorized clients into residential treatment as quickly as possible, and it is anticipated that placement may occur immediately and not within forty eight (48) hours of initial referral to QCM.

Re-Assessment

Re-assessments will be an important part of the DMC-ODS treatment process. Re-assessments allow the treatment team to review client progress, comparing the most recent client functioning and severity to the initial baseline assessment and to evaluate the client’s response (progress or lack thereof) to services. Each ASAM dimension will be reviewed to determine the current level of functioning and severity. Providers will be required to demonstrate that beneficiaries continue to meet current level of care criteria and medical necessity per Title 22 CCR rules and regulations.

All clients will be re-assessed on a regular basis and, as needed per Title 9 CCR requirements, whenever there is a significant change in his or her status, diagnosis, treatment plan revision or at the client’s request.

Contracted providers will reassess for medical necessity. **Table 1** describes the required reassessment timeframes:

Table 1: Level of Care ~ Reassessment Time Frame

Level of Care	Reassessment Timeframe Maximum
Residential Detoxification, Level 3.2	5 days
Residential Treatment, Level 3.1, 3.3, 3.5	30 days
Intensive Outpatient Treatment, Level 2.1	90 days
Outpatient Treatment, Level 2.1	90 days
Narcotic Treatment Programs	180 days and annual
MAT	90 days and annual
Recovery Support Services	90 days
Level of Care	Reassessment Timeframe Maximum
Case Management Services	90 days and as part of above service modality

Continuing Care (Transitions and Case Management)

All SUD providers are expected to individualize treatment and use the full continuum of services available to ensure that clients receive the appropriate treatment at the appropriate time. Case management and QCM services will help ensure clients move through the system (levels of care) and access treatment and ancillary services to support their recovery.

As clients move through the treatment system and from one level to another, they will be connected to recovery services and peer support systems to further their recovery and prevent relapse. Recovery Support services will be essential in managing chronic SUD conditions.

If a client relapses, peer support specialists or coaches can quickly reconnect the client to a provider for further care. In such cases, the ASAM screening and ASI will be re-administered, and level of care will be determined on medical necessity.

Care Coordination and Quality Management (Monitoring successful transitions)

Care coordination and quality management will be essential to ensure clinical and administrative accuracy. QCM reviews all residential authorizations and reauthorization requests for ASAM accuracy and medical necessity. Placement in Recovery Residences also require BeWell QCM authorization. This team will also monitor bed availability to facilitate rapid entry into residential services to ensure beneficiary access and utilization to the full continuum of services.

Physician consultation services will be made available to ensure care coordination and evidence based client care. DMC physicians will consult among themselves and or with other non DMC primary care physicians and psychiatrists to ensure that physical health, medication management and medication assisted treatment (MAT) plans are followed. The county of Santa Barbara has a network of ASAM and CSAM (CA Society of Addiction Medicine) psychiatrists and buprenorphine certified physicians within the Be Well system of care and outside in the local communities. A referral list of addictions experienced and knowledgeable physicians will be kept in order that DMC physicians will have the consultative support needed for the DMC-ODS system of care. Some relationships are already established and physician consultation is occurring. Current DMC physicians currently correspond with Be Well psychiatrists, the county of Santa Barbara Public Health Department (DPH), doctors within in the Cottage Medical Center and local addictions doctors to consult on specific cases and general types of cases. A local Opioid Task Force has been established and brings all of these physicians together to address opioid misuse and MAT in general. Exciting relationships are being established, primary care integration and MAT is being explored and expanded. In short, DMC physicians will have a network of primary care and addictions experts to call upon when needed to provide psychiatric assessments, medications, medication support services where pharmacists indicated will also be included for consultation. Consultation services may address medication selections, dosing, side effects, level of care considerations or other complexities such as COD that may arise. As DMC is a medical model, physician consultation will be an important part of the SB DMC ODS. DMC physicians will be experienced with SUD disorders, models of care and medication assisted treatment (MAT).

Of particular importance will be the care, case management and care for clients with complex needs and barriers to successful treatment. Sometimes referred to as “high utilizers”, regular triage meetings will be used to identify and focus on specific individuals who continue to cycle through systems of care unsuccessfully.

These meetings will be multidisciplinary and will include DMC and BeWell psychiatrists, pharmacists, social workers, SUD counselors and other pertinent LPHAs and social service workers. All multidisciplinary teams will be familiar with Motivational Interviewing and the Stages of Change model, ASAM Criteria, differential diagnosis and community resources. Each client will be case managed by name to ensure full wrap around services are provided.

Two of these meetings already exist within BeWell for clients with SPMI and mild to moderate MH disorders who also have SUD. An additional DMC-ODS Triage Meeting will be created to focus on DMC-ODS clients with complex needs. These meetings will be led by a DMC Quality Care Management Coordinator (QCMC) and will staff cases through all regions of the county.

SBC has a good record of monitoring provider compliance and client outcomes. With the ODS, BeWell QCM will become even more robust. Two (2) additional full time DMC ODS Quality Care Management Coordinators (QCMCs) will be hired to provide dedicated quality assurance and management services for the DMC ODS. The QCM department and QIC will provide oversight to the entire ODS. QCM will be part of and will audit team authorizations and reauthorizations, review individual client records, attend and monitor counseling groups to ensure that the entire ODS system is working in accordance with ASAM guidelines and that evidence based treatment models are meeting fidelity standards. Provider client charts will be reviewed and audited to ensure individualized client care is being provided according to Title 22 CCR standards. A minimum of five (5) percent or approximately one hundred and seventy five (175) of all DMC charts will be audited on a monthly basis.

System-wide data will be reviewed, such as length of stay in a particular level of care, to determine that care is provided according to assessment and reassessment. Successful completion data per CalOMS discharge will be kept and analyzed to ensure that treatment is effective and physical facilities will be evaluated to ensure all clients are entering a welcoming environment. Finally, transitions from one level of care to another will be scrutinized for evidence of important care coordination.

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 Americans with Disabilities Act (ADA) compliant.

There will be a twenty four/seven (24/7) Access Line for the DMC ODS. This toll free phone number will be included on the Behavioral Wellness website, brochures, meeting agendas and distributed to all partner agencies and community groups.

Once the DMC-ODS plan is approved and before implementation, formal letters and memos will be drafted and distributed throughout the community to provide essential information including this number and covered benefits, to ensure access. As described earlier, staff will employ an ASAM screening tool, which will be a standardized and validated instrument being used throughout the SUD and MH systems of care. In time, we anticipate that the County PHD may also use this ASAM screening to create a fully integrated system of care throughout the County. The Access Team will make every effort to employ bilingual staff, but will also train staff in the use of the Language Line. The Language Line will assist Access Team staff when clients call speaking other languages not spoken by the staff. The Access Line will also include a TTY.

A SBIRT model and protocol will be used by all Beneficiary Access Line staff. All staff from both lines will be trained and proficient with SBIRT and ASAM. ODS Access staff will be LPHAs or LPHA interns who will be trained in both MH/SUD and COD issues. Staff will be proficient with differential diagnosis and will be able to provide effective SBIRT/ASAM screenings within approximately 15 minutes of a request for services. Bilingual services, in our one threshold language (Spanish), will be available at all times.

The following data elements will be collected by Access Line staff for evaluation and Quality Improvement (QI) purposes:

- Number of calls, including the date, time and length of call
- Call duration
- Average wait times between calls and service delivery
- Number of calls requesting non-English translation and language
- Names or identifier of caller and name of staff taking the call
- Call disposition
- Number of calls that are determined to be emergency, urgent or routine
- Call abandonment
- Number of calls / individuals (potential individual clients or their significant others) screened and referred to DMC ODS services, including ASAM level of care
- Grievance calls – number, content and disposition

4. Treatment Services.

Describe the required types of DMC ODS services (W/D management, residential, intensive outpatient, outpatient, opioid/narcotic treatment programs, recovery services, case management, physician consultation) and optional (additional MAT, RR) 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.

SBC BeWell currently provides a quality SUD continuum of care. Contracted providers are proficient with EBP including MI, cognitive behavioral models, trauma informed care, community reinforcement approaches, contingency management, MAT (Methadone) and a variety of other evidence based approaches. SBC has been a pioneer in trauma informed care, establishing Seeking Safety and other trauma informed models for over fifteen (15) years. The department has been awarded several Substance Abuse and Mental Health Services Administration (SAMHSA) grants to expand and enhance trauma informed services and our staff as well as some of our contracted providers has been invited to speak at national conferences regarding our successes with trauma informed and perinatal systems of care. All SUD services are provided within a solid and well-regulated medical model.

SB ADP is a leading DMC oriented county, with a high DMC penetration rate and an excellent DMC compliance record. SBC has established a solid, compliant and high quality DMC medical model of care.

Over the past few years, the SBC BeWell Department has been transformed to become a welcoming, integrated and inclusive system of care, based on the principles of the Mental Health Services Act (MHSA). The name of the department was changed recently from Alcohol, Drug and Mental Health Services (ADMHS) to BeWell to reflect this holistic change. Likewise, our county's AOD Advisory Board and MH Commission are also currently merging to become the "BeWell Commission", further demonstrating our commitment to integration.

BeWell focuses on resiliency and recovery. Wellness and recovery are at the forefront of all treatment goals. Our departmental mission and values are:

Mission

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

Guiding Principles

Our mission is driven by the following guiding principles:

- ✓ Client driven and family oriented system of care
- ✓ Partnership culture
- ✓ Peer employment
- ✓ Integrated service experiences
- ✓ Cultural competence, diversity and inclusivity

- ✓ Focus on wellness, recovery and resilience
- ✓ Strengths-based perspective
- ✓ Fiscal responsibility
- ✓ Transparency and accountability

County BeWell ADP contracts with local community agencies to provide direct services. BeWell ADP currently maintains and monitors a network of approximately fifteen (15) treatment agencies with more than fifty (50) programs which provide individualized, evidence based services to adolescent and adult individuals, their families and significant others. All contracts are reviewed and approved by the county BOS and monitored closely by qualified ADP staff. All services meet Title 22 CCR DMC standards. Whether covered by DMC, Substance Abuse Prevention and Treatment (SAPT) or other funding, all clients who enter the SB BeWell treatment system must meet medical necessity to enroll and remain in treatment.

As part of the DMC ODS process, most if not all treatment and prevention contracts will be go through a DMC Provider Selection Process in accordance with our established Policies and Procedures (P&Ps) which will include sole source, Letter of Intent, Request for Quotes and Request for Proposals with DMC ODS requirements for selective contracting as described in the DMC ODS Waiver Terms and Conditions, 42 CFR Section 438 pertaining to Managed Care Entities, and the State/County DMC ODS contract.

Once the Implementation Plan has been approved, County BeWell ADP will begin Provider Selection Process for most if not all DMC ODS treatment services. All modalities included in DMC by treatment providers will be required to be DMC certified. As a baseline, all treatment providers will be required to have at least the minimum ASAM Co-Occurring Capable criteria standards. Every direct service clinician will be required to be AOD registered or certified by one of the three (3) current DHCS approved certifying agencies. They must be adept at differential diagnosis and quick to refer any and all clients to appropriate MH services if such services are beyond the scope of the clinician or agency. We anticipate that these services will be in place one year from the time of Implementation plan approval.

This DMC ODS plan will also include integrated services within our current MH system of care. All contracted treatment providers will be able to refer any client with MH issues to one of the BeWell clinics for an assessment. If the assessment indicates SPMI, the client will be admitted into the BeWell system of care. It is expected that all current SBC BeWell MH clinics will become DMC certified as part of the DMC ODS process.

Table 2 is a list of services SB BeWell will provide as part of its DMC ODS:

Table 2: DMC ODS Provided Services

Service Type	ASAM	Required, Optional and
Early Intervention / SBIRT	.05	Will be provided as part of ASAM Screening and in partnership with primary care providers.
Outpatient Treatment Services	1	<u>Required.</u> Will be provided regionally, county wide for of adults and adolescents.
Intensive Outpatient Treatment (IOT)	2.1	<u>Required.</u> Will be offered regionally, county wide.
Withdrawal Management Services	1 – WM	1 Level <u>Required.</u> Will be provided at regional detoxification centers. Medical detoxification services level 3.5 – 3.7 pending funding and
Residential Treatment Services	3.1, 3.3, 3.7	3.1 Level <u>Required</u> , 1 st year. 3.3 & 3.7 required within 3 years. 3.1 will be provided. (3.3 will be <u>optional 1st</u> year) may be provided for a limited number of clients 1 st year, funding
Narcotic Treatment Program (NTP)	1	<u>Required.</u> Will be provided in North (Santa Maria) and South (SB) County.
Additional Medication Assistance Treatment (MAT)	1	<u>Optional.</u> MAT will be provided in regionally within current MH clinics for clients with SPMI and SUD. Clients with mild to moderate MH issues and severe SUD will receive services at contracted AOD treatment providers
Recovery Services	N/A	<u>Required.</u> Will be provided throughout outpatient system of care.
Case Management	N/A	<u>Required.</u> Will be provided directly by BeWell staff and selected outpatient treatment providers.
Physician Consultation	N/A	<u>Required.</u> Will be provided by BeWell psychiatrists and MDs employed by contracted treatment providers
Recovery Residences	N/A	<u>Optional.</u> A limited number of beds may be provided to otherwise homeless clients while said clients receive outpatient treatment services, as funding allows.

Service Descriptions and Details

A. Early Intervention (ASAM Level 0.5)

BeWell ADP considers SBIRT an important part of its SUD continuum of care. BeWell Access Line staff and contracted treatment providers will use the ASAM screening tool and other SBIRT screening tools (where indicated), to screen and provide brief interventions to any and all clients who present for treatment. We expect many of the clients within this level will be adolescents. Therefore, SBIRT will continue to be used throughout the SB high school educational system to screen and provide primary and secondary prevention services to clients who do not meet medical necessity for SUD treatment. Indicated clients will receive brief interventions and referrals to appropriate secondary prevention services where indicated.

SBIRT services are provided by the County PHD clinics and with Cen Cal, our local managed care network. SBIRT services will also be coordinated with Cottage Hospital and all local FQHCs as well as our local Psychiatric Health Facility (PHF) and Crisis Triage and Stabilization units.

Of course, clients who receive an ASAM screening that rises to the level of meeting medical necessity for treatment will be referred to appropriate services

B. Outpatient Services (ASAM Level 1.0)

It is anticipated that Outpatient Services will continue to be the backbone of the department's DMC ODS and SUD continuum of care. Outpatient services consist of up to nine (9) hours/week of medically necessary group and individual counseling services for adults and less than six (6) hours/week of the same services for adolescents.

Services will include biopsychosocial assessments, individual treatment planning and counseling sessions, group and family counseling and educational services, MAT, collateral sessions, crisis intervention sessions and discharge planning and coordination. Services may be provided in-person, by telephone or by tele-health psychiatrist in any appropriate setting in the community.

C. Intensive Outpatient Services (ASAM Level 2.1)

Intensive outpatient treatment services involves structured programming provided to clients as medically necessary for a minimum of nine (9) hours and a maximum of nineteen (19) hours/week for adult perinatal and non-perinatal clients. Adolescents may be provided a minimum of six (6) and a maximum of nineteen (19) hours/week. Currently, SB BeWell contracts with providers to focus IOT on clients with COD. Per ASAM standards, strict medical necessity criteria must be established for IOT, including evidence that a client would not succeed in a lower level of a care, or said client has failed attempts at lower levels of care, along with COD issues.

With the DMC-ODS, IOT will be expanded to include clients with severe substance use disorder who may not have COD (though in our experience clients who need IOT almost invariably have COD and will need Co-Occurring Capable or Co-Occurring Enhanced treatment services). IOT Services include biopsychosocial assessment, treatment planning, individual and group counseling sessions, family counseling and educational services, MAT, collateral sessions, crisis intervention sessions and discharge planning and coordination.

D. W/D Management Services (ASAM Levels 1-WM, 3.2-4.0 WM)

SB BeWell currently provides W/D management services to indicated clients. County DMC ODS will provide several levels of W/D management, residential and ambulatory. W/D services are provided as medically necessary to clients and will include biopsychosocial assessment, observation, acupuncture, medication services, discharge planning, care coordination and MAT.

Current regional detoxification centers will provide residential W/D management in all three regions of the county, including MAT. Clients receiving residential W/D management services shall reside at the facility for monitoring during the detoxification process for up to fourteen (14) days. Therefore, BeWell offers and will continue to offer ASAM Level 1: Ambulatory W/D Management without Extended On-Site Monitoring. For a limited number of clients who have severe SUD, benzodiazepine or alcohol use, BeWell may contract with a medical model detoxification agency, as funding and community resources allow.

If medical detox is established, QCM staff will authorize all medical model detoxification referrals. Also, additional MAT services will be used to stabilize clients and detoxify them off of certain substances such as alcohol or opioids.

MAT will also be included in f W/D management. Medications will be used for ambulatory withdrawal where indicated. (See below, paragraph 4.G). Each of our current integrated MH and SUD regional clinics will have the capability provide Suboxone induction services for a growing number of clients who are opioid dependent. A policy and procedure will be established for induction and administration of Suboxone, including behavioral treatment services. Where indicated and per client driven practices, Suboxone and other medications can be used for W/D management and detoxification purposes. In addition, MAT services will include naltrexone as part of our MAT menu in the management and W/D of alcohol.

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

Level 3.1 Residential Treatment Services will be provided. Each residential provider will have ASAM 3.1 (at least) designation as a Clinically-Managed Low Intensity Residential Service and DMC certified by DHCS to provide residential services.

Between five (5) and nineteen (19) hours of treatment services will be provided including biopsychosocial assessment, treatment planning, individual and group counseling, family counseling and educational services, MAT, collateral sessions, crisis intervention sessions and discharge planning and coordination. All providers will be required to accept and support clients who are receiving medication-assisted treatments. Within the first three

(3) Years of DMC ODS Implementation it is anticipated that we will provide ASAM Level 3.3 – 3.5 during the first year of ODS implementation.

Clients who need level 3.7, Medically Monitored Intensive Inpatient Services and 4.0, Medically Managed Intensive Inpatient Services, will be referred to appropriate treatment programs, usually hospitals, within the communities. Case managers will coordinate care and ensure “warm handoffs” for those clients who need a higher level of residential treatment services than the DMC-ODS covered benefit. The hospitals that may be able to provide Medically Monitored and Medically Managed Intensive Inpatient Services (3.7 and 4.) are Cottage Hospital in Santa Barbara and Lompoc Community Health Center in Lompoc.

As described previously, clients will be approved for residential treatment through a prior authorization process based on the results of an ASAM screening and ASAM Multidimensional assessment by our QCM department. As described earlier, authorizations will occur within twenty four (24) hours of the referral. The length of stay for residential services will be ninety (90) days per admission, up to one hundred and eighty (180) days of residential services per year per client.

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

BeWell contracts with a licensed OTP/NTP, ASAM OTP Level 1 to offer services to clients who meet medical necessity criteria requirements. Services are provided in accordance with an individualized client treatment plan determined by a licensed prescriber. Prescribed medications offered include methadone, buprenorphine, and will be expanded to include other medications that may be included under the DMC-ODS formulary. Required medications will include:

1. Methadone
2. Disulfiram
3. Buprenorphine
4. Naltrexone
5. Naloxone

Additional medications will include

6. Naltrexone (injectable)
7. Acamprosate

OTP services include biopsychosocial assessment, treatment planning, individual and group counseling, patient education, medication services, medical management services, collateral services, crisis interventions and discharge planning services. Most clients will receive between fifty (50) and two hundred (200) minutes of counseling per calendar month with a therapist or counselor. Counseling or case management service needs will be determined on an individual case-by-case basis. All contracted Narcotic

Treatment providers will be referred to Keys to Recovery self-help or support groups as well as ancillary service linkages.

G. Additional MAT Services, Optional, ASAM Level 1

BeWell will offer additional MAT services to clients who meet medical necessity, especially those clients with COD who will need SUD medications in order to fully engage in recovery services. MAT will expand the use of medications for clients with chronic and severe alcohol and opioid related disorders. Medications will include naltrexone both oral and extended injectable release buprenorphine, acamprosate and disulfiram. Naloxone will be available throughout the entire system of care to targeted individuals, families and agencies who may be first responders to an opioid overdose.

BeWell has coordinated care and expanded the availability of MAT outside of the DMC ODS by building the capacity of the entire health care system to use these treatments for clients with a SUD. BeWell is training physicians, social workers, nurse practitioners, psychiatrists and other allied health professionals in primary care and specialty MH clinics on the efficacy of MAT, practice guidelines and medication administration

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

Recovery Support Services will be an important component in the SBC DMC-ODS. Recovery services will allow SUDs to be treated appropriately, as chronic rather than acute conditions. Recovery services are available once a beneficiary has completed the primary course of treatment and during the transition process and needs continuing care to further his or her recovery process. Beneficiaries accessing recovery services are supported to manage their health and health care, use effective self-support management strategies and use community resources to provide ongoing support. Recovery Services may be provided face-to-face or by telephone. Services may include individual or group counseling, recovery monitoring or recovery coaching, peer-to-peer services, relapse prevention, or Wellness Recovery Action Plan (WRAP) development. Any DMC eligible provider within the network may provide medically necessary recovery support services to beneficiaries.

Clients who have completed their treatment plan successfully and who have significant continuous sobriety time may also qualify for recovery support services and enter treatment again if they satisfy certain ASAM criteria.

Specifically, if a client presents to a treatment provider or the ODS Access Line with high risk in ASAM Dimensions 3: *Emotional, Behavioral, or Cognitive Conditions and Complications* and 5: *Relapse, Continued Use, or Continued Problem Potential*, and said client is in early to full remission, medical necessity will be established to enroll clients in recovery support services. In doing so, it must be noted that in this case, current Title 22 regulations and ASAM criteria may not be aligned.

SBC requests support for this service as a covered benefit per ASAM standards and to ensure client care; ASAM criteria indicates medical necessity.

I. Case Management Services

Case management services will be provided by BeWell staff and contracted providers. Case management will support beneficiaries as they move through the DMC ODS continuum of care. Case managers will be both LPHAs and certified AOD counselors. BeWell will follow DHCS Case Management guidelines. Client engagement strategies including MI, treatment planning and treatment plan review, will be just as important and part of the job as care coordination, linkages and monitoring the overall client case. SBC will use the comprehensive case management model outlined and defined in SAMHSA Treatment Improvement Protocol (TIP) 27: Comprehensive Case Management for Substance Abuse Treatment.

Case management services may include assessment and level of care identification, treatment or recovery plan development, care coordination with mental or physical health, monitoring access and transitions between levels of care, linkages to ancillary supports or needs. Case managers will be proficient in MI, Cognitive Behavioral Therapy (CBT), trauma informed care and general social work theories and practice. .As indicated below, case management services will be provided to clients in outpatient treatment whose complexity and needs will preclude them from succeeding in treatment without case management. We anticipate that approximately one quarter to one third of our outpatient clientele will need case management services. Of those, we anticipate upwards of fifty (50) to seventy five (75) percent of all adolescents will need case management. Generally speaking, those who will qualify for case management services will be indicated by high risk ASAM scores in several dimensions (2,3,5,6), those clients who have not been successful in previous treatment episodes and continually cycle through multiple service areas (“high utilizers” and clients with COD), and adolescents who require multi-family interventions to complete their treatment plans. It is expected that clients who are resistant to treatment or Pre-contemplative will not necessarily need case management since basic Motivational Interviewing can address ASAM Dimension 4. The ratio of clients to case managers will not exceed 35 – 1 per FTE case management staff.

Case management services will be necessary in our County run CSUs. It is estimated that over eighty percent (80%) of all clients who enter our CSUs test positive for substances or report significant substance related issues within the week prior to admission.

Our Crisis Units and CSUs are one of our entry points into our integrated system of care. Case management will be essential to provide medically necessary engagement and case management services to DMC beneficiaries. Case management services at our CSUs may include mobile outreach, ASAM assessment and SBIRT, linkages to appropriate and indicated levels of treatment, and client follow up.

J. Physician Consultation

The BeWell DMC ODS will be imbedded into an overall integrated health care system that uses a team based approach. As such, Physician consultation will be an important part of this medical model. Physician consultation services assist physicians and nurse practitioners seeking expert advice on complex client cases and designing the treatment plan in such cases as medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. As described above, DMC physicians will be able to seek consultation on complex cases and in designing treatment plans, for COD clients who may need MAT. As explained above, DMC physicians will be experienced with SUD disorders, models of care and medication assisted treatment (MAT). ASAM and or CSAM psychiatrists will be consulted on complex cases.

BeWell psychiatrists will be trained on important DMC ODS components such as health care integration, differential diagnosis and COD and administrative rules and regulations.

Both CBO and BeWell providers will offer consultation services that are clinically indicated and administratively sound and compliant with DMC ODS rules and regulations. Physician consultation will be made throughout the health care system.

K. Recovery Residences (RR)

Lack of housing is a serious issue in SBC. RR or Sober Living Environments (SLE) may need to be expanded for clients who require housing assistance in order to support their wellness and recovery process. As funds allow, a limited amount of RR may be developed to address housing needs. RR will only be provided to DMC ODS clients who are engaged in outpatient, intensive outpatient or MAT services. All RR will follow the California Consortium of Addiction Programs and Professionals (CCAPP) RR guidelines. (These guidelines were developed by the California Association of Addiction Recovery Resources (CAARR). CAARR and the California Association of Alcoholism and Drug Abuse Counselors (CAADAC) merged to form CCAPP in 2014).

L. Optional Service Levels Pending ASAM Utilization Review (UR)

Resources pending, BeWell will consider whether to offer additional services under the 1115 Waiver once baseline data has been captured and analyzed and service gaps are accurately determined. If and when an unmet need for service is identified, BeWell will amend this plan to incorporate the additional service(s) and will initiate Provider Selection Process to identify qualified providers.

It is anticipated that higher levels of W/D Management (ASAM 2 WM) and Partial Hospitalization Services (ASAM 2.5) will be developed during the second and or third years of the DMC-ODS plan.

M. Service Level Barriers

BeWell anticipates several service level barriers around funding and timing. These barriers include start-up and infrastructure development costs, adequate rates to cover BeWell and contracted provider costs, facility certification challenges (including zoning regulations), hiring and retaining qualified and culturally competent staff, staff turnover and ensuing training needs and costs, DMC certification delays and geographic location and related client transportation barriers.

N. Coordination with Surrounding Counties

SB has a strong relationship with its surrounding counties, namely San Luis Obispo and Ventura. We communicate with one another and some of our contracted providers hold contracts in multiple counties. We have and will continue to coordinate NTP services to clients in other counties. We will work with other counties to ensure clients can access and receive ODS services easily and quickly. We will also work together, if and when a regional approach is required to deliver a component that may be needed, but is unsupportable in one county.

5. Coordination with MH.

How will the county coordinate MH services for beneficiaries with CODs? 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 MH services. When these structures are separate, how is care coordinated?

BeWell is an integrated MH and SUD system of care. Using SAMHSA's Levels of Integration, BeWell provides services that range from Level 3: Basic Collaboration Onsite, to Level 5: Close Collaboration Approaching an Integrated Practice. We have AOD counselors co-located in our MH clinics and LPHAs or LPHA interns co-located in our contracted SUD treatment provider programs. There are distinct COD Teams in each of our department's MH clinics which provide services to clients with SPMI. BeWell direct service staff and administrators have been trained in COD and differential diagnosis. PHAs with limited education in SUD are receiving regular training in SUD best practices such as MI, CBT for SUD, Seeking Safety and other trauma informed practices.

MH services are also provided in select SUD contracted agencies. Several contracted agencies employ LPHAs to assess and treat mild to moderate co-occurring MH disorders. As DMC providers, CBOs have physicians who provide triage consultation with direct SUD and LPHA service staff.

If a client has a SPMI, contracted providers work with BeWell clinics and clinicians to provide COD services.

Regular Regional Partnership meetings have been established in all three regions of the County, North, South and West, where BeWell clinicians and contracted ADP and MH providers regularly meet to coordinate services and triage typical or complex cases. Contracted ADP staff attends regular BeWell meetings and engage in multidisciplinary staffing or case conference reviews with shared clients.

BeWell currently contracts with several service providers who provide intensive integrated care to clients with SPMI. The Co-Occurring teams in our Mental Health Clinics also deliver integrated care to clients with SPMI. We contract with other providers who are COD capable in providing integrated treatment to clients with mild to moderate MH disorders and moderate to severe SUD. We will continue to do so, requiring all contracted providers to become at least Co-Occurring Capable and preferring those who will be Co-Occurring Enhanced or Complexity Capable per ASAM criteria.

BeWell Mobile Crisis and Crisis Stabilization teams provide integrated MH and ADP service, as the majority of clients in crisis are under the influence of intoxicants when they make contact with the system. Crisis personnel are using an ASAM screening tool to help with differential diagnosis and placement options. In addition, BeWell is proposing to use MH Services Act "Innovation" funding to pilot a MAT project.

This project identifies current clients who are amenable to and can benefit from MAT. A plan has been drafted including integrated P&Ps for providing MAT to clients who contact the BeWell treatment system.

BeWell Psychiatrists are becoming Suboxone certified and familiar with other MAT medications and protocols. Where indicated, MAT is currently being provided on an individual case by case basis. SUD counselors are providing consultation to LPHAs on complex cases and on COD issues in general in regular meetings and on an as-needed basis.

With consultation from Dr. Ken Minkoff and Dr. Chris Cline, experts on Comprehensive, Continuous, Integrated System of Care, BeWell staff and programs have become more integrated.

In December, 2014, SBC CEO's Office hired an expert on integration, Dr. Alice Gleghorn, a clinical psychologist, who is a nationally recognized authority on MAT, COD and integration issues. She has worked closely with Dr's Minkoff and Cline to pioneer and expedite systems integration on all levels, clinical and administrative. Policies and Procedures (P & Ps), especially those on client access, service provisions, diagnosis, assessment and treatment planning are now integrated combining MH and SUD services.

The integration has occurred in spite of the fact that funding streams and current rules and regulations tend to segregate and silo MH from SUD. We move cautiously and deliberately, ensuring that all rules and regulations are followed, including client confidentiality. Nonetheless we will move forward towards SAMHSA Level 6 Integration: Full Collaboration in a Transformed/Merged Practice. If the services are ASAM indicated (medically necessary) and the outcomes and cost efficiencies are promising, we anticipate DHCS's support to blend and braid funding streams and to allow integration to proceed with reasonable flexibility and the least amount of audit disallowances.

It is important that COD services and MH / SUD integration be monitored carefully both clinically and administratively. Therefore, BeWell currently monitors these services and will expand and enhance the monitoring and quality control when we implement the DMC-ODS. County ADP monitors contracted ADP providers on four levels: General Administration, Programmatic, Documentation and actual Clinical Practices in which LPHA's actually sit in counseling groups to ensure good practice. Since a minimum of forty (40) to fifty (50) percent of all clients have COD, we ensure that clients who present with mental health issues (that cause functional impairments in major life domains) receive treatment to address those issues. Monitoring each provider once per year, a process that can last months and involve technical assistance and training, allows current staff to extensively monitor all aspects of client care. In the process, MH and COD issues are addressed and resolved. Treatment providers are either capable of providing basic COD services or are required to refer clients to COD capable providers. There are Regional Partnership Meetings involving BeWell staff, contracted ADP and MH providers who all meet once per month to discuss and resolve issues and better coordinate services. These meetings have been an important aspect of our integration efforts.

Monitoring COD within our own MH clinics is ongoing and intensive. Regular weekly triage meetings are held to discuss individual cases. Our QCM department regularly monitors all internal clinical practices to ensure that clients with COD receive the appropriate services. Our QCM department is becoming fully integrated in preparation for the DMC-ODS and to improve current integrated practices. We now have QCM staff monitoring both ADP specialty and MH specialty services to ensure integration. For a more detailed description of service monitoring, please see Section 12 below: Quality Assurance.

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?

Integration includes primary care. County BeWell ADP coordinates physical health services with our County PHD, Cottage and Marion (medical surgical) Hospitals,

Community Health Centers (CHC) of North County and SB Neighborhood Clinics (SBNC) of South County, our managed health plan, Cen Cal and Cen Cal's MH provider-the Holman Group. All FQHC's, as well as our PHF, provide SBIRT services to their patients. SBNC recently received a grant to provide integrated care including MAT. BeWell has reached out to SBNC to participate in MAT trainings so our entities can share learning and implementation strategies. ADP has sponsored UCLA SBIRT trainings to all of the above primary care agencies and helps coordinate SBIRT referrals.

BeWell ADP staff will continue to work closely with primary care physicians and clinical social workers in the County PHD clinics and local hospitals to ensure that any client who needs MH/SUD or COD services receive the appropriate interventions, referral to treatment and treatment services.

Cottage and Marion hospital emergency rooms (ERs) and psychiatric units work closely with our PHF, regional detox centers, MH/COD clinics and contracted SUD providers to ensure medical clearance (stabilization) and referrals to appropriate levels of care.

Consistent with DHCS licensure and DMC certification regulations, all contracted SUD treatment providers conduct a medical screening at admission, arrange for a physical examination as needed, and include a referral to physical health services as part of the client's SUD treatment plan. County BeWell ADP and contracted SUD treatment providers have paid attention to physical health/primary care issues of all clients per best practices and Title 22 Emergency regulations. As of fiscal year 14/15, County BeWell required every contracted treatment provider to include a wellness goal for each client entering SUD treatment.

With the DMC ODS, we will expand the wellness requirement to include the 3-4-50 model, a community health improvement strategy. Providers will be educated and trained to address the fact that three (3) behaviors – smoking, sedentary lifestyle and poor diet – contribute to four (4) conditions – cancer, cardiovascular disease, chronic low respiratory disease and diabetes – that cause fifty percent (50%) of premature deaths. In the process, greater linkages with primary care will be necessary and developed.

Medi-Cal beneficiaries have access to a full range of physical health services through the County's public health and managed health care organization (Cen Cal). Cen Cal contracts with the Holman Group to provide MH services to clients with mild to moderate MH services and coordinates physical health services with County PHD. County ADP Health Care Program Coordinators (HCPCs) and contracted SUD direct service staff have developed strong relationships with primary care physicians and ER hospital staff to coordinate medical services.

For example, PHD nurses are available at our detox centers and shelters to stabilize and medically clear clients and help formulate medical treatment planning if indicated. Treatment plans include care coordination with primary care doctors and facilities. All of these relationships will be strengthened with the availability of case management services through the DMC ODS.

Monitoring coordination with physical health services was expanded greatly with the DHCS emergency DMC guidelines issued in August of 2015. As we monitor our ADP providers we ensure that each client meets the treatment requirements listed above. We insist that each client have a physical examination and has medical issues addressed by requiring that counselors note such issues are addressed with every contact until such issues are addressed or that part of the treatment plan is completed. Counselors or providers who are out of compliance will receive a corrective action plan (CAP) and technical and clinical support to ensure the issue is resolved.

7. Coordination Assistance.

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

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

Comprehensive substance use, physical, and MH screening:

We do not anticipate any substantial challenges or technical assistance needs in this area. All agencies and staff will be trained in ASAM screening and multi-dimensional assessment, SBIRT and MI theory and practice. Broad workforce training in accurate biopsychosocial assessments including differential diagnosis will be a high priority for the SB DMC-ODS.

Beneficiary engagement and participation in an integrated care program as needed:

We anticipate possible training and technical assistance needs in this area, perhaps most on a systems level. MI will be used to engage clients and to encourage clients to sign releases of information (ROI) to receive fully integrated primary, MH and SUD care. Engaging PHD and primary care physicians, managed health plans and FQHC's may be more difficult; however, Access Line staff will facilitate the collaboration. All agencies and systems will be required to assess and provide brief interventions in three separate areas – physical health, MH and substance use. Optimally, psychiatrists and MH providers need to provide basic physical health screening and tests at MH/SUD clinics, primary care providers will need to assess and intervene with MH/SUD issues, and MH/SUD providers will need to integrate, coordinate and monitor physical health in behavioral treatment plans. It is anticipated that this level of integration (SAMHSA Level 6), will require time and resources to develop.

Shared development of care plans by the beneficiary, caregivers and all providers:

See above responses under, Beneficiary engagement, with the addition of vital cross training of clinical practices. The availability of case management services with the DMC ODS is expected to help facilitate this process.

Collaborative treatment planning with managed care:

Although we have begun this process with the establishment of a Memorandum of Understanding (MOU) between our local managed care provider and BeWell, we anticipate challenges and technical assistance needs this area. The mechanism for sharing information and coordination of service delivery will require primary care integration that has not yet been developed.

We may need guidance and technical assistance on developing a number of P & Ps to, for example, exchange Protected Health Information (PHI), refer clients to and from different systems of care, and resolve disputes between Managed Care Organization (MCO) primary providers and specialty SUD agencies.

For example, we need to ensure that clients referred from MCO providers include referral information and physical exam results. Developing clear and meaningful relationships between primary care and SUD agencies and agencies in order to coordinate care per section 151 "Care Coordination" of the STCs will be an essential part of DMC ODS health care integration and may require guidance and technical assistance.

Care coordination and effective communication among providers:

It is expected that the availability of case management services with the DMC ODS will help ensure care coordination. Developing an effective communication strategy among providers and an integrated primary care, MH and SUD system will be important. Understanding updated Federal guidance on HIPAA and 42CFR, Part 2, may also be needed.

We anticipate the need to develop a formal communication plan and may need training and technical assistance to develop this plan and coordinate care.

Navigation support for patients and caregivers:

We anticipate the need for a strong peer support system to ensure DMC ODS success. The SBC DMC ODS will require peers to be identified and trained for full implementation within our BeWell system of care. Our contracted SUD providers are well staffed with peer support staff and well equipped to support client's navigation support. Within our MH system, however, our peers support MH navigation and will need SUD education to ensure whole person care and appropriate navigation and referral. Some of our MH peers will also have lived SUD experience. Others may not yet still be valuable to the SUD recovery process. In other words, peers with MH lived experience only may provide meaningful peer support services to clients with SUD and COD. Regardless, though we anticipate case management services will help navigation support, we will need to train our current MH peers on SUD/COD theory and practice and DMC-ODS rules and regulations. In doing so, we anticipate challenges and the need for technical assistance.

Facilitation and tracking of referrals between systems:

We anticipate that DMC ODS case management and QCM will facilitate and track referrals adequately, but we may need training and technical assistance in this area.

8. Availability of Services.

Pursuant to 42 CFR 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:

- **The anticipated number of Medi-Cal clients.**
- **The expected utilization of services by service type.**

- **The numbers and types of providers required to furnish the contracted Medi-Cal services.**
- **A demonstration of how the current network of providers compares to the expected utilization by service type.**
- **Hours of operation of providers.**
- **Language capability for the county threshold languages.**
- **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.**
- **The geographic location of providers and Medi-Cal beneficiaries, considering distance, travel time, transportation, and access for beneficiaries with disabilities**
- **How will the county address service gaps, including access to MAT services?**
- **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).**

The anticipated number of Medi-Cal clients.

The following section will include anticipated number of Medi-Cal clients, DMC clients, and client characteristics that have informed and will inform our current and future continuum of care.

According to county social service officials, in June 2016, SBC had approximately one hundred and six thousand (106,000) Medi-Cal beneficiaries. It is estimated that approximately ten percent of these beneficiaries or approximately eleven thousand (11,000) would meet the diagnostic criteria for SUD and could benefit from treatment. SAMHSA estimates that only eleven percent of those who need treatment received treatment in a specialty SUD treatment program.

By this simple calculation, it is conservatively estimated that twelve hundred (1,200) clients will need and engage in specialty AOD treatment in SBC.

SB DMC penetration rate has been considerably higher. BeWell ADP currently engages over two and one half (2 ½) times these estimates, with three thousand two hundred and fifty seven (3,257) DMC clients receiving treatment services. **Chart 1** shows the number of unique MC/DMC clients and **Chart 2** shows the total number of admissions in the SB continuum of SUD care over the past six years.

Chart 1: Number of Unique MC/DMC Clients

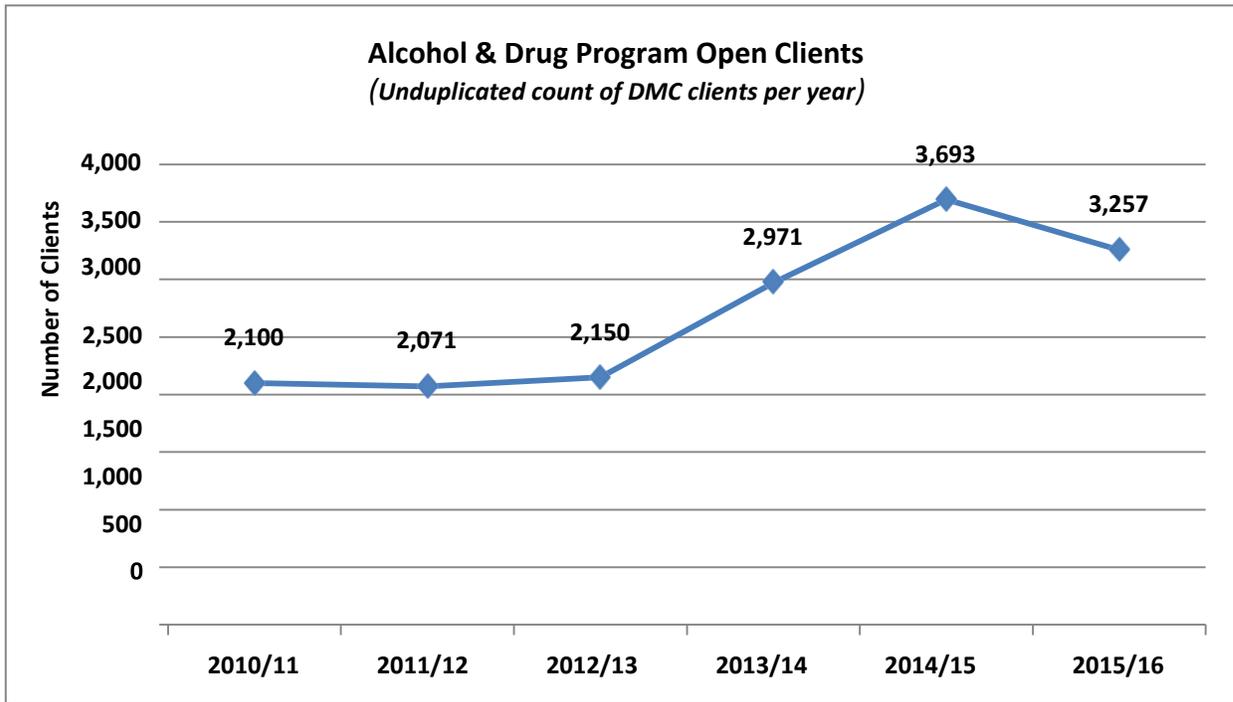


Chart 2: Number of Admissions

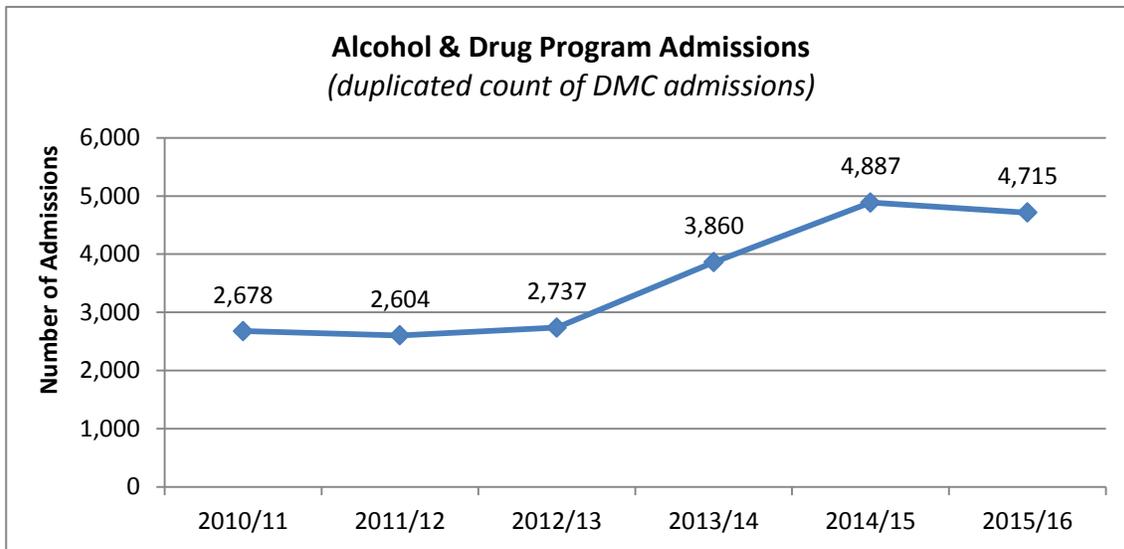
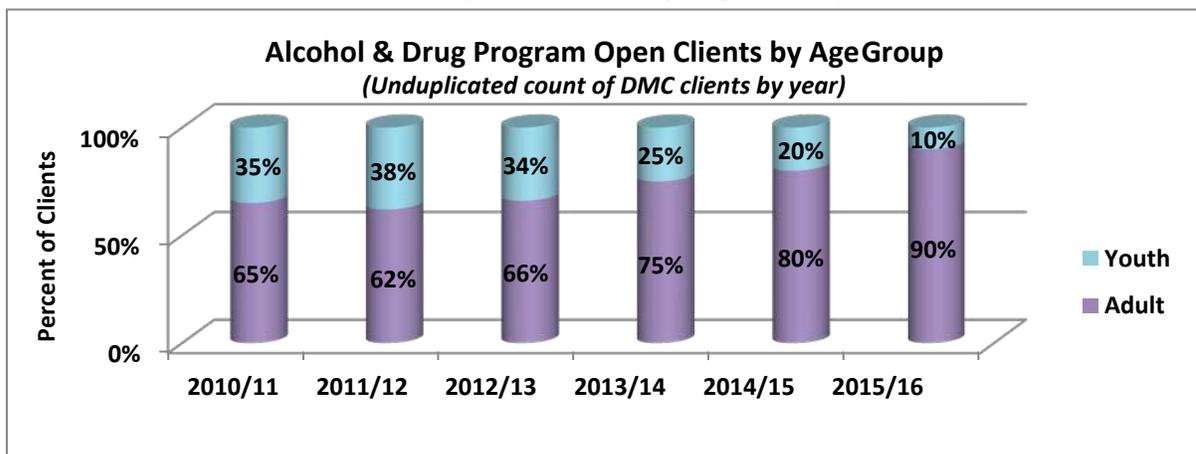


Chart 3 shows the distribution of youth and adults who have received treatment services within our current system of care. The significant reduction in DMC services for adolescents is the result of a change. In FY 13-14, SBC modified its adolescent treatment protocols. Minor Consent is provided to clients who need it, but the majority of clients do not. Youth services have now been transformed into SBIRT and secondary prevention per clinical indication. Most adolescents do not meet the Diagnostic and Statistical Manual (DSM-5) criteria for SUD and labeling adolescents with a SUD is contraindicated and can be damaging.

Chart 3: Open Clients by Age Group



Still, we believe there are a significant number of adolescents who may meet the criteria for SUD and who need to access DMC treatment services. The SB DMC ODS will increase the number of adolescent DMC clients by providing outreach, more accessible services and case management. Any and all youth who meet medical necessity for substance use disorder treatment will receive treatment pursuant to DMC Title 22 Regulations and the CA Family Code 6929(b) which states “a minor who is 12 years old or older may consent to medical care and counseling relating to the diagnosis and treatment of drug or alcohol related problems”. We also anticipate greater flexibility in providing youth services in the field. Whenever a DMC-ODS certified site creates a barrier to treatment and a youth has trouble accessing services at that site, counselors will go into the field to engage and connect that youth with treatment services.

Charts 4A and 4B shows open clients by ethnicity. **Charts 5 and 6** displays the ethnicities of our clients in treatment, along with their Drug of Choice (DOC) at admission. Unduplicated Hispanic clients are decreasing while unduplicated Caucasian clients are climbing. Hispanics make up the bulk of unique clients, especially in North County. Caucasian client numbers are increasing primarily because of the opioid epidemic. The SB opioid problem reflects a national trend of becoming increasingly an epidemic among middle-class Caucasian individuals. Opioid use disorder (addiction) is the fastest growing AOD problem and is afflicting Caucasians more than any other demographic. So, taken together, these figures indicate a need for bilingual/bicultural services and more treatment opportunities for opioid dependent clients.

Chart 4A: Open Adult Clients by Ethnicity

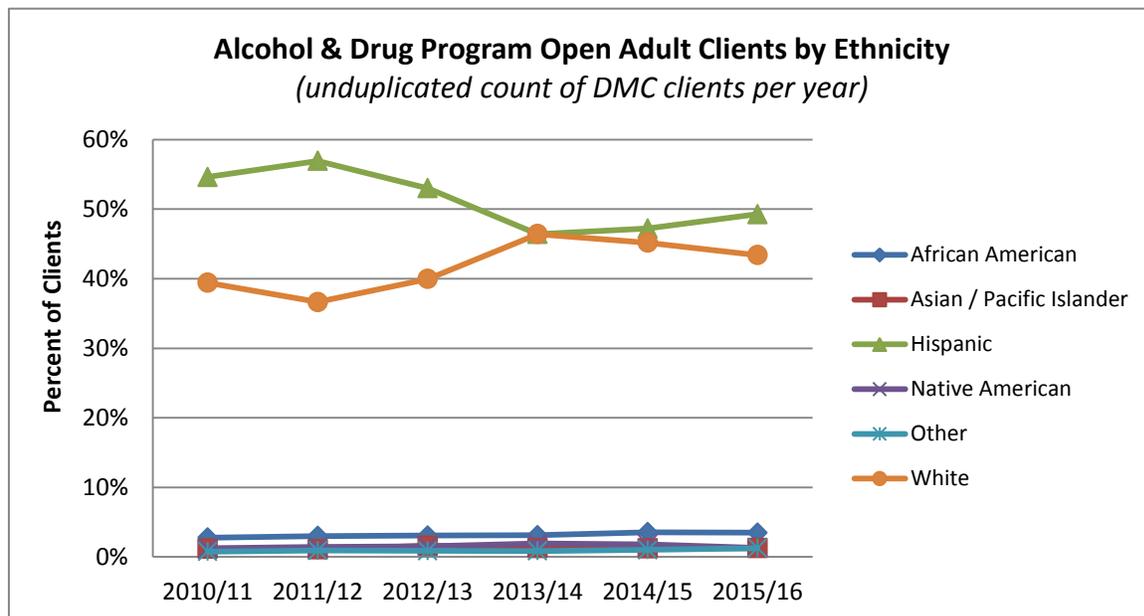


Chart 4B: Open Youth Clients by Ethnicity

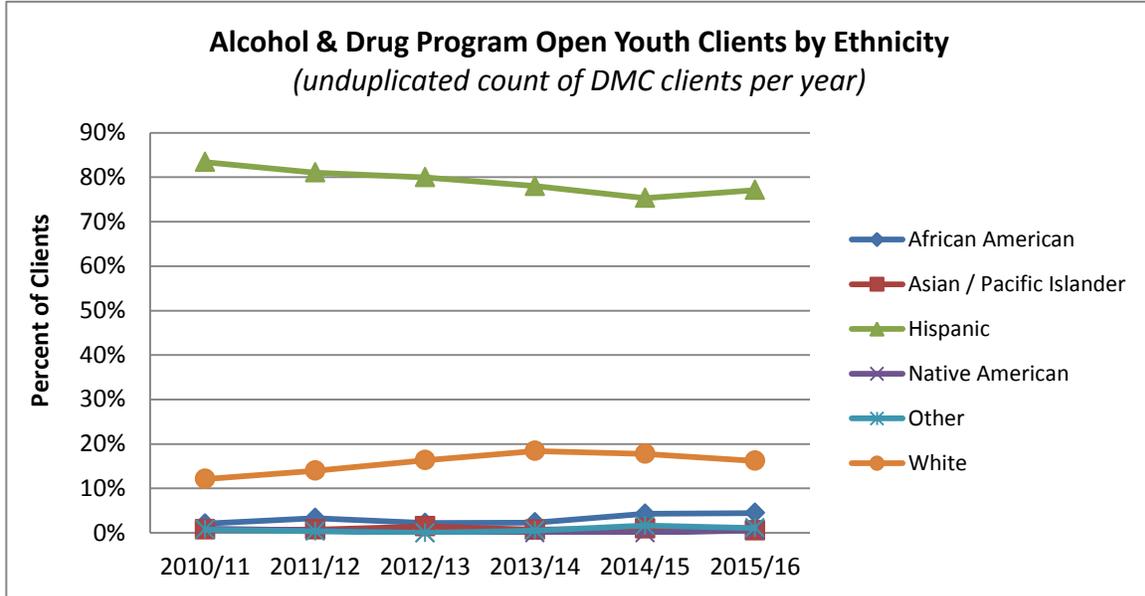


Chart 5: Drug of Choice at Admission for Adults

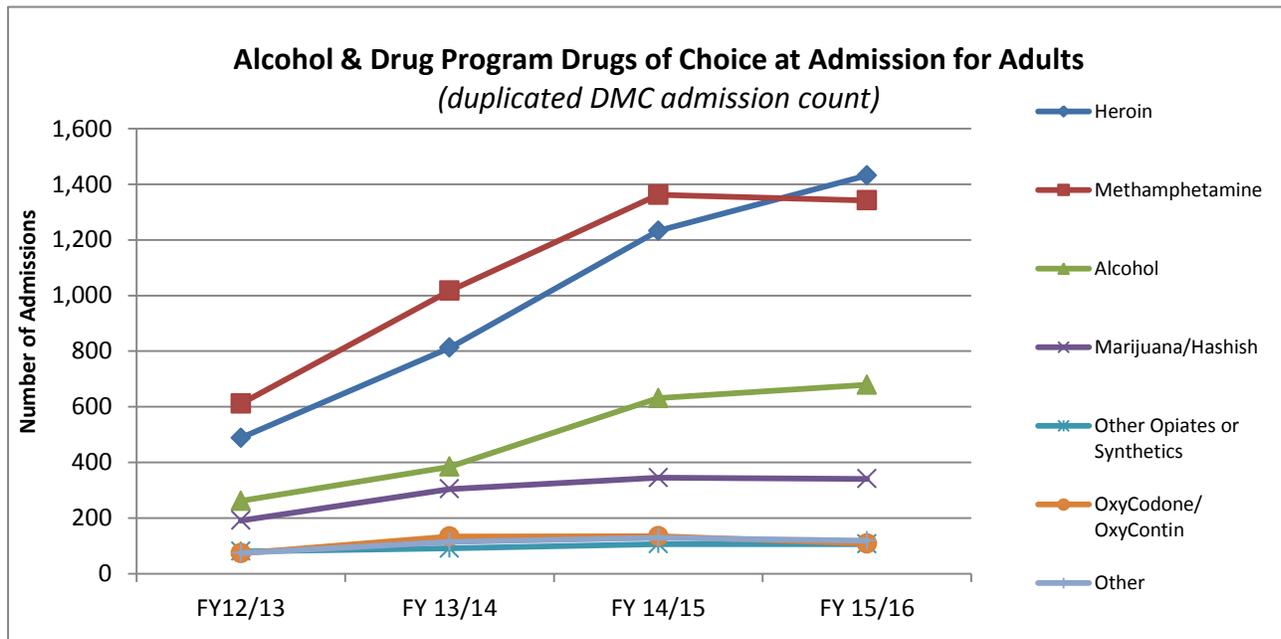
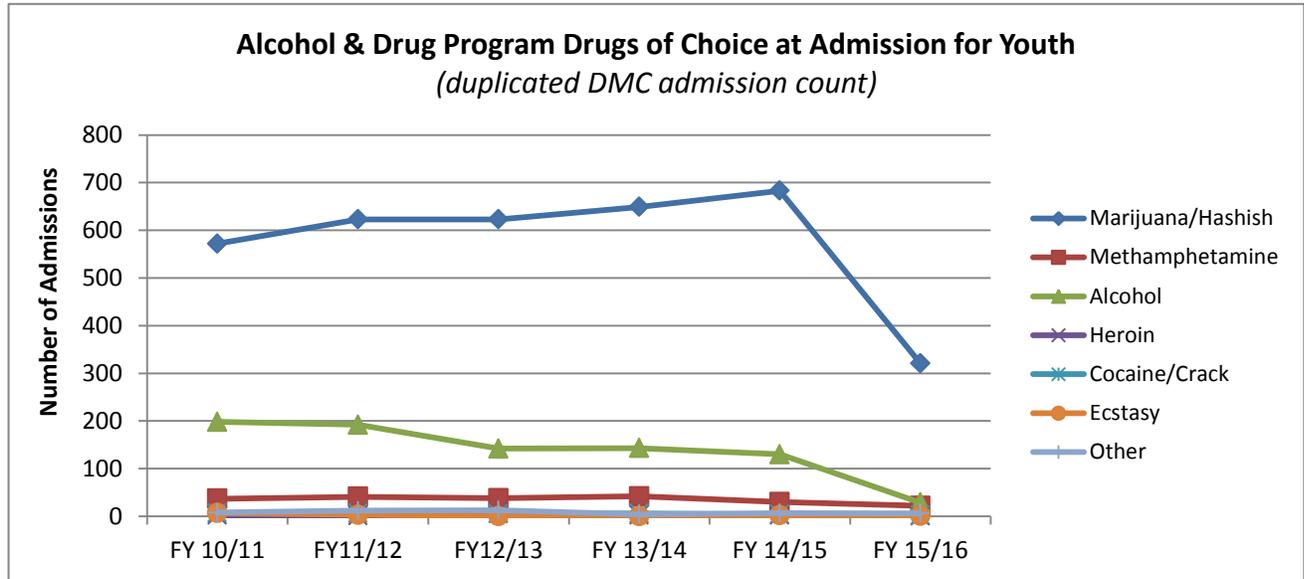


Chart 6: Drug of Choice at Admission for Youth



Once again, as noted on page 39, the significant reduction in DMC services for adolescents is the result of the elimination of Minor Consent for all but a minority of adolescents who needed it.

In looking at the actual number of clients served, it is clear that the current continuum of care will not be adequate to meet the projected needs of the Medi-Cal population in SBC. As the DMC ODS expands services to include non-perinatal residential treatment, recovery support services and increased access to MAT and IOT, it is expected that unique client counts and program admissions may increase. With increased case management services and coordination with primary care, managed health plans and other partner agencies, we anticipate our census to rise.

Finally, due to intensive case management and improved COD treatment models and protocols, we anticipate a decrease in program admissions, as better treatment will decrease relapse and recidivism rates.

As **Table 3** indicates, SBC has an approximate penetration rate of thirty percent (30%) of Medi-Cal beneficiaries who are expected to meet the diagnostic criteria for SUD. We anticipate an increase of ten percent (10%) per year over the next three (3) years.

Table 3: Penetration Rates

Penetration Calculations Projected Over 3 Years			
	FY 16/17	FY 17/18	FY 18/19
Penetration Rates	3583	3941	4335

The expected utilization of services by service type.

It is anticipated that outpatient services will continue to be the most utilized service modality in the DMC ODS. Non-perinatal residential services will be new to the SB County system of care. SB County currently combines transitional living with outpatient services for clients who need residential treatment services. New residential treatment services will increase the amount of clients entering our continuum of care, but it is challenging to ascertain exactly how many clients will need residential treatment. We have no history of ASAM Level 3.1 or beyond, nor can we accurately determine how many clients will utilize this service. Therefore, our estimates will be conservative. **Table 4** itemizes current and projected unique or unduplicated client counts with current and expanded services.

Table 4: Current and Projected Unique Client Counts

Unique Clients (DMC-Actual)			Unique Clients (DMC-Projected)			
Current Service Options	FY14/15	FY15/16	FY16/17	FY17/18	FY18/19	FY19/20
Day Care Rehabilitative (DCR)/IOT	61	106	117	129	142	156
NTP	1,476	1,586	1,745	1,920	2,112	2,323
Outpatient Group (Includes Adult and Youth)	2,393	2,056	2,262	2,488	2,737	3,011
Outpatient Individual (Includes Adult and Youth)	1,912	2,144	2,358	2,594	2,853	3,138

Expanded ODS Services						
Residential 3.1	N/A	N/A	N/A	100	110	121
Residential 3.5	N/A	N/A	N/A	10	11	12
W/D Management	N/A	N/A	N/A	25	28	31
Case Management	N/A	N/A	N/A	1,000	1,100	1,210
Recovery Support Services	N/A	N/A	N/A	814	895	984
MAT	N/A	N/A	25	50	75	100

The numbers and types of providers required to furnish the contracted Medi-Cal services. A demonstration of how the current network of providers compares to the expected utilization by service type.

Current services are provided throughout the county by contracted providers. SBC is divided by three distinct regions: South, West and North County. South County has four (4) outpatient programs, one (1) perinatal transitional living center, one (1) detox facility, and one (1) transitional housing facility. West County has four (4) outpatient programs; one (1) perinatal transitional living facility, one (1) residential treatment program and (1) detox facility. North County has five (5) outpatient programs, one (1) perinatal transitional living center and one (1) social detox facility. There are three (3) youth and family treatment centers, one per each region, see Attachment A. Providers with county contracts are DMC certified; we are encouraging additional programs to submit DMC applications as we see a need for increased capacity.

Though our capacity has been adequate thus far, we anticipate the need for more services with the implementation of our DMC-ODS. The DMC-ODS will attract more clients into our system of care, especially clients with COD and who may need MAT. Therefore, we anticipate increased capacity needs for adolescent and adult outpatient services in all three regions. This may not necessarily indicate a need for more contracted providers than indicated above. Current or single providers may expand service capacity to accommodate larger number of clients. Though it is difficult to estimate the gap between current capacity and expected utilization, we have estimated up to a ten percent (10%) growth per year for the first three (3) years of DMC-ODS implementation for all services. (Please see tables 3 – 4 above).

As we implement the DMC ODS, one of our greatest needs will be the development of non-perinatal Level 3.1 residential services. Our current detoxification providers might become certified to also provide residential treatment capacity. County of SB BeWell has encouraged our detoxification providers to include residential treatment in their services. Regardless, we will need added residential capacity and we will develop such capacity by contracting with CBOs. Current contracted providers and providers new to the county have expressed interest in developing residential services. Several have become ASAM designated and are in the process of applying for DMC certification.

Residential services will be needed most in North County or the Santa Maria region, but there is need in South County as well. We will be particularly interested in and recruiting providers who could accommodate from twenty (20) to forty (40) clients in single locations.

We anticipate the need for approximately twenty five (25) residential beds in North County, ten (10) beds in West County (Lompoc) and twenty (20) beds in South County, or some combination thereof. For clients with COD who may need medical detoxification services, we hope to purchase two (2) to three (3) beds on a continual basis in a 3.5 – 3.7 residential treatment system, if funding allows.

Though our current outpatient and intensive outpatient treatment program has accommodated our clients thus far, increased need for services, especially IOT, will demand expanded capacity. As the DMC ODS is implemented, we anticipate contracting with more providers with the DMC ODS, especially in West County where client numbers are growing. Current provider facilities and staffing levels will not be able to accommodate this expanded need, especially since it is anticipated that client retention will increase and recovery support services will be required at every treatment site.

In short, the more clients remain in treatment for longer periods of time, the more treatment capacity will need to expand. To date, the largest growth in DMC clients has been in our NTPs. County BeWell currently contracts with one NTP provider that delivers services in SB and Santa Maria. This provider has been able to increase its capacity with the current demand but expanded facilities and locations appear to be indicated, as the current opioid epidemic continues unabated. It is anticipated that NTP services may be expanded into the West or Lompoc region with the DMC-ODS, although MAT services providing alternates to methadone may moderate this need. We anticipate our current NTP to create a “spoke” of its Santa Maria “hub” in Lompoc to provide methadone dosing services. With DMC-ODS implementation this spoke will also provide buprenorphine. At the same time, BeWell is developing a MAT program to create office based opioid treatment (OBOT) programming to serve West and other regions of the county. We anticipate additional MAT services outside of our NTP services to be available by FY 18-19 in every region of the county.

Hours of operation of providers.

For new referrals, appointments will be made five days a week during normal business hours, 8:00 a.m. – 5:00 p.m. for all programs. Hours of operation for specific services will be as follows:

- Outpatient Drug Free (ODF): M – F, 8:00 AM – 7:00PM; SA 9:00AM – 12:00PM
- Intensive Outpatient Treatment (IOT): Same as ODF
- Residential Treatment: 24/7
- NTP/OTP: M – F: 6:00AM – 1:30PM, SA and SU: 6:00AM – 9:00AM
- W/D Mgmt. and MAT: M – F, 8:00 – 5:00

During the first year of the Waiver, the Department will review hours of operation and make changes that best meet the needs of the Medi-Cal beneficiaries including the availability of extended evening and weekend hours.

Language capability for the county threshold languages.

Spanish is the only threshold language for SBC. BeWell employs bi-lingual/bi-cultural staff to serve the Spanish speaking population. Contract providers also have bilingual /bicultural staff that provides clinical and administrative services in Spanish. Our department's Cultural Competency Plan (currently under development) requires signage and informational brochures to be provided in threshold languages in all clinics. The county also has access to a language line and sign language interpreters upon request.

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

Quick access to services will be provided to DMC-ODS beneficiaries. County BeWell has prioritized access to services as a high of priority for the department. Urgent and crisis conditions will be addressed immediately, with interventions and referrals made within twenty four (24) hours of request. Emergency situations requiring individual safety will be addressed immediately through our mobile crisis teams and crisis triage units. Clients who are assessed as a threat to themselves, others or who are gravely disabled will be assessed under our 5150 protocols and be hospitalized in our Psychiatric Health Facility (PHF) or referred to our Crisis Stabilization Units (CSU) where indicated. All crisis staff will be able to provide immediate clinical interventions to clients with urgent conditions. As described above, urgent SUD conditions will be referred to a contracted provider or one of our MH clinics within 24 hours for an assessment. After hours treatment can be provided. County ADP currently has no waiting lists for outpatient and intensive outpatient services and will not allow waiting lists for residential services with the DMC-ODS. By providing expanded services and more treatment options, we would expect the DMC ODS will either eliminate waiting lists and provide case management services to assist clients to engage in the treatment process.

County ADP will require all treatment agencies to provide at least four (4) face to face treatment and/or recovery sessions to each client within the first thirty (30) days of admission to ODF and IOT services. The frequency of follow up appointments will be in accordance with individualized treatment plans. All outpatient providers will be expected to provide an initial treatment service (intake) within fourteen (14) calendar days of the referral from the Access Line or the CSUs. 3.1 Level Residential services will provide a minimum of at least five (5) hours of treatment per calendar week in addition to a full range of self-help and peer- based recovery activities.

In 2008, County ADP established a system of alternative self-help groups called Recovery Oriented System of Care (ROSC) groups throughout every region. These groups are small, often facilitated by registered or certified SUD counselors, and encourage cross-talk and open discussion of issues. Some of the groups are educational. Others concentrate on coping skills while others are formal Self-Management for Addiction Recovery Training (SMART Recovery® groups). All of them provide individual support, encouragement and utilize MI, and CBT to engage and move clients toward less self-defeating behaviors. These ROSC groups will continue and be expanded with the DMC ODS.

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

BeWell has developed an array of services within the major geographic locations of the county including South County, West County and North County where Medi-Cal beneficiaries are most located. All treatment sites are on or near public transportation zones and are accessible within thirty (30) to sixty (60) minutes with public transportation. Every provider is ADA compliant and provides access for beneficiaries with disabilities. The Quality Improvement (QI) team will review the county’s census tracts to determine if the treatment locations are adequate to meet the Medi-Cal population service needs. If and when not, services will be expanded to ensure easy and quick access to services.

Charts 7A and 7B shows the regional distribution of current DMC clients in our system of care.

Chart 7A: Open Adult Clients by Region

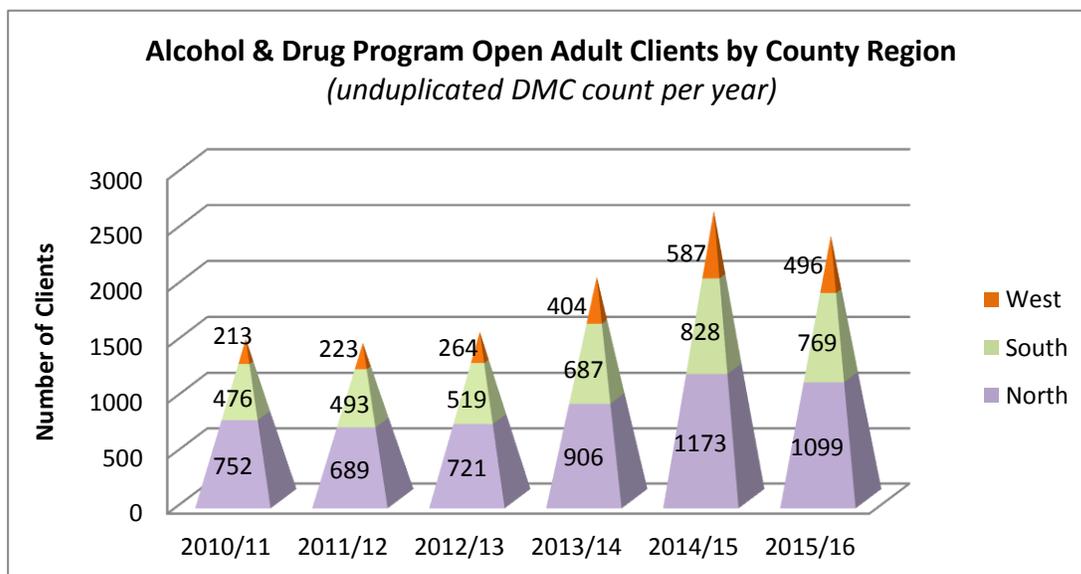
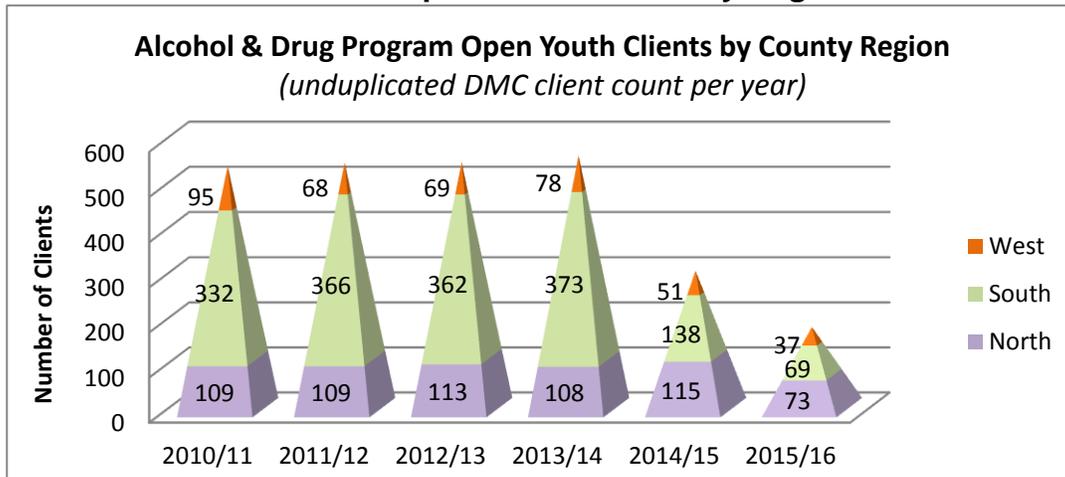


Chart 7B: Open Youth Clients by Region



While all regions have seen an increase in numbers, the greatest increase has been in the West County (Lompoc region). North County continues to have the highest number of DMC clients so the majority of expanded services will be located in the Santa Maria region.

Table 5 provides greater detail to the regional differences and informs the level of service needs in the different regions of the county, based on gender, ethnicity and DOC at admission. All of these factors contribute to the decision-making of current and additional treatment facilities and services.

Table 5: Medi-Cal Client Data
Alcohol & Drug Program DMC Client Data FY 2015/16

Client Counts in FY15/16				
	South	West	North	County-wide
Unique Client Count	1,187	675	1,539	3,257
Discharges from Treatment	999	771	1,356	3,126
Admissions	1,035	814	1,412	3,261
Total Open During FY15/16	1,591	999	2,125	4,715
Client Gender at Admission by Region (Unique Client Count in FY15/16)				
	South	West	North	County-wide
Female	38%	37%	40%	38%
Male	62%	63%	60%	62%
Missing	<1%	0%	0%	<1%
Client Ethnicity at Admission by Region (Unique Client Count FY15/16)				
	South	West	North	County-wide
Asian/Pacific Islander	1%	<1%	1%	1%
Black or African American	2%	6%	2%	3%
Hispanic	41%	52%	57%	51%
Native American	1%	1%	1%	1%

Other	3%	3%	1%	2%
White or Caucasian	50%	37%	37%	42%
Unknown/Missing	1%	0%	0%	<1%
Client Primary Language at Admission (Unique Clients FY15/16)				
	South	West	North	County-wide
Cantonese	1%	1%	1%	1%
English	81%	76%	71%	75%
Farsi	<1%	<1%	<1%	<1%
Hebrew	<1%	<1%	0%	<1%
Japanese	0%	0%	<1%	<1%
Mixtec	0%	0%	<1%	<1%
Missing	14%	20%	26%	21%
Spanish	4%	4%	4%	4%
Unknown / Not Reported	0%	<1%	0%	<1%
Client DOC at Admission by Region (Admissions in FY15/16)				
	South	West	North	County-wide
Alcohol	19%	15%	12%	15%
Barbiturates	<1%	<1%	<1%	<1%
Cocaine/Crack	2%	1%	1%	1%
Ecstasy	<1%	<1%	<1%	<1%
Heroin	43%	10%	30%	30%
Inhalants	<1%	<1%	<1%	<1%
Marijuana/Hashish	14%	18%	12%	14%
Methamphetamine	15%	51%	29%	29%
None	<1%	<1%	<1%	<1%
Non-Prescription Methadone	<1%	<1%	<1%	1%
Other	<1%	<1%	<1%	<1%
Other Amphetamines	<1%	<1%	<1%	<1%

How will the county address service gaps, including access to MAT services?

The DMC ODS, outlined in this implementation plan, will address many of the service gaps we have identified in SB County. For example, the provision of non-perinatal residential services will address a significant and long standing gap in our continuum of care. Addressing service gaps will be an ongoing process. By measuring data and collaborating with contracted treatment providers, community forums, the BeWell Commission and partner agencies, we will identify and address service needs. Our collaboration with primary care and the SB PHD will be especially important to address the physical needs of our clients. In other words, our DMC-ODS infrastructure will allow us to monitor what our clients and community members want and need. We currently use and will expand client satisfaction surveys to improve and inform our service delivery system. The new state required EQRO process for SUD will also help us identify and address service needs.

Addressing MAT service gaps will be especially important. Our pilot MAT Innovations project has been developed to address MAT needs and efficacies on our crisis populations. By the time our DMC ODS plan is approved, we will better understand MAT client needs and the processes required to address those needs. We will analyze our BeWell secondary SUD diagnoses to inform possible MAT needs within our SPMI population. We will continue to monitor our client DOC data, state and national drug data statistics and trends to shape our MAT programming. Finally, we will monitor the application of Suboxone within NTP clinics. In the process we anticipate that MAT will be expanded during the course of our DMC-ODS.

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).

Please see Attachment A.

9. Access to Services.

In accordance with 42 CFR 438.206, describe how the County will assure the following:

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

Access to services is based on Title 22 CCR DMC standards. Access measures are primarily focused on wait-times, intervals between key clinical events such as intake, first treatment session and completion of treatment plan, utilization rates and re-admissions. BeWell – ADP Access to Services Plan (currently in development) will include the following mechanisms to ensure timely access, compliance with timely access, and appropriate corrective action if there is a failure to comply with timely access requirements:

- Create database reports to assess average time frames between intake and first treatment session. It is expected that first treatment session will be offered within three (3) days of intake. For those providers who do not have 80% compliance for the report period, a Corrective Action Plan (CAP) will be initiated.
- Create database reports to assess average time frames between intake and completion of treatment plan. The treatment plan is required to be completed within 30 days of intake. For those providers who do not have 80% compliance for the report period, a CAP will be initiated.

DMC-ODS hours of operation will be client driven. As described above, all providers will be required to have evening and weekend hours to accommodate clients and their families who work or are looking for work during the day. The hours of operation will be no less than the hours of operation during which the providers offer services to non DMC clients. .

Our Beneficiary Access Line will be open 24 hours a day, 7 days a week to provide ASAM Screening and SBIRT services to clients who call. Where indicated, clients or significant others who call after hours will be ASAM screened to determine medical necessity and referred to services as quickly as possible. Our CSUs, Mobile Crisis and Crisis Triage units and personnel are responsible for providing after hours services. As mentioned earlier, DMC ODS case management services will also be provided by our crisis staff to stabilize, engage and link clients to services in times of need, 24-7.

The integrated BeWell QCM team will provide an array of oversight activities to ensure compliance with DMC regulations. (See response to Question #12 below). These activities will provide both clinical and administrative oversight, ensuring that the implementation plan is being followed and that clinical services are being provided appropriately. ODS QCM and other ADP staff will develop a full range of P & Ps to ensure compliance with ODS requirements. An integrated BeWell Access P&Ps has already been developed and approved that will help ensure timely access to DMC ODS services. All ODS providers will be informed of and trained on this and other P & Ps to ensure compliance.

Though formal reviews will be administered yearly, County ODS QCM staff will focus on monitoring client access on a weekly basis during at least the first six (6) months of plan implementation.

Calls and ASAM screenings will be audited. Data will be collected and analyzed to monitor and ensure timely access. All providers will be monitored to ensure compliance. If providers are not compliant with access requirements, CAPS will be issued.

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?

Initial and ongoing clinical and administrative training will be pivotal to the success of the SBC ODS. County BeWell has always required EBPs for AOD treatment. The following EBP clinical trainings will be required of all DMC-ODS providers:

Table 6: Clinical Training

Clinical Training	Frequency
ASAM Theory and Practice	Twice, first year, twice, second year as needed but at least yearly thereafter
Addiction Severity Index (ASI)	As needed or at least yearly
Motivational Interviewing (MI)	As needed or at least yearly
Cognitive Behavioral Therapy (CBT)	Twice, first year and yearly thereafter
Trauma Informed Care	As needed or at least yearly
Community Reinforcement Approach /Adolescent Community Reinforcement Approach (ACRA)	As needed or at least yearly
Countertransference	Yearly
Co-Occurring Disorders (ODs)	As needed or at least yearly
Medication Assisted Treatment (MAT)	Twice, first yearly and yearly or as needed thereafter
Ethics	Yearly

The following administrative trainings will be required of all DMC-ODS providers:

Table 7: Administrative Training

Administrative Training	Frequency
DMC documentation and Title 22 CCR	Twice, first year and yearly or as needed thereafter
Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2	Yearly
Electronic Health Record (Share Care and Clinician’s Gateway) and CalOMS	Monthly

All trainings will be facilitated by BeWell or contracted provider staff and will be provided either face to face or online. The frequency and priority of the trainings will be based upon importance to ensure DMC ODS success. Generally speaking, newer or less familiar theories and models will require more exposure and more frequent and intensive trainings.

ASAM and MAT, trainings, for example, will be among the most intensive and frequent, for at least the first year of the DMC ODS implementation. Though SBC is well trained on DMC documentation and Title 22 CCR standards, ongoing training and technical assistance in this area will always be important. On the other hand, our entire treatment system and most SUD professionals are familiar with and experienced in providing basic CBT and ASI assessments; training in these areas will be less important.

The quality of the trainings and ongoing clinical and administrative support will be more important than the frequency. All topics, theories, models and practices will be monitored by our QCM and ADP administrative staff to ensure fidelity to the models. This will especially be the case with ASAM. It is anticipated that ensuring proper levels of care per ASAM standards will be the most time and resource intensive training. We will rely on DHCS and State contractors to help with this ASAM training, though we plan on providing a very robust ASAM training ourselves.

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

BeWell requests technical assistance in the following areas:

- ASAM training, resources, and tools. A “Train the Trainer” model would be preferred to build internal system capacity and meet ongoing training needs to accommodate new staff and providers, to ensure inter-rater reliability for placement decisions, and for utilization management.
- Fidelity assessment for Evidence Based Practices.
- Provide a current list of all California licensed and DMC certified youth residential facilities by ASAM level.
- Assist BeWell in care coordination with acute services. We request DHCS provide a list of facilities in California to provide Levels 3.7 and 4.0 residential and W/D management services. On this list, please indicate which facilities accept full scope Medi-Cal and which Medi-Cal aid codes are billable by facility based on their Diagnostic Related Group (DRG) and National Provider Identifier (NPI) numbers for both 3.7 and 4.0 residential and W/D management services. Please also distinguish facilities which can provide services to youth, and which serve adults.
- Standards associated with Cost Report and Audit principles.

12. Quality Assurance.

Describe the County’s Quality Management and QI programs. This includes a description of the QIC (or integration of DMC ODS responsibilities into the existing Mental Health Plan (MHP) QI Committee).

The monitoring of accessibility of services outlined in the QI 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 MH 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.**

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.**

All of the above activities, from monitoring and ensuring timeliness of first initial contact to face-to face- appointment to requirements of state fair hearings, will be monitored, measured and ensured by a robust quality assurance program. Every call into the Access Line and subsequent referral is and will be tracked through computer generated reports and reviewed on at least a monthly basis. Random reviews are also administered by having staff call into the Access Line while other QCM staff randomly checks reports. Logs will be kept and reviewed at monthly QIC meetings. Client satisfaction surveys will be administered and reviewed in an effort to "delight the client" or surprising a client by exceeding his or her expectations and thus creating a positive emotional reaction.

Our Quality Improvement Plan (QIP, please see page 52) will pay particular attention to monitoring accessibility of services. QCM generally and Utilization Review specifically will provide accurate and consistent service monitoring, ensuring that clients have quick access to appropriate levels of treatment. Our QCM department will monitor the frequency of follow up appointments, the timeliness of services for the first dose of NTP services, and access to after-hours care by regularly reviewing client electronic health records, conducting regular site reviews, reviewing CalOMS Admissions data and quarterly data and narrative reports required by Be Well.

A strong and specialized Utilization Review process within the DMC-ODS will be established to ensure that each client utilizes only the most medically necessary and beneficial services to ensure recovery success. The placement and transitioning of clients from one level of treatment to another, including the coordination of physical and mental health services with waiver services at the provider level, will be one of the most important tasks within the QCM department and QIC activities. Each client will be assessed and reassessed per ASAM criteria to ensure quick service access to the appropriate level of care. Medical necessity will be monitored regularly in every service level by random chart (Elec.HR) auditing, reviews of treatment plan and annual update reviews, CalOMS and other internal data reports. In order to reduce avoidable hospitalizations, our mobile crisis teams and crisis stabilization units have been ASAM trained to immediately address deescalate and treat chemically induced crises. The proper use and monitoring of MAT will also ameliorate avoidable hospitalizations.

Every client has a right to file a grievance with BeWell; and BeWell takes every grievance seriously. We have developed a formal Policy and Procedure entitled “Beneficiary Problem Resolution Process” outlining the specific rights and ways that a client can issue a complaint against the department. Essentially, a client can file a grievance in any way to any staff that then records the grievance and sends the record to the QCM manager. A specific grievance committee will address each complaint and begin an investigation that is usually settled within seven (7) calendar days but no longer than sixty calendar (60) days from the date of the complaint. The QIC committee is also part of the process as any grievance may indicate a need for systematic quality improvement. During the process, the client will be made aware of his/her right to support and assistance from a Patients’ Rights Advocate, whose designation is to receive and investigate complaints quickly and to advise clients of their rights and the requirements of state fair hearings.

As the SBC DMC ODS will pivot on integration, integration will pivot on quality assurance. County BeWell will develop an integrated and strong quality assurance, quality management, and QI and UR system to ensure the successful implementation of the organized delivery system. As mentioned earlier, two (2) QCMCs will be hired to provide dedicated QCM, assurance and improvement to the ODS. Both are LPHA staff. Both QCMCs will have extensive experience providing Title 9 CCR full scope MC QCM and regulations, and will have been involved in the MH EQRO process and are quickly learning DMC Title 22 CCR and ODS STCs. Both will have extensive direct service experience working with clients with COD.

Some case management services will be provided by the county and some by contracted providers. In addition, BeWell ADP employs two (2) HCPCs and a Team Supervisor who have provided quality control and management to our current DMC system of care.

These staff will continue to perform their duties with the ODS implementation. Finally and perhaps most significantly SUD and MH QCM will be a fully integrated department with the DMC ODS. All MH QCMCs will be cross trained in SUD and vice versa.

Everyone will be proficient with differential diagnosis and understand the importance integrating of primary care into behavioral health both administratively and clinically.

The integrated BeWell QCM Department will provide an array of oversight activities to ensure compliance with DMC regulations. These activities will provide both clinical and administrative oversight, ensuring that the implementation plan is being followed and that clinical services are being provided appropriately. Clinically, these activities include regular documentation (chart) monitoring, review and auditing, oversight of site certifications, monitoring of actual counseling groups and individual sessions and assessment of technical assistance, training needs and QI policy development.

The monitoring will be intensive, frequent. A minimum of five (5) percent of client charts will be audited monthly and site certifications visits will occur as required. Formal annual programmatic and fiscal audits will be conducted for all treatment activities. Copies of annual audits will be submitted to DHCS within thirty (30) days.

The importance and value of monitoring the actual group and individual counseling process cannot be overstated. County BeWell ADP currently attends group and individual sessions to provide support and guidance of treatment service. Providers have reported this activity has been invaluable in helping them maintain fidelity to established treatment models. Because the SB DMC ODS calls for SAMHSA Level 5 – 6 Integration, this activity can only become more important. In an effort to prevent clinical fidelity drift, BeWell clinical staff who works in BeWell ADP California Work Opportunity and Responsibility to Kids (CalWORKs) programs will attend treatment activities and provide technical assistance to individual direct service counselors and agencies to prevent clinical drift. Clinical supervision will also be provided, especially to those contracted direct service counselors and clinicians who may suffer from vicarious trauma in their work.

Compliance will be monitored in the same way. County BeWell ADP currently employs an extensive contract monitoring system that will be continued with the DMC ODS. Whenever administrative or clinical non-compliance issues arise, they are documented fully and issued on a formal monitoring report. The report is drafted carefully and a CAP is issued. Providers have thirty (30) calendar days to complete and submit the CAP to the satisfaction of County ADP (which of course is the satisfaction of Title 22 CCR, ASAM and this DMC-ODS plan). All monitoring and CAPs will be helpful and non-punitive. Every effort will be made, as is the case now, to correct any and all deficiencies on the spot, as they exist and to help the provider and or direct service staff in a collaborative manner.

Our DMC ODS will be formally integrated into our MH QI Plan and protocols. Our current QI Work plan states:

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

An ADP DMC ODS Subcommittee will be integrated within the current QI Program and Plan. The QI Program coordinates performance monitoring activities throughout the delivery of services for MH and it will coordinate services for the ADP Plan (MH/ADP), including:

- Service delivery capacity
- Accessibility of services
- Timeliness of services
- Beneficiary satisfaction
- Service delivery system monitoring and analysis
- Service coordination with physical healthcare and other agencies
- Monitoring provider appeals
- Tracking and resolution of beneficiary grievances, appeals, and fair hearings, as well as provider appeals
- Performance Improvement Projects (PIPs)
- Consumer and system outcomes
- Utilization management
- Credentialing

The QI Program also assesses beneficiary and provider satisfaction and conducts clinical records review. The DMC ODS QI Program is consulted in the contracting process for hospitals, as well as individual, group and organizational providers. The MHP QI Program has access to, and reviews as necessary, relevant clinical records to the extent permitted by State and Federal laws.

SBC MHP QIC embodies in its charter, the process of continuous QI. The mission statement reflects the focus of review of the quality of specialty MH services provided to beneficiaries and service recipients throughout the overall BeWell system of care and recovery, focusing on continuous QI. A very substantial aspect of that mandate relates to reviewing and selecting performance indicators and using data to evaluate and improve the performance of SBC's behavioral health system of Care and Recovery.

QIC Program Description

The QIC promotes the QI program and supports recognition of both individual and team accomplishments. Its members are responsible for helping create a QI culture. In this culture, employees use QI principles and tools in their day-to-day work, with extensive support and guidance from leadership.

The QIC reports to the Core Leadership Team and other management and staff work teams.

The QIC is responsible for:

1. Recommending policy decisions
2. Initiating, coordinating, reviewing and evaluating the results of QI activities
3. Reviewing and evaluating PIPs
4. Institution of needed QI actions
5. Guiding system-wide selection and application of QI methods
6. Ensuring follow-up of QI processes
7. Documenting QIC meetings regarding decisions and actions taken
8. Developing the annual QI Work Plan as well as the evaluation of the Work Plan.
9. Facilitation of routine committee activity reports.

The QIC meets monthly throughout the year. Meetings are facilitated by the Chief Quality and Strategy Officer, who is a licensed practitioner and oversees the Office of Quality and Strategy Management.

The QIC assigns and receives reports from QI sub-Committees and coordinates with the work of the Compliance Committee, reviews and evaluates the results of QI activities, recommends actions to appropriate departmental staff/divisions and ensures follow-up evaluation of actions. When appropriate, the QIC may recommend policy proposals for SBC's MHP Executive Team's consideration. On a quarterly basis, The QCM Manager presents the activities and recommendations of the QIC activities to the SBC MHP Executive Leadership Team. QIC decisions and actions are memorialized by dated minutes that are signed by the QCM Manager.

The QI Committee (QIC) is composed of:

- Chief Quality and Strategy Officer (OQSM team)
- ADP Program Administrator
- Research and Evaluation Program Coordinator (OQSM team), including ODS QCMCs
- SBCMHP Chief of Compliance
- SBCMHP Medical Director
- SBCMHP Deputy Director
- QCM Manager
- UR staff
- QCM psychiatrist
- BeWell Regional Program Managers
- Management staff of CBOs
- Program Manager of BeWell Management Information Systems
- Consumers and Family Members
- Patient Rights Advocates
- Consumer Empowerment Manager
- Peer Support Employees

The ADP-ODS Sub Committee will be created to specifically ensure that healthcare integration proceeds and that ASAM and Title 22 CCR standards are followed. The ADP-ODS Sub Committee will work closely with a current QIC committee to ensure that client access is timely and that clients can transition seamlessly from one level of care to another.

13. EBP.

How will the counties ensure that providers are implementing at least two of the identified EBPs? What action will the county take if the provider is found to be in non-compliance?

BeWell has always required its contracted treatment providers to employ EBPs only. Our entire SUD Treatment and MH and criminal justice systems use MI, and CBT. Our SUD treatment system uses Seeking Safety and is fully trauma informed.

SBC has long been recognized by SAMHSA as a pioneer in the field of trauma informed care. With the DMC ODS, we plan to build on the solid foundation of EBPs we have already established. MI, including the Stages of Change and the Trans-Theoretical Model, will continue be the bedrock of all EBPs for SUD and COD services. MI is the foundation of the Matrix Model (MM) that we have been using for over ten (10) years, and continues to be the fundamental counseling and communication style to engage and keep clients engaged in all treatment levels. MI can be basic or sophisticated.

Another CBT model, Rational Emotive Behavioral Therapy (REBT) will also be part of the treatment menu. All providers will learn how to help clients and will be trained in ABCs: identifying the Activating events that can trouble clients, exploring Belief systems and evaluating the Consequences of those belief systems, Disputing irrational beliefs, and then changing self-defeating thinking patterns into Effective new thinking in order to encourage more pro-social and constructive behaviors. The ABCs of REBT. SMART Recovery® self-help groups that are based upon REBT will be offered throughout the County as a compliment to 12 Step Groups.

Acupuncture is an EBP that is indicated for ASAM Dimension 1: Acute Intoxication and/or W/D Potential and Dimension 5: Relapse, Continued Use, or Continued Problem Potential. County BeWell DMC-ODS plans on providing acupuncture services as a pilot project within our residential treatment system of care. Contracted residential providers may provide up to four (4) acupuncture sessions per client per treatment episode at our residential detox and treatment facilities, two (2) for detox and two (2) for relapse prevention. Acupuncture will be administered as a group process, administered in a group setting, to clients who volunteer for the treatment method. The County will not claim FFP for these acupuncture services. However, will use other funding streams for this service. It is anticipated that acupuncture services will be limited to four (4) sessions total.

Every effort will be made to separate all clients into groups most appropriate and advantageous for client care. County BeWell has already established segregated gender specific groups. Adults and adolescents are and will continue to be separated per the state DHCS Youth Treatment Guidelines.

For clients with SPMI and COD who are within our MH system or receiving treatment with one of our Co-Occurring Enhanced contracted agencies, Dialectical Behavioral Therapy (DBT) can be used where indicated and needed. This model will be provided by LPHAs beyond the scope of certified AOD counselor. But licensed psychotherapists have used the model with great success in the treatment of COD, especially with clients who are personality disordered.

For adolescents, a combination of MI with the ACRA will be used. BeWell was awarded a SAMHSA grant to utilize the ACRA from 2010–2013. The grant was successful but could not be sustained because DMC services did not cover the regular 1:1 individual counseling the model required. Adolescents need more individual attention than adults, and group counseling, especially for clients from rival gangs, might be contraindicated and dangerous. Therefore, we will use the ACRA treatment model along with a case management approach called Assertive Community Care (ACC) for adolescent treatment.

ACRA is an alcohol and substance use treatment model which uses a behavioral intervention approach that works with adolescents and their primary caregivers and seeks to increase the family, social, educational and vocational reinforcers to support recovery. Using a functional analysis, positive and negative reinforcers are identified. Negative reinforcers are replaced with positive reinforcers to limit high risk situations and behaviors. This model requires regular individual counseling sessions, at least one per week that currently goes beyond the Title 22 CCR DMC benefit. This is an efficacious model that will engage and maintain adolescents in treatment and recovery.

The above EBPs are culturally adaptable. County BeWell adheres to Culturally and Linguistically Appropriate Services (CLAS) standards. We have developed a culturally competent assessment process based upon the fifteen (15) CLAS standards and the DSM-5 culturally diagnostic criteria. A thorough Cultural Competence Plan has been developed incorporating American Psychological Association (APA) and DSM-5 cultural standards. A large segment of our community members who need to access treatment services are Spanish speaking, especially in North County or the Santa Maria region. We also have a growing Native American population to consider. We will therefore provide treatment services with cultural humility and adapt all treatment models to the cultures within which they are presented and applied. The employment of bilingual and bicultural counselors will be required for all direct service treatment providers.

Fidelity to all treatment models will be required. All of the above EBPs have fidelity models that will need to be followed. BeWell QCM and administrative staff will ensure fidelity by mastering the models and requiring adherence to the fidelity scales. Lack of adherence to EBP model fidelity, commonly referred to as “clinical drift, will be addressed as part of the clinical monitoring process. A standardized tool has been developed to assess general and specific clinical strengths and weaknesses, including fidelity compliance. Of course, some evidenced based practices such as the Matrix Model or Seeking Safety have come with specific fidelity scales. These will be used in addition to the BeWell ADP tool. Non-compliance to fidelity or clinical drift will result in specific clinical redirection and training as needed. If fidelity noncompliance or clinical drift is not corrected within thirty (30) calendar days of the assessment, a corrective action plan (CAP) will be issued. If the CAP is not followed, BeWell reserves the right to cancel the provider’s contract.

14. Regional Model.

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

As indicated previously, County BeWell will not be implementing a regional model. However, SB has a strong relationship with its surrounding counties, namely San Luis Obispo and Ventura. We have and will continue to coordinate NTP services for our clients with other counties when necessary. We will work with other counties to ensure clients can access and receive ODS services easily and quickly. We will work together when a regional approach is required to deliver a component, which may be needed, but is unsupportable in one county. Providing adolescent residential services, for example, will require a regional approach.

15. Memorandum of Understanding (MOU).

Submit a signed copy of each 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 Section 152 “Care Coordination” 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).

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 MH 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.**

The MOU between the county and the managed care plan (MCP) provider, Cen Cal, has been completed and submitted to the State of CA Department of Health Care Services (DHCS). The MOU will outline the mechanism for sharing information and coordination of service delivery as described in Section 152 “Care Coordination” of the STCs.

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).

County BeWell currently has telehealth psychiatric services in place at our CSU’s and will have Telehealth capabilities within the BeWell SPMI system of care. It is anticipated that these services will be made available to DMC ODS clients once the BeWell MH clinics are DMC certified. Currently, our mental health clinics do not provide SUD services other than addressing secondary SUD diagnoses within a primary MH diagnosis. Lack of SUD clinical services is a gap in our current system of care we will address with the DMC-ODS grant by DMC certifying our MH clinics. DMC certification of our mental health clinics will be a considerable undertaking, involving administrative and clinical care to ensure proper diagnoses, record keeping and billing practices, intensive training as well as an overall shift in culture. We will begin the process of DMC certification of our MH clinics by August of 2017 and anticipate certification of our MH clinics no later than July 1, 2018. We anticipate certifying one of our three mental health clinics as a pilot by the end of calendar year, 2017. All telehealth psychiatric service providers will be trained in and monitored for compliance with PHI and HIPAA confidentiality regulations.

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?

SBC BeWell complies with SBC P & Ps for the selection and retention of service providers as described in the County Purchasing Manual. These P & Ps apply equally to all providers regardless of public, private, for-profit or non-profit status, and without regard to whether a provider treats persons who require high-risk or specialized services.

A formal Provider Selection Process (PSP) will be used for most if not all DMC services. This process includes the publishing of the projects/program scope of work, the requisite provider organizational characteristics, a description of how services will be delivered that aligns with the terms and conditions of the RFP, and a budget that is sufficient to deliver the services and achieve the desired outcomes. Once proposals are received, BeWell convenes a review panel that typically includes content experts, members of the AOD Advisory Board, and community members. The panel is given criterion to evaluate each proposal and make recommendations to the BeWell Director for funding. If necessary in order to make a final recommendation, the panel may choose to interview one or more of the applicants. The PSP will include an Appeal process. Once approved by the BeWell Director, a formal recommendation for approval is recommended to the SBC BOS. Once approved by the BOS, the contract is officially executed.

Contract Term

The County has a 3-year contract term limit. A Contract Collaboration process is in place to review each contract, on an annual basis, with the County department head, the Contract Compliance staff, Fiscal staff, and contracted Provider staff to ensure contractual agreements can be renewed for another 3-year contract term.

Appeals Process

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

If a responding applicant desires to protest the County's selection decision, the responding applicant must submit by facsimile and e-mail a written protest within five (5) business days after delivery of the notice about the decision.

The written protest should be submitted to the Deputy Director for Administration and Operations as outlined below. Protest received after the deadlines are not accepted.

Protests must be in writing, must include the name and address of the Proposer and the RFP numbers, and must state all the specific ground(s) for the protest. A protest that merely addresses a single aspect of the selected proposal (for example, comparing the cost of the selected proposal in relation to the non-selected proposal) is not sufficient to support a protest. A successful protest will include sufficient evidence and analysis to support a conclusion that the selected proposal, taken as a whole, is an inferior proposal.

The Deputy Director for Administration and Operations will respond to a protest within ten (10) business days of receiving it, and the Department may, at its election, set up a meeting with the proposer to discuss the concerns raised by the protest. Providers that submit a bid to be a contract provider, but are not selected, must exhaust the county's protest procedure if a provider wishes to challenge the denial to the DHCS. If the county does not render a decision within 30 calendar days after the protest was filed with the county, the protest shall be deemed denied and the provider may appeal the County's provider selection to DHCS. A provider may appeal to DHCS as outlined in Attachment Y of Medi-Cal 2020 Waiver, p. 335).

If a current DMC provider is not awarded a DMC contract through our RFP process above, care will be taken to ensure that current clients continue to receive the services that are medically necessary. County ADP and QCM staff, along with the BeWell Compliance Officer if need be, will oversee the referral process. Each client will be assessed using ASAM criteria and transitioned to a level indicated and that is agreeable to the client. Any client who does not meet medical necessity will be completed with a discharge plan.

18. Additional MAT.

If the county chooses to implement additional MAT beyond the requirement for NTP services, describe the MAT and delivery system.

As described above (see response above to Question #4.G) BeWell will offer additional MAT services to clients who meet medical necessity, especially those clients with COD who will need SUD medications in order to engage in the recovery process. MAT will expand the use of medications for clients with chronic and severe alcohol and opioid related disorders. Medications will include naltrexone both oral (ReVia) and extended injectable release (Vivitrol), buprenorphine (Suboxone and Subutex), acamprosate (Campral), and Disulfiram (Antabuse). Naloxone (Narcan) will be available throughout the entire system of care to targeted individuals, families and agencies who may be first responders to an opioid overdose.

BeWell has coordinated care and expanded the availability of MAT outside of the DMC-ODS by building capacity with the entire health care system to use these treatments for clients with a SUD. BeWell is training physicians, social workers, nurse practitioners, psychiatrists and other allied health professionals in primary care and specialty MH clinics on the efficacy of MAT, practice guidelines and medication administration. Physician consultation will be utilized to provide and guide the

expansion of MAT.

BeWell is in the process of developing a MAT program within our current system of care. As reported earlier, many clients who present to our crisis teams – Mobile Crisis, Crisis Triage and the CSU screen positive for AOD or report SUD crises within the past week. Too often some of these clients are stabilized, referred to treatment and fall out of treatment for reasons that might have been ameliorated by SUD medications. We are also identifying clients within our current severe and persistent mental illness (SPMI) population who may benefit from SUD MAT services. We are developing a policy and procedure to provide MAT to clients who meet established MAT criteria as defined by the following nationally developed guidelines:

Federal evidenced-based criteria will be used to determine eligibility for MAT. These criteria will follow and adhere to the following publications:

1. Federal Guidelines for Opioid Treatment Programs (SAMHSA, 2015)
2. TIP 43: Medication Assisted Treatment for Opioid Addiction and Opioid Treatment Programs
3. TIP 40: Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction
4. Medication for the Treatment of Alcohol Use Disorder: A Brief Guide (SAMHSA, 2015)

Included in this P & P is a screening and referral process for providing MAT to clients with mild to moderate mental health disorders. Clients who do not meet SPMI criteria but have COD that might benefit from MAT will be referred to our contracted ADP providers who provide MAT. The referral will be a “warm handoff”.

Case management services will be included for all MAT clients to ensure client engagement in treatment and recovery services. If successful, we anticipate that this program, now funded by MHS Innovation, will be sustained by our DMC-ODS.

19. Residential Authorization.

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

As discussed earlier (See responses above to Section #4 Treatment Services, E Residential Treatment Services), if an initial screening indicates the need for residential services, a QCM staff will review and authorize residential services within twenty four (24) hours of request and place client in appropriate residential treatment facility within another twenty four (24) hours. Quality Control Management (QCM) will monitor all residential authorizations and QCM staff may be included in the authorization process from the beginning.



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.

SBC anticipates meeting all mandatory requirements upon implementation.

County Authorization

The County Behavioral Health Director must review and approve the Implementation Plan. The signature below verifies this approval.

County Behavioral Health Director

County

Date

Attachment A

DMC ODS Implementation Plan SUD Provider Capacity Appendix

Agency	Program	Facility Service Address	DMC Certification #	Days of Operation	Current Capacity	Total Treatment Capacity
North County						
Aegis Treatment Centers	NTP-Methadone	115 E. Fesler St. Santa Maria, Ca 93454	4269	Monday-Friday 8:00 a.m. - 7:00 p.m. Saturday and Sunday 6:00 a.m. – 9:00a.m.	417	375
Coast Valley Substance Abuse Treatment Center	ODF Treatment Youth and Family Treatment PC 1000-Drug Diversion VETS/ROSC	1414 S. Miller St., Suite 11 Santa Maria, Ca 93454	42AE	Monday-Friday 8:00 a.m. - 7:00 p.m.	391	252
Good Samaritan	ODF Treatment VETS/ROSC	245 E. Inger Dr., Suite 103B Santa Maria, CA 93458	4225	Monday-Friday 8:30 a.m. -5:00	131	100
Good Samaritan	Detox	401 "B" W. Morrison Ave. Santa Maria, CA 93458	N/A	Open 24/7	12	12
Good Samaritan	Perinatal Treatment Residential	412 E. Tunnel St. Santa Maria, CA 93454	N/A	Open 24/7, Treatment services Monday-Sunday 8:30 a.m. - 5:00 p.m.	21	21
Good Samaritan	ODF Treatment	403 W. Morrison Ave., Suite B Santa Maria, CA 93454	42AI	Monday-Friday 8:30 a.m. - 5:00 p .m.	26	26
LAGS Recovery Center	IOT Treatment	801 E. Chapel St. Santa Maria, CA 93454	42AK	Monday-Friday 8:00 a.m. – 7:00 p .m.	15	30
Santa Maria Valley Youth & Family	Youth & Family Treatment	105 N. Lincoln St. Santa Maria, CA 93458	4262	Monday-Thursday 9:00 a.m. - 7:00 p.m. Friday 9:00 a.m. - 5:00 p.m.	29	30
South County						
Aegis Treatment Centers	NTP-Methadone	4129 State St., Suite B Santa Barbara, Ca 93110	4272	Monday-Friday 8:00 a.m. - 7:00p.m. Saturday and Sunday 6:00 a.m. – 9:00 a.m.	471	325
CADA-Council on Alcoholism and Drug Abuse	ODF Treatment Perinatal Outpatient	133 E. Haley St. Santa Barbara, CA 93101	4224	Monday-Friday 9:00 a.m. - 7:00 p.m.	109	170

Santa Barbara County Department of Behavioral Wellness
Drug Medi-Cal Organized Delivery System
(DMC ODS) County Implementation Plan

CADA-Council on Alcoholism and Drug Abuse	Detox	1020 Placido Ave. Santa Barbara, CA 93101	N/A	Open 24/7	12	12
CADA-Council on Alcoholism and Drug Abuse	Youth & Family Treatment	1111 Garden St. Santa Barbara, CA 93101	4276	Monday-Friday 9:00 a.m. - 7:00 p.m.	64	140
Agency	Program	Facility Service Address	DMC Certification #	Days of Operation	Current Capacity	Total Treatment
Casa Serena	Residential Treatment	1515 Bath St. Santa Barbara, CA 93101	N/A	Monday-Friday 9:00 a.m. - 5:00 p.m.	18	32
Casa Serena	Perinatal	147 Oliver Rd. Santa Barbara, CA 93109	N/A	Monday-Friday 9:00 a.m. - 5:00 p.m.	18	32
Crescent Health	ODF Treatment Dual Diagnosis	107 E. Micheltorena St. Santa Barbara, CA 93101	4275	Monday-Friday 9:00 a.m. - 5:00 p.m.	61	50
Sanctuary Centers of SB	ODF Treatment Dual Diagnosis IOT	222. W. Valerio St. Santa Barbara, CA 93101	4203	Monday-Friday 10:00 a.m. - 6:00 p.m.	3	120
Sanctuary Centers of SB	ODF Treatment Dual Diagnosis IOT	Arlington Day Treatment 1136 De La Vina St. Santa Barbara, CA 93101	4203	Monday-Friday 10:00 a.m. - 6:00 p.m.	91	120
West County						
Coast Valley Substance Abuse Treatment Center	ODF Treatment PC 1000-Drug Diversion	1133 N. H Street, Suite F Lompoc, CA 93436	42AL	Monday-Friday 8:00 a.m. - 7:00 p.m.	118	253
Coast Valley Substance Abuse Treatment Center	ODF Treatment Youth and Family Treatment	133 N. F Street Lompoc, CA 93436	42AF	Monday-Friday 8:00 a.m. - 7:00 p.m.	118	253
Good Samaritan	Detox	113 S. M Street Lompoc, CA 93436	N/A	Open 24/7	6	6
Good Samaritan	ODF Treatment IOT	104 S. C Street, Suite A Lompoc, CA 93436	42AJ	Monday-Friday 8:30 a.m. - 5:00 p.m.	34	34
Good Samaritan	Perinatal Transitional Living	604 W. Ocean Ave. Lompoc, CA 93436	N/A	Monday-Friday 8:30 a.m. - 5:00 p.m.	16	16
Good Samaritan	ODF Treatment Perinatal	604 W. Ocean Ave. Lompoc, CA 93436	42AH	Monday-Friday 8:30 a.m. - 5:00 p.m.	40	35

Appendix

ACRONOYM GUIDE

1. ABC	Activating, Belief systems and the Consequences
2. ACC	Assertive Community Care
3. ACRA	Adolescent Community Reinforcement Approach
4. ADA	Americans with Disabilities Act
5. ADMHS	Alcohol, Drug and Mental Health Services
6. ADP	Alcohol and Drug Program
7. AOD	Alcohol and Other Drugs
8. APA	American Psychological Association
9. ASAM	American Society of Addiction Medicine
10. ASI	Addiction Severity Index
11. BeWell	Behavioral Wellness
12. BOS	Board of Supervisors
13. CAADAC	California Association of Alcohol and Drug Counselors
14. CAARR	California Association of Addiction Recovery Resources
15. CalOMS	California Outcome Measurement Service
16. CalWORKs	California Work Opportunity and Responsibility to Kids
17. CAP	Corrective Action Plan
18. CBO	Community Based Organization
19. CBT	Cognitive Behavioral Therapy
20. CC	Core Committee
21. CCAPP	California Consortium of Addiction Programs and Professionals
22. CCR	California Code of Regulations
23. CEO	County Executive Officer
24. CHC	Community Health Centers
25. CLAS	Culturally and Linguistically Appropriate Services
26. COD	Co-Occurring Disorder
27. CSU	Crisis Stabilization Units
28. DBT	Dialectical Behavioral Therapy
29. DCR	Day Care Rehabilitative
30. DHCS	Department of Health Care Services
31. DMC	Drug Medi-Cal
32. DOC	Drug of Choice
33. DRG	Diagnostic Related Group
34. DSM	Diagnostic and Statistical Manual
35. DSS	Department of Social Services
36. EBPs	Evidence Based Practices
37. EQR	External Quality Review

38. EQRO	External Quality Review Organization
39. ER's	Emergency Rooms
40. FQHC	Federal Qualified Health Centers
41. HCPCs	Health Care Program Coordinators
42. HIPAA	Health Insurance Portability and Accountability Act
43. IOT	Intensive Outpatient Treatment
44. LPHA	Licensed Practitioner of the Healing Arts
45. MAT	Medication Assisted Treatment
46. MCO	Managed Care Organization
47. MH	Mental Health
48. MHP	Mental Health Plan
49. MHSA	Mental Health Services Act
50. MI	Motivational Interviewing
51. MM	Matrix Model
52. MOU	Memorandum of Understanding
53. NAMI	National Alliance on Mental Illness
54. NPI	National Provider Identifier
55. NTP	Narcotic Treatment Program
56. ODS	Organized Delivery System
57. OQSM	Office of Quality and Strategy Management
58. OTP	Opioid Treatment Program
59. P&Ps	Policies and Procedures
60. PHD	Public Health Department
61. PHF	Psychiatric Health Facility
62. PHI	Protected Health Information
63. PIPs	Performance Improvement Projects
64. PSP	Provider Selection Process
65. QCM	Quality Care Management
66. QCMC	Quality Care Management Coordinators
67. QI	Quality Improvement
68. QIC	Quality Improvement Committee
69. REBT/SMART	Rational Emotive Behavioral Therapy/Self-Management for Addiction Recovery Training
70. RFP	Request for Proposals
71. ROI	Release of Information
72. ROSC	Recovery Oriented System of Care
73. RR	Recovery Residences
74. SAMHSA	Substance Abuse and Mental Health Services Administration
75. SAPT	Substance Abuse Prevention and Treatment
76. SB	Santa Barbara

77. SBC	Santa Barbara County
78. SBIRT	Screening, Brief Intervention and Referral to Treatment
79. SBNC	Santa Barbara Neighborhood Clinics
80. SLE	Sober Living Environments
81. SPMI	Severe and Persistent Mental Illness
82. STC	Standard Terms and Conditions
83. SUD	Substance Use Disorders
84. TIP	Treatment Improvement Protocol
85. UCLA	University of California Los Angeles
86. UR	Utilization Review
87. W/D	Withdrawal
88. WM	Withdrawal Management
89. WRAP	Wellness Recovery Action Plan