Drug Medi-Cal Organized Delivery System

Implementation Plan

For

County of San Luis Obispo

Health Agency

Behavioral Health Department

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PART I
PLAN QUESTIONS

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

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

- ☒ County Behavioral Health Agency
- ☒ County Substance Use Disorder Agency
- ☒ Providers of drug/alcohol treatment services in the community
- ☒ Representatives of drug/alcohol treatment associations in the community (Recovery)
- ☒ Physical Health Care Providers
- ☒ Medi-Cal Managed Care Plans
- ☒ Federally Qualified Health Centers (FQHCs)
- ☒ Clients/Client Advocate Groups
- ☒ County Executive Office (individual meeting)
- ☒ County Public Health
- ☒ County Social Services/Child Welfare Services
- ☒ Foster Care Agencies/Social Workers
- ☒ Law Enforcement
- ☒ Court/District Attorney/Defense Attorneys/Family Attorneys/County Counsel/Judges
- ☒ Probation Department
- ☒ Education
- ☒ Recovery support service providers (including recovery residences)
- ☒ Health Information technology stakeholders (Behavioral Health Department staff)
- ☒ Other (specify): Behavioral Health Board, Members of the general public

2. How was community input collected?

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

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

- ☐ Monthly
- ☐ Bi-monthly
- ☒ Quarterly
- ☐ Other:

Review Note: One box must be checked.

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

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

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

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

How will these required services be provided?

☐ All County operated
☒ Some County and some contracted
☐ All contracted

OPTIONAL
☒ Additional Medication Assisted Treatment
☐ Partial Hospitalization
☒ Recovery Residences
☒ Other (specify): Telehealth

6. Has the county established a toll free 24/7 number with prevalent languages for prospective clients to call to access DMC-ODS services?
☒ Yes (required): 1-800-838-1381

☒ No. Plan to establish by: September 30, 2016. We may choose to contract with another organization for the 24/7 overnight call services.
Review Note: If the county is establishing a number, please note the date it will be established and operational.

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

☒ Yes (required)
☐ No

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

☒ Yes (required)
☐ No

9. Each county's Quality Improvement Committee will review the following data at 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 EQRO protocol:

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

☒ Yes (required)
☐ No

PART II
PLAN DESCRIPTION (Narrative)

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.

The collaborative process utilized to develop this DMC-ODS Implementation Plan by San Luis Obispo County Behavioral Health Department (SLOBH) included interviews with key informants and providers, multiple group meetings, and public input meetings. The table listed below demonstrates the collaborative process by the number of group and public input meetings and target audience. The decision was made to incorporate the planning process for DMC-ODS into existing stakeholder group meetings. In our medium, rural County, many of the stakeholders are the same and it was determined to utilize existing meetings as the public input meetings. Four presenters were used: Star Graber, PhD, LMFT, Division Manager for Drug and Alcohol Services; Anne Robin, LMFT, Behavioral Health Administrator; Clark Guest, MA, Program Supervisor for Drug and Alcohol Services; and Teresa Pemberton, LMFT, Program Supervisor for Behavioral Health Department. Two power point presentations were developed and used in the public information dissemination about the DMC-ODS, see copy in Attachment A. All presentations were approximately one hour.

Table 1. Individuals and Community Groups Engaged for Implementation Plan

Date	Group	Regional Location	Target Audience Members
11/4/2015	Behavioral Health Department Fiscal	San Luis Obispo	Behavioral Health Department Fiscal and Administrative staff
11/20/2015	District Attorney Office	San Luis Obispo	District Attorney's Office staff
1/12/2016	San Luis Obispo DAS Clinic	San Luis Obispo	Treatment providers, clinicians, people in recovery, Health Information Technicians, drug testing staff
1/13/2016	Criminal Defense Attorneys	San Luis Obispo	Public Defender's Office staff and other criminal defense attorneys
1/19/2016	Atascadero DAS Clinic	Atascadero	Treatment providers, clinicians, people in recovery, Health Information Technicians, drug testing staff
2/2/2016	Grover Beach DAS Clinic	Grover Beach	Treatment providers, clinicians, people in recovery, Health Information Technicians, drug testing staff
2/16/2016	ACA Planning Group	San Luis Obispo	County Public Health staff, County Department of Social Services (Medi-Cal) staff, community medical providers, client advocacy groups
2/17/2016	Behavioral Health Board	County-wide	Family members, persons with lived experience, agency representatives, Mental Health providers
3/2/2016	Child Welfare Services	County-wide	Department of Social Services, Child Welfare Services, Foster Care representatives
3/15/2016	Family Treatment Court Steering Committee	County-wide	Court Commissioner, Department of Social Services Social Workers, County Counsel, persons

			with lived experiences, treatment providers
3/29/2016	Paso Robles DAS Clinic	Paso Robles	Treatment providers, clinicians, people in recovery, Health Information Technicians, drug testing staff
4/21/2016	Inter-agency Group Meeting	County-wide	Treatment and social service agencies representatives who work on behalf of families
4/27/2016	Superior Court Judges	County-wide	Superior Court Judges who work in all areas of law, including specialty courts, criminal courts, and dependency/delinquency courts
5/25/2016	Homeless Services Oversight Council	County-wide	Representative of organizations who serve the homeless in San Luis Obispo County
5/27/2016	ARCH Benefits Group	County-wide	Agency representatives and advocates who work on behalf of low income citizens to access appropriate eligibility benefits
6/2/2016	Recovery Provider	Atascadero	Recovery organizations, providers, and individuals who represent the recovery community

After the power point presentation, each group was given the opportunity to answer the following questions in an unstructured manner:

1. What are the benefits of participating in the DMC-ODS for our County?
2. Which of the levels of care that need the most attention?
3. What might be some challenges in developing this system of care?
4. Are services in San Luis Obispo County accessible for the individuals who need the service? Geographically, linguistically, timely?
5. How to best coordinate care with the physical health care providers?
6. What are some of innovative ideas for Recovery Support Services given personal knowledge of the clientele?
7. Feedback about current providers of the treatment services in the County? Other potential providers?

The major themes from these presentations that impacted the development of the plan are summarized below.

Table 2. Major Themes from Community Engagement	
CAT Team embedded in the community, add SUD	Transportation services needed for the clients
More services out in the field. Home visits. Hospital visits.	Provide treatment services at high risk population locations including Syringe Exchange, Homeless Shelter and Resource Centers
Cal Poly treatment location for Young Adult Treatment	Cuesta College treatment location for re-entry DMC students
Trainings and ongoing technical assistance will be needed for the new providers. Need to attract new residential treatment providers to the County	Recovery Residences and Transitional Housing will be needed
12 Step Meetings on-site at DAS treatment clinics	Family member services such as Art Work, Naranon meetings, Celebrating Families, CAM (children services)
Services available in the evenings and seven days a week	Sober community activities like Walk for Recovery and providing community services opportunities for clients
Life Skills needed, such as credit counseling, financial skills and resources	Vocational training and work with employers

Wellness activities such as dental providers, nutrition, and fitness	Co-parents need help too, expand and engage in Family Education and Parenting groups
Bilingual services available to commensurate with the Hispanic population (North County, South County, Cambria)	Integration efforts with physical health, Emergency Departments, and coordinate continuity of care between Primary Care Physicians and specialty Drug and Alcohol Services
Residential treatment program placements and transportation to out of County contracted providers	Change in the County's social norms which center around the wine industry, drinking activities, need awareness campaign of the treatment resources
Provide social and extra-curricular activities that are sobriety based (sports, outdoor activities, hikes, surfing, equestrian therapy)	More individual therapy and family therapy options, including the use of individual network providers. Family education would be really important.
Recovery services should occur at all points in the continuum of care, 1 – 90 days; 91days - 6 months; then after treatment episode for long-term recovery support	Recovery Coaching should be used as an evidence based practice and coaches should be paid or earn a stipend
Expansion of the covered treatment services to include co-occurring disorder individuals who are in pre-contemplation stage.	Use the shelter system to provide services in the community and offer services for a variety of stages of recovery
Community Health Centers and Primary Care offices need linkage to Behavioral Health services and provider training to the Medical Doctors and Medical staff.	In working with local hospitals, consider senior citizens who have fallen may also have SUD as there are lots of retirees in our community. How to reach this population, can use those recovery coaches perhaps.
Monumental increase in services available	Support for opting in for San Luis Obispo County

Opportunities for ongoing involvement by the various stakeholder groups during implementation will occur in a variety of settings, including but not limited to, ongoing and regularly scheduled meetings between Behavioral Health Department and Behavioral Health Board and other ongoing collaborative meetings such as the Community Corrections Partnership and the ACA Planning meeting or updates to regular meetings as listed above. The DMC-ODS is being managed by the Behavioral Health Department's management team which holds meetings on a regular weekly basis and DMC-ODS planning and implementation issues will continue to be addressed throughout the next few years.

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 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.

The mission of the San Luis Obispo County Health Agency is:

> *The Health Agency provides a broad array of services essential to the health and well-being of those living in and visiting San Luis Obispo.*

The mission of the San Luis Obispo County Behavioral Health Department is:

> *San Luis Obispo County Behavioral Health Department works in collaboration with the community to provide services necessary to improve and maintain the health and safety of individuals and families affected by mental illness and/or substance abuse. Services are designed to assist in the recovery process to achieve the highest quality of life by providing culturally competent, strength based and client and family centered strategies utilizing best practices.*

The mission of the Drug and Alcohol Services Treatment Division is:

> *We provide professional, ethical, accessible alcohol and drug treatment that promotes recovery and improves the quality of life of clients, their families, and the community.*

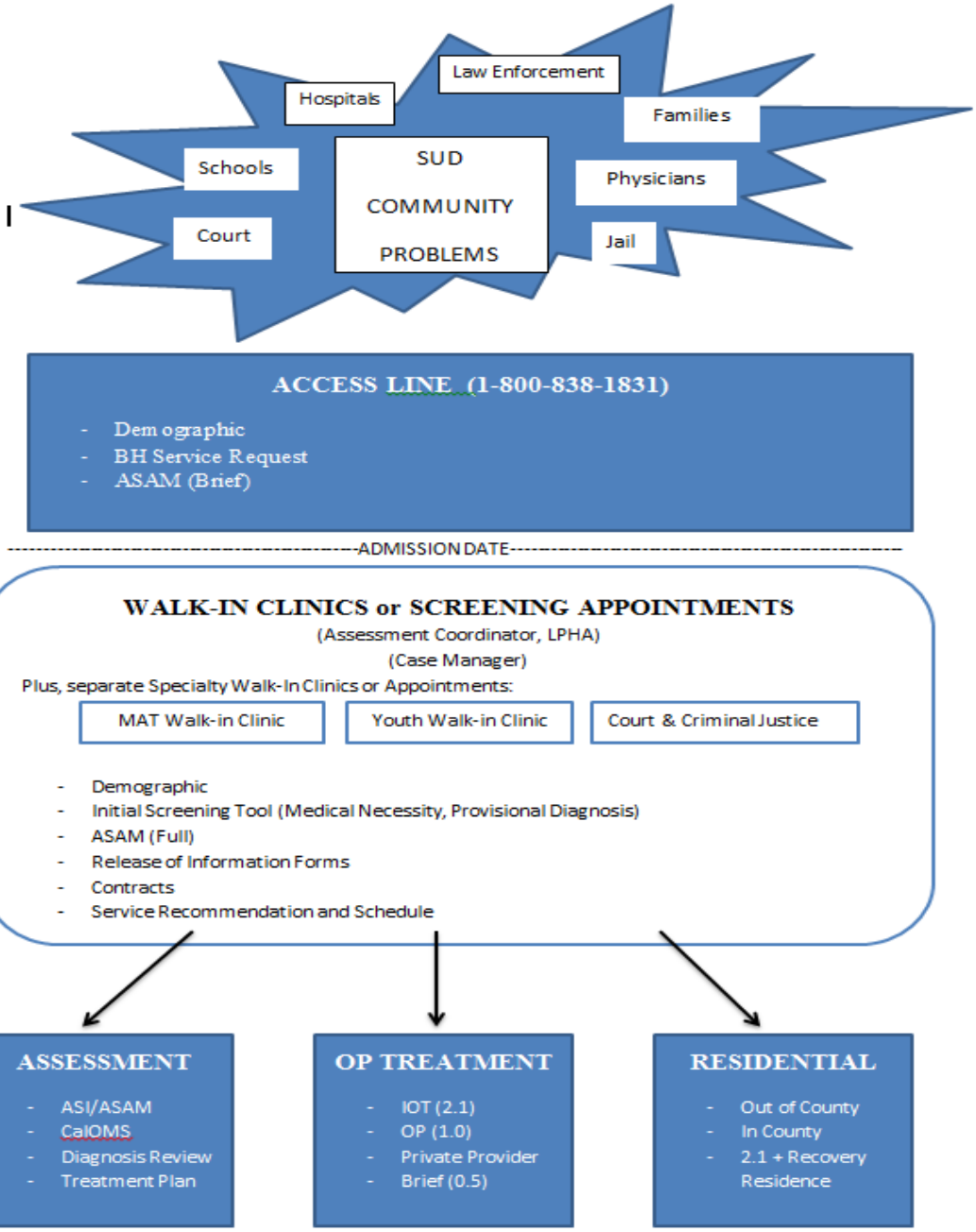
Referrals come from a variety of sources—self-referral, family members, employers, primary care providers, emergency departments at the four local hospitals, schools and colleges, criminal justice systems, and other community based social and human services. Operationally, a value of open no-wrong door, regional walk-in clinics are available on a weekly basis in each County-operated treatment clinic. Once a client comes to the walk-in clinic, they are immediately screened for substance use disorder diagnostic criteria (medical necessity), level of care using ASAM criteria, and given the treatment recommendations by a Licensed Practitioner of the Healing Arts (LPHA) clinician. With some motivational interviewing, the client may accept the treatment recommendation and attend an outpatient treatment group as soon as the same day. Once accepted to the outpatient treatment program, the client is also scheduled for an individual full assessment, given a schedule for their groups, and assigned random color code drug testing as indicated. The Assessment Coordinator (LPHA) facilitates a warm hand-off to the assigned primary treatment Specialist and provides introductions to the staff and tours the clinic.

Streamlined group orientations are held for our agency partners who refer clients for many of the court ordered treatment programs such as Judges, Probation, and Attorneys. Driving Under the Influence programs, Deferred Entry of Judgement diversion program, Proposition 36 Treatment program, AB109 Re-Entry and community based treatment services, and specialty treatment courts. All provide separate registration, orientation and screening processes. Additional treatment requirements may exist for the criminal justice clientele and their questions can be answered and introductions made to the specialized treatment staff. Each of the court ordered treatment programs have a continuum of care built into the criminal justice programming depending upon the client's individual needs. These are not 'cookie cutter' programs, but rather consist of the same screening, assessment, and treatment planning services that all clients attend conducted by the Assessment Coordinator (LPHA). The referrals may be made pre-plea or post-plea, for misdemeanors or felonies, for moderate to high criminal factors, or low criminal factors but with mild to severe substance use disorders.

Co-occurring Disorders (mild to moderate mental health diagnosis in combination with mild to severe substance use disorders) are served by San Luis Obispo County Drug and Alcohol Services division. Drug Medi-Cal will only be billed for the appropriate substance use disorder allowable services under the DMC-ODS waiver.

With the new DMC-ODS allowance to serve clients in any "appropriate community setting", we are currently conducting screening services at the Court House, at the County Jail, at Emergency Rooms in the local hospitals, and at the Homeless Shelter. For youth treatment services, referrals and screening services are conducted at many County high school, continuation and community school sites, as well as regional Family Resource Centers.

Diagram 3. Client Flow Chart



Requesting Services and Referrals: Referrals to DMC-ODS services will come through five primary gates, including 1) calls to the Behavioral Health Department Access Line/Managed Care which may result in an individual screening appointment being scheduled with an Assessment Coordinator in one of the County-operated clinics; 2) individuals walk-in to one of the County-operated clinics as a result of a referral (health care or other community based organizations), seeing information on the County or Program website (www.slodas.org) regarding the walk-in clinics and meet with an Assessment Coordinator; 3) potential clients may request an individual appointment time in lieu of a walk-in clinic access; 4) direct referral from criminal justice entities to the weekly scheduled registration and orientation session for specific programs; and 5) direct contact by members of the public with the Narcotic Treatment Program.

Referrals can be formalized using the Universal Referral Form and Consent for Release of Information which is signed in advance of the referral and then faxed to San Luis Obispo (SLO) Drug and Alcohol Services at (805) 781-1227. These referral forms are entered into the electronic health record system for ease of access to all County-operated clinics. These forms include basic information about the client who is being referred and the reason for the referral. Since the form also contains an Authorization for Release of Information, feedback can be provided to the referring party about the status of the referral. Regardless of the entry point, each individual is registered and screened following the same process and tools described below in the Initial Screening section.

If the phone call comes into the Behavioral Health Department Access Line (1-800-838-1831), the Clinician fills out a Service Request form (see Attachment B) and schedules the individual to attend a walk-in clinic or schedules a screening appointment with the Assessment Coordinator at the desired clinic location. See Client Flow Chart above.

Initial Service Screening, Authorization, and Placement: All individuals are triaged for risk (suicidality, homelessness, emergent physical health needs), insurance coverage/eligibility verification and are advised of the benefits to which they are entitled under the DMC-ODS. A uniform Behavioral Health Department/Substance Use Disorder Screening tool and decision tree based on the American Society of Addiction Medicine (ASAM) dimensions is in use. See Attachment B. The screening also includes: client eligibility and demographics; review of Health Questionnaire, preliminary DSM5 diagnostic impressions, and preliminary SUD ASAM level of care determination. Screenings are all conducted by Licensed Practitioners of the Healing Arts (LPHA) Clinician or Program Supervisors (who may be certified SUD Counselors). The basic referral and screening process is mirrored in the Youth System and Medication Assisted Treatment (MAT)/Withdrawal Management system with some variations required by the specific needs of the target population.

Once screened using the Initial Screening Tool (see Attachment B), the beneficiary will be referred or linked directly to the appropriate ASAM Level of Care treatment. The Assessment Coordinator will introduce the client to the primary outpatient treatment Specialist, set the recommended outpatient treatment group schedule, assign the color code random drug testing

(if needed), tour the outpatient treatment clinic, and schedule the follow-up individual assessment appointment with the Assessment Coordinator. All clients are given the Client Handbook which describes the various documents signed, program rules, and potential referral information. If the client has immediate case management needs, such as housing, recovery residence, residential treatment or other community based needs (primary care), the Assessment Coordinator will introduce the client to the clinic's Case Manager. Placement considerations include findings from the screening, initial drug testing results, geographic accessibility, threshold language needs, age, criminal justice requirements, and beneficiary preference. All staff performing screening and assessment may refer beneficiaries directly to any SUD network provider for the following services:

- Outpatient and Intensive Outpatient Treatment Services (County-operated or individual network providers)
- Narcotic Treatment Program Services (contract provider)
- Outpatient Withdrawal Management Services (County-operated)
- Medication Assisted Treatment Services (County-operated, contract or network providers, or individual community healthcare prescribers)
- Recovery Support Services (County-operated)
- Case Management Services (County-operated)
- Recovery Residences (contract providers). Not paid for with Medi-Cal funding, but is listed here to illustrate the full scope of available services.

Note that if the screening or assessment of the beneficiary determines that the medical necessity criteria has not been met and the beneficiary is not entitled to any substance use disorder treatment services from the County of San Luis Obispo, then a written Notice of Action will be issued in accordance with 42CFR 438.404.

Assessment and final Medical Necessity Determination: Once a beneficiary has completed the initial screening process and it is confirmed that SUD treatment may be appropriate, the client will be offered an individual assessment appointment with the Assessment Coordinator. The use of the Addiction Severity Index (XtraLite), ASAM Criteria, and CalOMS admission data will be administered during the assessment process. Other diagnostic and assessment tools may be used, including a drug screen, and finalization the DSM5 Diagnostic Review tool, all of which are recorded into the EHR. Medical necessity for services must be determined as part of the intake assessment process and will be performed through a face-to-face interview or via telehealth. The Medical Director, a licensed physician, or a Licensed Practitioner of the Healing Arts (LPHA) must diagnose the beneficiary as having at least one DSM5 Substance Use Disorder, excluding Tobacco-Related Disorder and non-substance related disorders. A qualifying diagnosis for beneficiaries under the age 18 includes "an assessed risk" for developing a substance use disorder. The Medical Director, a licensed physician, or a LPHA can also diagnose mental health disorders for access to co-occurring disorder integrated services. Withdrawal Management services, Medication Assisted Treatment, and Psychotropic Medication Evaluations may also be performed by a licensed Nurse Practitioner or other medically licensed staff. All providers must document the diagnoses in the client electronic health record (EHR) and indicate how the client

meets the ASAM Criteria definition for services. Psychotropic medication services are not covered through DMC-ODS, but again are provided for illustration of the one-stop services for co-occurring disorders. Psychotropic medication services are paid for from other funding sources.

In the event that the comprehensive intake assessment yields an ASAM level of care recommendation that does not agree with the preliminary ASAM screening result, the LPHA or Case Manager must work with the client to transition to the appropriate level of care, up to and including transitioning the client to a residential treatment provider. If it is determined residential detoxification or residential treatment is required, the Specialist shall request prior authorization from the Assessment Coordinator, provide evidence of meeting the criteria for Level 3.0+ residential services and request assistance from the clinic Case Manager. The Case Manager is critical to ensure the successful transition of high-risk utilizers and those at risk of drop-out during the transition of level of care. The County of San Luis Obispo has a long history of collaborative working relationships and the majority of the SUD treatment services are operated by the County (which makes the treatment system more seamless).

Transitions to another Level of Care, Authorization, and Case Management: This may include step-up or step-down in SUD treatment services (e.g. transition to intensive outpatient treatment plus recovery residence following completion of residential treatment). For complicated care transitions, Case Managers will provide warm hand-offs and transportation to the new program as needed. If the client is transferring to a residential treatment provider outside of San Luis Obispo County, a Discharge Summary will be prepared for the residential treatment provider and faxed to them (with appropriate Authorization to Release Information) prior to arrival of the client. When the client returns to SLO County, the Access Clinician, the regional Assessment Coordinator and the clinic Case Manager will be the primary contacts. DMC-ODS providers will aim to admit eligible beneficiaries within five (5) business days—but no later than 10 business days—from the assessment. In the unlikely event that admission to treatment will be greater than 10 business days due to non-budget related capacity issues, DMC-ODS providers shall provide interim services and seek to link the beneficiary with another provider offering the appropriate ASAM level of care. In instances where a residential treatment provider submits a prior authorization request to the Access Coordinator, SLO County will respond with an approval or denial within 24 hours of the request. Authorization requests for after hours, County holiday or weekend admissions should be initiated on the morning of the next business day.

In order to prevent delays in admissions to treatment, Access will allow presumptive authorizations for the bed days provided for after hours, County holiday or weekend admissions for San Luis Obispo County residents who are Medi-Cal beneficiaries. Presumptive authorization does not guarantee payment and submission of claims to Medi-Cal are subject to a client's eligibility and services being rendered and documented in accordance with Title 22, the ASAM Criteria, and the DMC-ODS Standard Terms and Conditions.

Upon receipt of request for an Authorization and Assessment summary from a residential provider, Access staff will review the request and based on the review, provide one of the following responses to the requesting agency within 24 hours: Approved as Requested, Approved as Modified, Deferred, or Denied. Beneficiaries participating in a face-to-face assessment with SLO County's Assessment Coordinator that meet the Title 22 and ASAM Criteria definitions of medical necessity for residential treatment will be referred to the appropriate ASAM level of care. The Assessment Coordinator will authorize residential treatment services and sends an authorization approval to the provider in coordination with the Access Team.

The length of residential services range from 1 to 90 days maximum for adults and 30-day maximum for adolescents, unless medical necessity requires a one-time extension of up to 30 days on an annual basis. Only two non-continuous 90-day residential stay episodes will be authorized in a one-year period. Perinatal and criminal justice clients may receive a longer length of stay based on medical necessity. If even longer lengths of stay are needed, other non-Medi-Cal funds may be used. The referrals, authorizations and preliminary payor source will be tracked by the County of San Luis Obispo Access Team. Authorizations and re-authorizations will be required on a monthly basis for residential treatment.

Re-Assessment and Time Frames: All treatment clients will be re-assessed at a maximum of every 90 days, unless there are significant changes warranting more frequent re-assessments. Re-assessments allow the treatment team to review client progress, comparing the most recent client functioning and severity to the initial assessment and to evaluate the client's response to care in treatment services. Changes that could warrant a re-assessment and possibly a transfer to a higher or lower level of care include, but are not limited to:

- Achieving treatment plan goals
- Inability to achieve treatment plan goals despite amendments to the treatment plan
- Identification of intensified or new problems that cannot adequately be addressed in the current level of care
- Lack of beneficiary capacity to resolve his/her problems
- At the request of the beneficiary

Clients who are initially authorized for residential treatment will be re-assessed at a maximum of every 30 days, unless there are significant changes warranting more frequent re-assessments. Re-authorizations will be processed in accordance with the re-assessment results as needed.

Case Management and Recovery Support Services: All SUD providers are expected to individualize treatment and use the full continuum of services available to beneficiaries to ensure clients receive the most appropriate care at the correct time. Case management services will help ensure clients move through the system and access other needed health and ancillary services to support their recovery. As beneficiaries complete primary treatment, they are connected to recovery support services to build connections within the recovery community and to continue to develop self-management strategies to prevent relapse. If an

individual does relapse, Recovery Support Workers can quickly reconnect the beneficiary back to treatment for further care through the Assessment Coordinator in each regional clinic.

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

Access Line:

SLOBH Managed Care program operates a toll free 24/7 Central Access Line (1-800-838-1381)

- The Central Access Line is staffed by Managed Care's Licensed Practitioner of the Healing Arts (LPHA) staff during regular business hours.
- Live assistance is available in English and Spanish (threshold languages) and through Language Line Solutions for all other languages spoken in the community.
- After-hours, callers have the option of obtaining information, leaving a message or interacting with a live person. Services are available 24/7 to treat a beneficiary's urgent conditions such as psychiatric or medical emergencies.
- SLOBH contracts with Transitions Mental Health Association (TMHA), who operates SLO Hotline, an accredited suicide prevention hotline, for after-hours access line coverage. Additional information about SLO Hotline is available at: http://t-mha.org/main/main_hl.html

Screening:

Beneficiaries who request substance use disorder treatment will be screened via telephone to determine the urgency of the request. A more complete face-to-face screening to determine ASAM level of care will be scheduled. For beneficiaries whose phone screening suggests that withdrawal management, medication assisted treatment and/or residential treatment is necessary, the face-to-face screening will be scheduled within 1 business day.

Screening to determine mental health treatment needs will also be completed at agency phone contact and any necessary referrals for assessment and treatment will be completed. Options will range from scheduling a comprehensive assessment at a Mental Health clinic or Integrated Treatment program or referral to the contracted network providers for MH treatment.

Data Collection:

A Behavioral Health Service Request form (see Attachment B for sample form) will be completed to record each call. Information on calls received is tracked separately by MH or SUD primary issue. Every effort will be made to obtain as much of the following information as possible:

Contact Information

- Date and time of call (required)
- Caller's name (required)
- Caller's phone number

- Referral Source
- Legal Status/Responsible Party contact information

Caller Demographics
- Age/DOB/Gender
- Address/Phone
- Contact preferences or restrictions

Caller Insurance/Medi-Cal information

Language Needs and Preferences
- Primary/Preferred language
- Interpretation needs
- Offer of free interpreter services

Risk Factors/Urgency Level
- Risk of danger to self or others
- Special status (hospital discharge, jail release)
- Overview of Functional Impairments
- Call Urgency (Crisis, Urgent, Routine)
- Initial determination of need for residential or withdrawal management treatment

Disposition of Call (required)
- Was a screening offered?
- Date/time/location/provider of offered screening
- Whether client accepted offered screening
- Wait time (in days) to offered screening

Data reporting/outputs:
Call data will be evaluated on a monthly basis and will include (tracked separately for English, Spanish, and Other speaking callers):
- Number of calls requesting substance use disorder treatment
- Number of callers referred for screening
- Wait time for screening at regional clinics
- Number of clients referred for screening who attend screening within 30 days of referral
- Number of grievance, appeal or complaint calls

4. Treatment Services. Describe the required types of DMC-ODS services (withdrawal management, residential, intensive outpatient, outpatient, opioid/narcotic treatment programs, recovery services, case management, physician consultation) and optional (additional medication assisted treatment, recovery residences, telehealth) 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.

All DMC-ODS treatment provider facilities are required to maintain DHCS SUD certifications in addition to the DMC certifications. Perinatal Services Network Guidelines are followed by the County-operated clinics. Youth Treatment Guidelines are followed by the County-operated clinics for adolescent substance use disorder treatment services. County staff are licensed or certified and are in compliance with certification requirements. All providers are required to comply with Federal, State, and local requirements, including County standards and evidence-based practices that meet the DMC-ODS quality requirements. County of San Luis Obispo will provide all opt-in waiver required services for outpatient, withdrawal management, medication assisted treatment, recovery support services, and case management.

Table 4. Drug Medi-Cal Organized Delivery System Required Services			
DMC Services	State Benefit Plan (Non-Waiver)	Opt-in Waiver Required	Opt-in Waiver Optional
Outpatient Services	Required	Outpatient Treatment Intensive Outpatient	Partial Hospitalization
Narcotic Treatment Program	Required	Required	
Residential	Perinatal only	At least one level of service	Additional levels
Withdrawal Management		At least one level of service	Additional levels
Medication Assisted Treatment		Required	Additional medications
Recovery Support Services		Required	
Case Management		Required	
Physician Consultation		Required	

Specifically, below is a list of services that the County of San Luis Obispo will provide as part of the DMC-ODS system of care.

Table 5. Services Available in San Luis Obispo County			
	Service Type	ASAM Level	Required or Optional
A	Early Intervention Services/SBIRT	.50	Provided in partnership with existing primary care providers
B	Outpatient Treatment Services	1.0	Required
C	Intensive Outpatient Treatment Services	2.1	Required
D	Withdrawal Management Services (WM)	1 – WM and 2 – WM	1 Level Required
E	Residential Treatment Services	3.1 (to be determined)	1 Level Required
F	Narcotic Treatment Program (NTP)	1.0 -- NTP	Required
G	Medication Assisted Treatment	1.0 OBOT and 1.0 -- NTP	Optional/Required
H	Recovery Support Services	N/A	Required
I	Case Management	N/A	Required
J	Physician Consultation	N/A	Required
K	Recovery Residence	N/A	Optional
L	Telehealth	N/A	Optional

Service Descriptions:

A. Early Intervention (ASAM Level .50)
County staff provides Screening, Brief Intervention, and Referral to Treatment (SBIRT) for all substance use disorders in collaboration with primary care providers, Emergency Departments at four local hospitals, and the Psychiatric Health Facility (PHF). Beneficiaries at risk of developing a SUD or those with an existing SUD are identified and offered screening for adults, brief treatment as medically necessary, and when indicated a referral to treatment.

B. Outpatient Services (ASAM Level 1.0)
Outpatient services consist of up to 9 hours per week of medically necessary services for adults and less than 6 hours per week of services for adolescents. County-operated services will offer ASAM Level 1.0 including: assessment, treatment planning, individual and group counseling, family therapy, patient education, medication services, collateral services, crisis intervention services, and discharge planning and coordination. Services may be provided in-person, by telephone, or by telehealth, or in any appropriate setting in the community.

C. Intensive Outpatient Treatment (IOT) (ASAM Level 2.1)
Intensive outpatient treatment involves structured programming provided to beneficiaries as medically necessary for a minimum of nine (9) hours and a maximum of 19 hours per week for adult perinatal and non-perinatal. Adolescents are provided a minimum of six (6) and a maximum of 19 hours of services per week. Services include: assessment, treatment planning, individual and/or group counseling, patient education, family therapy, medication services, collateral services, crisis intervention services, treatment planning, and discharge planning and coordination. Services may be provided in-person, by telephone or by telehealth, or in any appropriate setting in the community.

D. Withdrawal Management Services (ASAM Levels 1 – WM and 2 – WM)
Withdrawal Management services are provided as medically necessary to beneficiaries and include: assessment, observation, medication services, and discharge planning and coordination. Beneficiaries receiving a residential withdrawal management shall reside at the facility for monitoring during the detoxification process. San Luis Obispo County Behavioral Health Department will offer ASAM Level 1 – WM: Ambulatory Withdrawal Management without extended on-site monitoring. In addition, working together with specially designated recovery residences, San Luis Obispo County Behavioral Health Department will offer ASAM Level 2 – WM: Ambulatory Withdrawal Management with

extended monitoring and at night the client stays at a recovery residence. This is for those clients who are participating in ASAM Level 1 Ambulatory Withdrawal Management, but do not have a supportive family or living situation.

San Luis Obispo County Behavioral Health Department will work with all four local hospitals (Arroyo Grande Community Hospital, French Hospital, Sierra Vista Hospital, and Twin Cities Community Hospital) and other area service providers to assist beneficiaries to access ASAM Level 3.7 – WM (Medically Monitored Inpatient Withdrawal Management) and ASAM Level 4.0 – WM (Medically Managed Inpatient Withdrawal Management) when medically necessary. Currently, the local hospitals refer clients to out of county facilities. SLOBH will coordinate with these providers to smoothly transition and support beneficiaries to less intensive levels of care as soon as possible within the DMC-ODS.

At this time, SLOBH will not offer ASAM Level 3.2 – WM Clinically managed residential withdrawal management (commonly known as social model detoxification), however, we will review utilization and ASAM data and make a determination by the end of implementation Year 2 whether there is a demonstrated need for this level of care within our continuum. Should a need be substantiated an RFP would be released for ASAM Level 3.2 – WM or we will contract with out of county providers for this level of withdrawal management.

E. Residential Treatment Services (ASAM Level 3.1 – pending DHCS approval)

Residential treatment is a 24-hour, non-institutional, non-medical, short-term service that provides residential rehabilitation services to youth, adult, and perinatal beneficiaries. Residential services are provided in facilities designated by DHCS as capable of delivering care consistent with ASAM Level 3.1: Clinically managed low intensity residential. This level of care provides 24-hour structure with available trained personnel, at least five hours of clinical service per week and prepare for outpatient treatment. Beneficiaries are approved for residential treatment through a prior authorization process based on the results identified by the ASAM assessment. The length of stay for residential services may range from one day to ninety (90) days, unless a re-assessment of medical necessity justifies a one-time extension of up to 30 days. Only two non-continuous 90-day regimens will be authorized in a one-year period. Perinatal and criminal justice involved clients may receive a longer length of stay based on medical necessity. A monthly re-authorization process is implemented to ensure that the client continues to benefit and need the residential treatment services.

Residential treatment services includes assessment, treatment planning, individual and group counseling, client education, family therapy, collateral services, crisis intervention services, transportation to all medically necessary treatments, and discharge planning and coordination. All providers are required to accept and support patients who are receiving medication assisted treatments.

SLOBH is awaiting DHCS to issue DMC licensure and provisional ASAM designations for our currently contracted perinatal residential provider (Bryan's House). This provider may be designated as ASAM Level 3.1 and/or Level 3.5 (Clinically managed high intensity residential services). SLOBH will ensure that all ASAM Levels (3.1, 3.3, and 3.5) are available within three years of final approval of the County's Implementation Plan and will follow the County policy and process for selecting new providers. It is anticipated that some of the residential treatment providers may be out of county and contractual relationships will be developed.

For clients in any residential treatment program, case management services will be provided by County staff to facilitate 'step down' to lower levels of care and support. County staff will also provide the transportation services (if needed) to the medically necessary facility.

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

SLOBH contracts with a licensed Narcotic Treatment Program (Aegis Treatment Centers) to offer services to beneficiaries who meet medical necessity criteria requirements. Services are provided in accordance with an individualized client plan determined by a licensed prescriber.

Services provided as part of an NTP include: assessment, treatment planning, individual and group counseling, patient education, medication services, collateral services, crisis intervention services, medical psychotherapy, and discharge services. Clients receive between 50 and 200 minutes of counseling per calendar month with a therapist or certified counselor, and when medically necessary, additional services may be provided.

- Language Capability is Spanish and English.
- No wait list for new admissions and patients are scheduled the same week or following week on Monday and Wednesday.
- Patients are scheduled for their first face to face service on the same day they are admitted to do their 5 in 5 and intake.

- Medical Doctor Appointments are scheduled 7 day and 14 day follow-up or sooner at the patient's request.
- Atascadero Aegis Treatment Center provides Bus Passes, and utilizes public transportation, and Dial a Ride, when transportation is needed for patients with hardships and/or disabilities.

Aegis currently provides the following services: Detoxification, Extended Detoxification, and Methadone Maintenance. The total current capacity is 256 clients with the distribution as follows:

Table 6. Current Census at Aegis Treatment Centers, Atascadero		
Service	#Patients	Average Days in Treatment
Detoxification	10	17
Extended Detoxification	4	18
Methadone Maintenance	242	1,284
Total	256	---

A review of the zip code data has determined that five (2%) of the clients currently seen in the Atascadero clinic are from Monterey County. A review of the zip code data from the Aegis Treatment Center in Santa Maria (Santa Barbara County) has determined that 75 (20%) of the clients are from San Luis Obispo County. A satellite methadone clinic would be ideally located in the South County of San Luis Obispo to serve the NTP clients within our county for DMC-ODS service. Aegis Treatment Centers will provide the required methadone services for NTP under the DMC-ODS.

G. Additional Medication Assisted Treatment (MAT) Services (Optional, ASAM Level 1)

SLOBH offers medically necessary MAT services through Behavioral Health Department staff and contracted providers, an NTP program, and a provider network licensed as primary care clinics. Services include: assessment, treatment planning, medication assisted treatment, ordering, prescribing, administering, and monitoring of medications for substance use disorders.

MAT will expand the use of medications for beneficiaries with chronic alcohol related disorders and opiate use. Medications may include: naltrexone, both oral (ReVia) and extended release injectable (Vivitrol), topiramate (Topomax), gabapentin (Neurotin), acamprosate (Campral), and disulfiram (Antabuse). Other medications may be prescribed as indicated for substance use disorders (including those that may become available in the future):

- Opiate overdose prevention: naloxone (Narcan). See Attachment D for naloxone policy and procedures for the County of San Luis Obispo.
- Opiate use treatment: buprenorphine-naloxone (Suboxone) and naltrexone (oral and extended release). Note: Methadone will continue to be available through the licensed narcotic treatment program.
- For tobacco cessation and nicotine replacement therapy as indicated.

Additionally, SLOBH is currently coordinating care and expanding the availability of MAT outside the DMC-ODS by building the capacity of the entire local health system to use these treatments for beneficiaries with a substance use disorder. Behavioral Health Department facilitates a grant funded Opiate Safety Coalition that is training physicians, nurse practitioners, and psychiatrists in primary care and specialty mental health clinics on the efficacy of using MAT, practice guidelines, and medication administration. In addition, the Behavioral Health Department is the expert on naloxone distribution in the County, and we are currently training pharmacies to prescribe this overdose antidote to extend the availability of naloxone in the community. Physician consultation is supporting implementation in areas such as: medication selection, dosing, side effect management, adherence, and drug-drug interactions.

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

Recovery Support Services are available once a beneficiary has completed the recommended course of treatment. Beneficiaries accessing Recovery Support Services are taught to manage their own health and health care, use effective self-management strategies, and use community resources to provide ongoing long-term lifestyle management.

Recovery Support Services may be provided face-to-face, by telephone, via internet, or elsewhere in the community. Services may include: outpatient individual or group counseling to support the stabilization of the client or reassess the need for further care; recovery monitoring/recovery coaching; peer-to-peer services and relapse prevention; Wellness Recovery Action Plan (WRAP) development; education and job skills; family support and family recovery services (such as Celebrating Families!); self-help and community support groups; socialization; and linkages to various ancillary services (housing, transportation, and case management). County staff will coordinate, monitor and support a cadre of peer recovery support workers and volunteers to provide Substance Abuse Assistance and Relapse Prevention—the “Recovery Network”. This will provide the necessary linkage between the community and the County to ensure smooth transitions in both directions.

I. Case Management Services

Case management services support beneficiaries as they move through the DMC-ODS continuum of care from initial engagement and early intervention, through treatment, to recovery services. Case management is provided for clients who may be pre-contemplative and challenging to engage, and/or those needing assistance connecting to treatment services, and/or those stepping down or up to other levels of care and support. San Luis Obispo will use a comprehensive case management model based on the ASAM bio-psycho-social assessment to identify needs and develop a case plan and follow the SAMHSA CSAT TIP 27 (Treatment Improvement Protocol) Comprehensive Case Management for Substance Abuse Treatment.

Case management services may include: comprehensive assessment of needs and services, client plan development, coordination of care with mental health and physical health, monitoring access, client advocacy and linkages to other supports including but not limited to: mental health, housing, transportation, food, and benefits enrollments. Case Managers will be trained and utilize Motivational Interviewing (MI) and Motivational Enhancement Therapy (MET), harm reduction, and strength-based, trauma informed approaches. Case management services will be provided by County staff. All case management services are consistent with confidentiality requirements identified in 42CFR, Part 2, California law, and the Health Insurance Portability and Accountability Act (HIPAA). See Case Management Specialist Manual in Attachment E.

J. Physician Consultation

Physician consultation services assist physicians and nurse practitioners seeking expert advice on complex client cases and designing the treatment plan in such areas as: medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. SLOBH trains psychiatrists and psychiatric nurse practitioners in integrated settings on medication guidelines and offers the opportunity for them to consult one-on-one with a psychiatrist who has an addiction medicine background. Physician consultation to primary care and behavioral health providers for the use of vivitrol, buprenorphine, other SUD medications, and pain management is made available in an effort to build the capacity of the entire health system to treat beneficiaries with SUD. San Luis Obispo County may use existing physician staff, or contract with addiction medicine physicians, addiction certified psychiatrists, or telehealth providers, or clinical pharmacists to provide consultation services. In the future, expansion of telehealth will continue to increase access for physician consultations.

K. Recovery Residences

Recovery Residences (RR) are available for beneficiaries who require housing assistance in order to support their health, wellness and recovery. There is no formal treatment provided at these facilities, however, residents are required to actively participate in outpatient treatment and/or recovery support services during their stay. The recommended maximum length of stay is six months, with the beneficiary contributing towards the cost of the housing after two-three months. A potential subsidy (not Medi-Cal funding) is available (on a reducing scale) for up to six months, although not all clients need or qualify for the subsidy. See the Self-Sufficiency policy in Attachment F. Authorizations for length of stay are made on a monthly basis to the Recovery Residence provider. Exceptions to the six month maximum length of stay can be made as clinically necessary and approved by the Division Manager of the Behavioral Health Department.

San Luis Obispo County has developed standards for contracted RR providers and has been monitoring to these standards. RRs are not reimbursable through Medi-Cal, but in a community with few residential treatment beds, the RRs are invaluable partners to achieving a lifestyle of recovery for the beneficiaries. When the client concurrently receives outpatient treatment or intensive outpatient treatment in close collaboration with the Recovery Residence, the level of treatment provided surpasses the Level 3.1 ASAM Residential level. We have been successfully using the combination of Recovery Residence (non-Medi-cal funded) and the concurrent outpatient treatment in lieu of residential treatment for many years for SAMHSA funded grant projects. ***The Recovery Residence is County monitored, contracted, and works collaboratively in a close relationship with the County-operated outpatient treatment provider.*** See Attachment F for Recovery Residence sample contract, self-sufficiency policy, and monitoring tools.

L. Optional Services Levels pending ASAM utilization review

SLOBH will consider whether to offer additional optional services available under the waiver once baseline data on beneficiary ASAM service need and utilization has been collected and analyzed. If an unmet need for a service is determined, SLOBH will amend this plan to incorporate the additional service(s) and will initiate a RFP process to identify qualified providers or provide County-operated services. Service levels which SLOBH anticipates for possible expansion include: Withdrawal Management (ASAM-WM Level 3.1) and Partial Hospitalization Services (ASAM Level 2.5) in the future.

M. Service Level Barriers

SLOBH anticipates the following barriers to providing a number of services within the DMC-ODS continuum of care: start-up costs associated with starting new facilities and programming; facility siting challenges including zoning; hiring and retaining qualified staff, particularly those able to meet threshold language needs; DMC certification delays; and geographic location and related beneficiary transportation barriers. Housing and transportation services are the biggest service barriers in our county.

N. Coordination with Surrounding Counties

SLOBH has established relationships with surrounding counties' substance use service divisions through state level associations and local collaborations. We meet quarterly at the CBHDA/SAPT committee meetings to discuss various service challenges and opportunities. SLOBH will provide original DMC modalities to any beneficiary in an opt-out county seeking services within San Luis Obispo County and we will coordinate with other neighboring counties, whether opt-in or opt-out, to ensure beneficiaries can access services easily and quickly. We will also work together as needed, when a regional approach is required to deliver a component of the continuum of care, e.g. youth residential treatment.

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

There is a significant prevalence of individuals with complex conditions, including beneficiaries with co-occurring mental health and substance use disorders. In FY2015-16, 26% of Medi-Cal beneficiaries who received mental health and/or substance use disorder services were identified as having co-occurring disorders. This is higher than the previous fiscal year which was at 18% of Medi-Cal beneficiaries who received mental health and/or substance use disorders were identified as having co-occurring disorders.

<u>County Structure to Deliver Substance Use and Mental Health Services</u>

The current county structure is an integrated Behavioral Health Department under the San Luis Obispo County Health Agency. The Behavioral Health Department is comprised of six different Divisions: Adult Mental Health Services, Youth Mental Health Services, Prevention and Outreach, Quality Support Team, Medical, and Drug and Alcohol Services/Integrated Forensics Services. The co-occurring disorders (COD) treatment is primarily provided through the Integrated Forensics Services. In addition, the Drug and Alcohol Services Division conducts county-operated treatment of those with mild-severe substance use disorders and with mild-

moderate mental health disorders. Thus, meaning that beneficiaries can access both substance use and mental health services from the same provider at the same site.

The Mental Health Services Act (MHSA) provided an opportunity to expand co-occurring disorder services in San Luis Obispo County in accordance with stakeholder input. The Adult Full Service Partnership (FSP) program targets adults 26-59 years of age with serious mental illness. The Adult FSP participants are at risk of institutional care because their needs are greater than behavioral health outpatient services typically provide. The individual may be homeless, a frequent consumer of the Psychiatric Health Facility (PHF) or hospital emergency department services, involved with the justice system, or suffering with a co-occurring substance abuse disorder. The overall goal of Adult FSP is to divert adults with serious and persistent mental illness from acute or long term institutionalization and, instead, maintain recovery in the community as independently as possible.

There were two traditional Adult FSP teams in 2013-2014, serving a combined average of 36 clients per month. The core FSP teams include a County Mental Health Therapist and a Personal Services Specialist (PSS) provided by Transitions-Mental Health Association (TMHA). Also available to the team is a co-occurring disorders specialist, psychiatrist, and program supervisor that serve participants in all of the FSP age group programs. A Spanish speaking therapist is made available to these programs to assist in providing a full range of mental health treatment.

Two Co-occurring Specialists, funded by MHSA, provides an Integrated Dual Disorders Treatment program, developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) which includes intervention, intense treatment, and education. Individualized case plans are specific to each client's needs. In 2013-2014 the Integrated Dual Disorders Treatment program served an average of 36 consumers each month. One of the co-occurring Specialists is located in the Mental Health Division and one of the co-occurring Specialists is located in the Drug and Alcohol Services Division. Co-location of the COD services is important to maintain access to integrated care for the clients with both disorders.

Specialty Mental Health Services, serving adults with serious and persistent mental illness and youth with severe emotional disturbances, are managed by the San Luis Obispo County Mental Health Plan, and are delivered through a combination of County-operated and community – based providers. Mental health services for beneficiaries with mild to moderate mental health issues are provided by the Holman Group (contracted by CenCal Health) through its network of community providers.

<u>Coordination of Care: Co-Occurring Mental Health and Substance Use Disorders</u>

The Behavioral Health Department deliberately set out in the DMC-ODS planning process to avoid the expansion of the silos, and instead we looked for opportunities to continue to propel agency and system integration to the next level. Taking this approach, BHD expanded the support structures already in existence within the BHD quality and administrative arenas. In addition, to coordinate mental health services for beneficiaries with co-occurring disorders in

both integrated and separate structures, San Luis Obispo County BHD currently is utilizing, or plans to utilize within Implementation Year 1, the following strategies:

- Integrated Access Line: The Beneficiary Access Line is a County-operated integrated mental health and substance use disorder toll-free Access Line (1-800-838-1381) available 24/7. Integration of information, screening, and referral services will create a centralized repository of services for the whole behavioral health system of care.
- MOU with Medi-Cal Managed Care (CenCal Health): Implement the screening, referral and care coordination activities outlined in the MOU between SLO Behavioral Health Department and CenCal Health.
- Expand Mental Health Network Providers: For DMC-ODS, mental health providers that are currently in the provider network will be provided technical assistance, if needed, to educate them on the available resources and referral processes for services for co-occurring disorders. The goal is to assist the mental health contractors to explore the feasibility, capacity, and need for pursuing a contract which covers both mental health and substance use disorders services.
- Case Management: For all beneficiaries in the DMC-ODS, case management services will be available to ensure and facilitate, as needed, coordination with mental health services with both Holman Group referrals and Specialty Mental Health services.
- Integrated BHD Screening and Assessment processes: Screening and assessment provides the opportunity to identify co-occurring disorders at a service system entry point and ensure that appropriate releases are signed to begin the care coordination process. The approach is that people with co-occurring disorders are the 'expectations' and not the 'exceptions.' In addition, by walking into a screening and assessment process anywhere within the Behavioral Health Department, the beneficiary is entitled to the whole array of mental health and substance use disorder treatment. Integrated treatment is the best option and ease of access for the complex needs beneficiary. Single screening and assessment procedures and tools to identify co-occurring mental health and substance use disorders have been developed by BHD.
- County-operated Drug and Alcohol Services treatment program: Currently, BHD coordinates services between programs for individuals with co-occurring disorders through a single electronic health record, coordinated treatment and recovery plans, and integrated or coordinated service teams that remain in regular communication with one another since employees belong to the same organization, are often co-located, share the same email, calendaring, and telephone systems. All HIPAA and 42CFR, Page 2 requirements are met. San Luis Obispo County has been operating co-occurring disorder treatment for many years and many of the Drug and Alcohol Services clinics are dual certified by Department of Health Care Services for both drug Medi-Cal and for mental health Medi-Cal. There are currently COD identified programs within adult and youth Drug and Alcohol Services and there are currently identified clinicians who are COD capable.
- Quality Support Team integration: The Quality Support Team will expand its oversight to the DMC-ODS programs and services, as well as to staff and contract providers. The

experience and skills of the quality review staff in cooperation with fiscal, technical, and administrative staff will prove invaluable during performance reviews, audits, reporting, and evaluations, assuring compliance with the DMC-ODS requirements (such as EQRO) which are based upon the mental health regulations. This approach provides the support to conduct regular internal reviews and ongoing internal monitoring to test for compliance and helps to achieve performance standards and benchmarks. Additionally, this creates opportunities for more holistic quality improvement measures that incorporate both SUD and MH practices, which will have greater impact on client outcomes when conducted within an integrated service delivery system.

The Quality Support Team will provide written procedures for linking beneficiaries with mental health services and co-occurring disorder treatment services and including the referral process for Holman Group, from Holman Group, and the referral process with individual contract providers. See Attachment G.

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?

San Luis Obispo County has participated in a Behavioral Health Integration Program (BHIP) planning process since 2014. This collaborative has been funded through a grant by the Blue Shield Community Foundation, and includes decision makers from local hospitals, the Federally Qualified Health Center, public health, behavioral health, and several community based organizations. The goals of this collaborative are to bring education to physical health care providers on mental health and substance use disorder identification and treatment, develop interagency coordination protocols (including a universal release of information process), promote the development of Health Information Exchange in San Luis Obispo County, and promote the Triple Aim of Better Care, Improved Health and Lower Costs.

One BHIP's goals for the new grant year will be to provide education and training on SBIRT to a wide variety of physical health care practitioners. By both educating the health care practitioners on an evidenced based brief screening, and providing the system navigators, Promotores, case managers, and peer coaches in all of the County and allied services with information about referral resources and procedures, we intend to increase the number of individuals successfully engaged to SUD services. BHIP recently sponsored Peer Navigator training for 21 individuals. We anticipate a similar training program for peer navigators within the SUD system to enhance access to physical health care and other community services. BHD has contracted with a local CBO to utilize trained Promotores for interpretation services in our mental health clinics. These Promotores will also become available for SUD services, as well as become effective navigators for Spanish speaking clients to BH and primary care services.

Community Health Centers of the Central Coast (CHC) is the primary provider of outpatient physical health care for Medi-Cal eligibles in the County. Currently, the Health Agency Drug and Alcohol (DAS) division staff has informal procedures and connections for referral and care of

clients to CHC. Over the next quarter, plans will be made to formalize referral processes for both assessments and ongoing medical care at CHC. A proposal to bring the mobile medical van to DAS sites was vetted in 2015, but due to changes at CHC the program did not begin. This project will be reviewed again in the next fiscal year as grant funds may become available to support the coordination of this project.

SLOBH has had working relationships with the emergency departments of all four local hospitals for several years. During quarterly meetings with Emergency Department directors and staff, issues of concern related to mental health holds and crisis referrals are dealt with in open, problem solving discussions. Patients with substance use disorder needs are also discussed in this context, and several initiatives have started to better identify and refer these individuals. The new case management and field based services, which are eligible services under the waiver, will allow DAS to respond to both the ED's for urgent responses and to the hospital inpatient settings for initial screening and discharge planning.

The Managed Care Plan, CenCal Health, is an active participant in many of the integration and collaborative planning committees throughout the County. The MCP's involvement has been essential to moving several initiatives forward, including assistance for Medically Fragile individuals into temporary supported housing units, enhanced payments for skilled nursing facilities, and data sharing. Individuals with substance use disorders make up a high percentage of the medically fragile population, especially among the homeless. System navigation, peer support, and transitional housing with supports have all been developed and coordinated within the County through collaborative efforts including County and MCP funds.

The SLO County Health Agency BHD is the primary provider of SUD Medi-Cal services in the County. Policies and procedures for collaboration, referral, and consultation with primary health care are in development and will be finalized during the first quarter of the new fiscal year. In the future, contracted agencies will be required to follow similar protocols for coordination. A new position within the Quality Support Division will be dedicated to quality and utilization review for SUD services. This position will be tasked with monitoring compliance to policies as well as ongoing documentation and quality review. Quality review committees are already in place and will add collaboration and referral to physical health care providers to the review elements.

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 mental health screening: There are areas of increased technical assistance, including SBIRT in physical health care, ensuring that all physical health and mental health partners understand the requirements related to 42CFR, Part 2, and that procedures and forms are updated to effectively enable the communication necessary for effective care coordination, shared plan development and

collaborative treatment planning. With increased medical staffing associated with DMC-ODS (in withdrawal management and in medication assisted treatment (MAT)), the cross communication between primary physical care points of entry will by necessity improve for beneficiaries. We currently have a Blue Shield Community Foundation grant to assist in this collaboration under BHIP (see above section).

- Beneficiary engagement and participation in an integrated care program as needed: We have been using motivational interviewing techniques to offer beneficiaries participation in an integrated care program as needed.
- Shared development of care plans by the beneficiary, caregivers and all providers: San Luis Obispo County is a medium county with a number of collaborative treatment planning meetings, including those for youth and families, those who are in the criminal justice system and for those involved in the child welfare system. We can adapt the joint planning meetings to a broader mission of serving all Medi-Cal beneficiaries.
- Collaborative treatment planning with managed care: This is new to the substance use disorder treatment field, but under our Behavioral Health Department, we will integrate our DMC-ODS with the mental health managed care existing processes and procedures.
- Care coordination and effective communication among providers: With the implementation of the full continuum of care of the DMC-ODS and the emphasis on the levels of care based on ASAM criteria, there will be an increased expectation and need for care coordination among the providers. We anticipate some challenges, of course, during the initial implementation, especially regarding the higher levels of care (3+ residential and 4+ medical services). However, BHD will work closely to identify the obstacles and develop improvements among the providers. BHD will also evaluate any Consumer Grievances due to problems with care coordination. We anticipate being able to resolve these issues locally and get to solutions.
- Navigation support for patients and caregivers: The implementation of case management and recovery support services will be significant improvements in assisting clients in navigating other services. Drug and Alcohol Services has been able to implement case management services in several co-occurring disorder grants and AB109 programs and we have many years of experience in navigation within substance use disorder treatment. San Luis Obispo County has recently provided training for Peer Navigators and we are able to provide more trainings for healthcare system navigators through the BHIP. We are confident in our experience to provide local comprehensive case management, no challenges are anticipated in this arena.
- Facilitation and tracking of referrals between systems: We currently have an electronic health record (EHR) which can incorporate all behavioral health providers and will eventually be able to provide continuity of care summaries to physical healthcare within the County through Health Information Exchange. The Health Information Exchange is a continuing project in San Luis Obispo. The Universal Release form facilitates referrals and tracking of the referrals between systems.

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

8a. The Anticipated Number of Medi-Cal Clients

It is estimated in the California Mental Health and Substance Use Needs Assessment (2012) that 10.3% of adults and 3% of youth has an alcohol or drug diagnosis. Based on these rates, it is estimated that 1,515 youth ages 0-19 and 23,542 adults may experience a need for substance use treatment as compared to the population in San Luis Obispo County. The Behavioral Health Department is responsible for treatment of individuals who are eligible for Medi-Cal as well as for individuals referred through the criminal justice system.

According to the San Luis Obispo Health Initiative, CenCal Health has 39,693 Medi-Cal beneficiaries (December, 2015) in the county over the age of 12. Prevalence rates vary and very limited historical data is available to use in making the projections for the number of Medi-Cal clients who will utilize the DMC-ODS services. However, we know up to 14.2% of the Medicaid population meets the diagnostic criteria for a substance use disorder according to NSDUH (2008-2010 National Survey of Drug Use and Health, 2013 American Community Survey), while the California Department of Health Care Services (DHCS Behavioral Health Needs Assessment, Vol 2 2013, page 30) estimates 10.3% of the population meets criteria for a SUD. Using these prevalence estimates, BHD projects between 4,088 to 5,636 Medi-Cal youth and adult beneficiaries have a SUD and could benefit from treatment.

Table 7. SUD Prevalence and SUD Medi-Cal Clients in San Luis Obispo County

Beneficiaries	Population of SLO County (2014)	SUD prevalence	CenCal # beneficiaries	DHCS prevalence SUD	Medicaid prevalence SUD
Youth (12-21)	50,514	1,515	9,961	1,026	1,414
Adult (21+)	228,569	23,542	29,732	3,062	4,222
Total	279,083	25,057	39,693	4,088	5,636

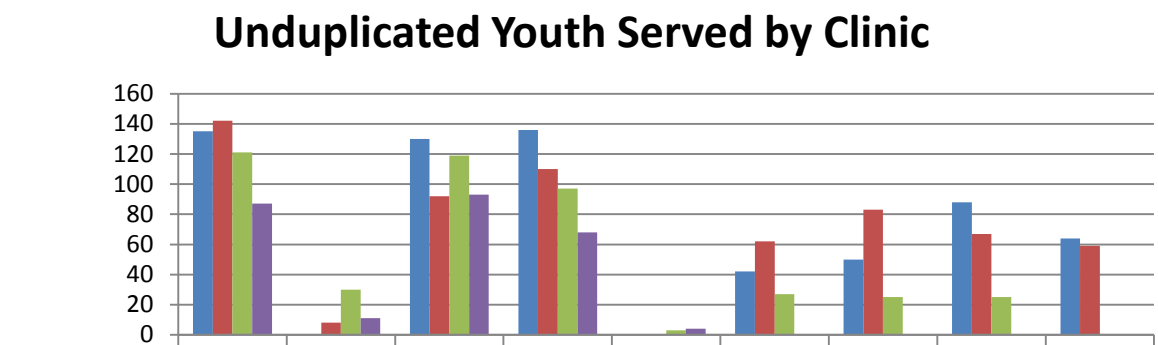
Estimates developed by Mercer (2013) projected a 24% penetration rate for those Medi-Cal beneficiaries with a SUD who would seek treatment. This penetration rate was multiplied by the number of Medi-Cal beneficiaries with a SUD disorder in San Luis Obispo County as of December 2015 (data provided by CenCal Health) to arrive at the projected number of Medi-Cal beneficiaries seeking SUD treatment under the DMC-ODS program.

Table 8. Estimated SUD Medi-Cal Clients Seeking SUD Treatment

Beneficiaries	DHCS prevalence SUD	Penetration rate estimate (24%)	Medicaid prevalence SUD	Penetration rate estimate (24%)
Youth (12-21)	1,026	245	1,414	339
Adult (21+)	3,062	735	4,222	1,013
Total	4,088	980	5,636	1,353

The projection models would demonstrate client counts for youth between 245 and 339 in San Luis Obispo County. For adults, the projection would have between 735 and 1,013 being served in SUD treatment. However, reviewing the last three years of data on unduplicated client counts (below), we can see that in San Luis Obispo County we are reaching a higher penetration rate than expected.

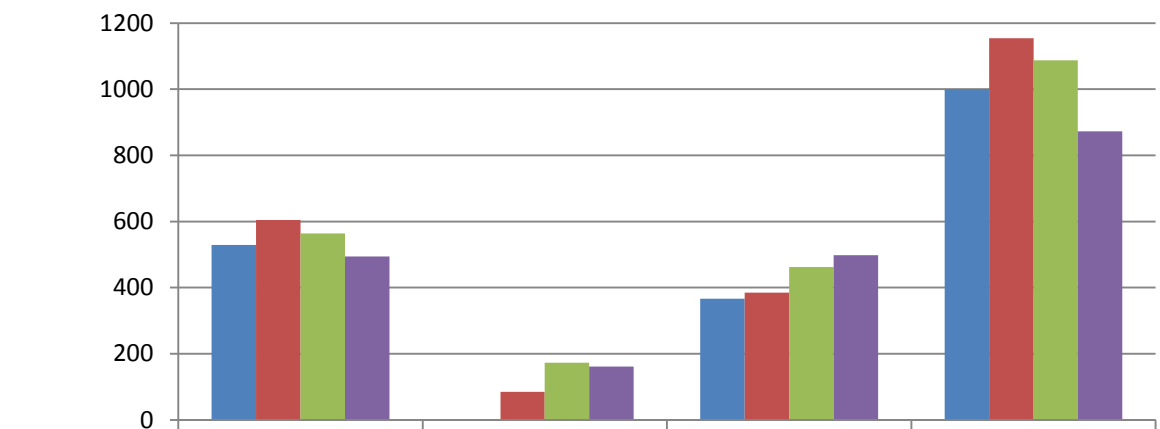
Graph 9. Unduplicated Youth Served by Clinic



	Atascadero	Paso Robles	Grover Beach	SLO	South Street	Sober Schools Loma Vista	Sober Schools Chalk Mountain	Sober Schools Mesa View	Sober Schools Vicente
FY '12-'13	135	0	130	136	0	42	50	88	64
FY '13-'14	142	8	92	110	0	62	83	67	59
FY '14-'15	121	30	119	97	3	27	25	25	0
FYTD '15-'16	87	11	93	68	4	0	0	0	0

Although the unduplicated youth served has gone down over the past three fiscal years, the numbers are currently in the projected range. With our DMC-ODS Implementation Plan for youth treatment, there does appear to be adequate outpatient treatment providers currently. For youth, the addition of intensive outpatient treatment services and case management for the severe substance use disorder adolescent is to be implemented in January, 2017.

Graph 10. Unduplicated Adults Served by Clinic

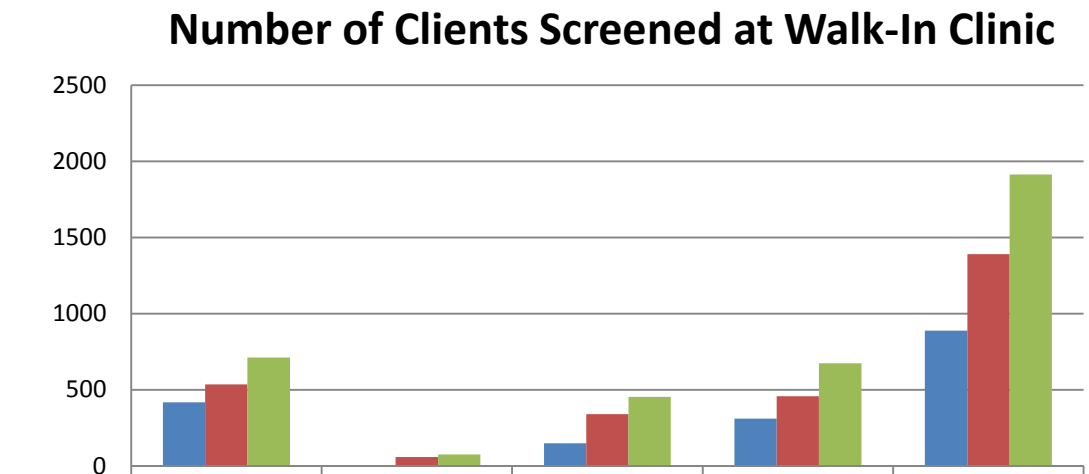


	Atascadero	Paso Robles	Grover Beach	SLO
FY '12-'13	529	0	367	1000
FY '13-'14	605	85	385	1154
FY '14-'15	564	173	462	1087
FYTD '15-'16	494	161	498	873

The unduplicated adults served by clinics is much higher than the projection model would have anticipated, meaning the numbers (FY2014-15 n=2,286) are currently more than the expected range (735 – 1,013). This may be due to the high prevalence of adult criminal justice clients in the unduplicated client counts.

The San Luis Obispo County Implementation Plan is to re-distribute the population between the Atascadero regional clinic and the Paso Robles regional clinic. By increasing the availability of treatment in the Paso Robles region, we would expect at least 5% increase in the overall numbers of unduplicated clients served in the total of North County. We would also expect continual slight increase in the Grover Beach clinic as indicated by the trend line, approximately 2%. The overall numbers for the San Luis Obispo clinic should be projected to remain the same.

Graph 11. Number of clients screened at a walk-in clinic



	Atascadero	Paso Robles	Grover Beach	SLO	All Clinics
FY13-14	418	2	149	310	889
FY14-15	534	58	340	457	1390
FY15-16	712	75	454	673	1914

Reviewing the data from the last three fiscal years to determine the number of unduplicated clients seeking to access SUD treatment services through a regional walk-in clinic, illustrates the tremendous impact that the Affordable Care Act has had on the SUD treatment system. These numbers are limited by the capacity of the staffing in each geographic region. When the DMC-ODS waiver expands the access capacity, the numbers of people seeking treatment services are expected to continue to climb for the next few years. In Paso Robles, we would expect the number of clients screened to be similar to the other geographic regions.

The San Luis Obispo County Implementation Plan will also expand the DMC-ODS services not previously allowed, such as Case Management, Recovery Support Services, and Residential Treatment.

8b. The Expected Utilization of Services by modality

Utilization of services in the DMC-ODS is expected to be similar to service utilization in the current system of care, except where prior funding shortfalls have resulted in restrictions in the level of care or duration of services, and where new services available under the DMC-ODS are being implemented that are not readily available currently. In FY2014-15, there were 447 unduplicated youth and 2,286 unduplicated adult clients within the County outpatient treatment system. Of these, the current rate of Medi-Cal beneficiaries is 85%.

- Withdrawal management (detoxification): Admission to the outpatient withdrawal management program accounted for 7.7% of the total of FY2014-15 treatment admissions (175/2,286). The average length of stay was 79 days and approximately 7%

of them were repeats. With the implementation of the DMC-ODS, the number of clients admitted to the outpatient withdrawal services is expected to increase, but we also plan to increase the length of stay, and increase the number of successful completions. Of the 175 detoxification admissions, fourteen (14), or 8%, were assigned to a Recovery Residence simultaneously, meaning they could have benefitted from a residential withdrawal management facility.

- Residential treatment: Currently there are limited funding resources for residential treatment. The clients who may need residential treatment have been admitted to outpatient or intensive outpatient treatment plus a Recovery Residence. It is estimated that authorization of residential treatment services that is based upon the ASAM Criteria will increase residential treatment utilization; it could be up to 25% of the admissions who may need residential treatment services. Currently, for example, 54% of the AB109 referrals in the County receive outpatient treatment services plus Recovery Residence stay up to six months. The monthly average number of the County's clients that are in a Recovery Residence is 115. The average length of stay in the recovery residence is 79 days. These high numbers of clients who are in Recovery Residence, however, is more due to the shortage of housing in the area, rather than the true need for residential treatment. Therefore, San Luis Obispo County will continue to utilize this model of Recovery Residence plus outpatient SUD/COD treatment as first step prior to residential treatment assignment. Only those clients who have not shown significant progress in outpatient treatment (through the use of the ASAM Criteria) will be authorized for residential treatment. This is in line with the ASAM Criteria of 'least restrictive environment' for treatment and in addition, will provide cost savings.

- Outpatient treatment: This level of care currently amounts to 90% of the total treatment admissions in FY2014-15 and the average length of stay for outpatient services was 95 days. The average length of stay is anticipated to be the same for DMC-ODS planning purposes.

- Narcotic Treatment Program (methadone maintenance): Methadone maintenance and detoxification services currently account for approximately 10% of the FY2014-15 treatment admissions in San Luis Obispo County with an average length of stay of 1,284 days. Aegis Treatment Centers has determined that they will not be significantly expanding methadone treatment services in the next year. The focus will be to serve the clients that are currently going to Santa Barbara County for their methadone services (75 clients).

- Case management: Access to case management has not been a covered benefit prior to DMC-ODS. However, the County of San Luis Obispo has experience over the past four years in providing case management services to clients with AB109 funding. The AB109 clients receive assessment and active support to enter treatment, but also receive ongoing case management services over the course of their treatment (lasting months). For the clients who receive ongoing case management, the intensity of the case

management is increased or decreased depending on the client's level of need over time. In the current year, 50 – 60% of the AB109 clients received case management services. The average case manager to client ratio was 1.0 full-time equivalent (FTE) Case Manager to 30 clients.

Approximately 2,256/12 months is 188 new clients per month, approximately 60% of the clients will need case management which is 112 clients needing case management per month. With a ratio of 1:30 clients, San Luis Obispo County proposes to hire 4.0 FTE total new Case Managers to provide case management services for the County. We will place 1.0 FTE in each of the four regional clinics to handle the case management needs for each clinic working together with the designated Assessment Coordinator with a focus on the transitions between level of care.

- Recovery support services: Recovery support services are currently not available and there is little data available from SUD systems of care outside of the County to support estimates of utilization of recovery support services. Recovery support services will be needed by clients who complete outpatient and intensive outpatient treatment services. If we anticipate that 45% of the clients will finish their program successfully, then 1,015 adult clients will need recovery support services. The County Implementation Plan is to hire 1.0 FTE of a Recovery Support Specialist (who is a person with lived experience) to act as a Recovery Coordinator, including the solicitation of a cadre of peer volunteers to conduct the Substance Abuse Assistance and Relapse Prevention services. In addition, County staff will conduct Medi-Cal Recovery Support Services (such as Recovery Coaching, Monitoring, Group Counseling, Family Support Services, Celebrating Families!, Peer-to-Peer Substance Abuse Assistance).

8c. The number and types of providers required to furnish the contracted Medi-Cal Services

All providers in the DMC-ODS must be Medi-Cal certified and DHCS certified to provide the services to eligible beneficiaries. A more detailed list of number and types of providers including current patient load, capacity, and population served is in the Attachment J.

Table 12. Numbers and Types of Providers

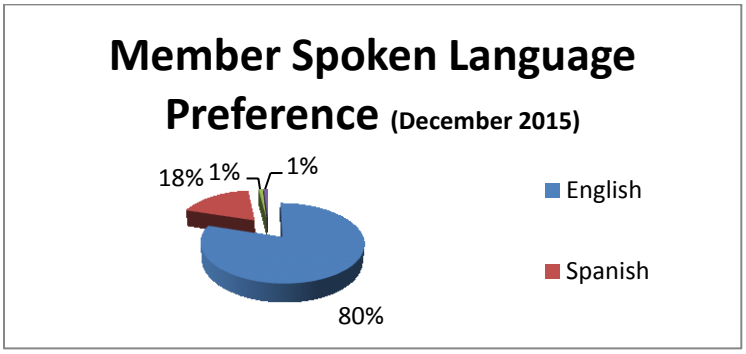
Type of Provider	Current Providers	Needed Providers
Narcotic Treatment Program	Aegis Treatment Centers	Adequate
Outpatient Treatment Program	County-operated (5) clinics (youth & adult)	Private individual network providers
Intensive Outpatient Treatment	County-operated (5) clinics (youth & adult)	Expansion requested
Withdrawal Management	County-operated	Expansion requested
Medication Assisted Treatment	County-operated	Expansion requested Private network prescribers Primary care providers
Residential Treatment	Bryan's House (5 beds for women and 10 children)	Approximately 60 residential treatment placements are

		anticipated
Youth Residential Treatment	None	Approximately 20 residential treatment placements are anticipated
Case Management	County-operated (5) clinics (youth & adult)	Expansion requested

8d. Language capability for the county threshold languages

The threshold languages for San Luis Obispo County are English and Spanish, which accounts for the primary language reported by 98% of the Medi-Cal beneficiaries. Based on an analysis of current (December 2015) San Luis Obispo County Medi-Cal beneficiaries, 81% report English as their primary language and 18% report Spanish as their primary language. As such, all Behavioral Health Department clinics will offer services in Spanish, either through hiring bilingual staff or having access to oral interpreter services, including: screening, assessment, outpatient and intensive outpatient treatment services for adults and youth, who are either monolingual Spanish-speaking or bi/multilingual, with a preference for services to be provided in their primary language. For County-operated services, we would strive to have a minimum of 18% of the treatment staff who are bilingual in each regional clinic.

Diagram 13. Threshold Language of Medi-Cal Beneficiaries



8e. Timeliness of first face-to-face visit, timeliness of services for urgent conditions and access after-hours care

Table 14. Timelines for Services

Code	Type of Care	Time Frame (days are calendar days)
D	Emergency/Crisis	Immediately, 24 hours per day, 7 days per week
U	Urgent: Within 7 days	Appointment given within 7 days
V	Urgent: Within 8 – 14 days	Appointment given within 8 – 14 days
R	Routine/Non-Urgent	Appointment offered with 15 calendar days

These timelines for DMC-ODS services will be reflected in the Quality Improvement Plan and all providers are committed to timely access to services. The current standard is for each beneficiary to be offered a first appointment within ten days for non-urgent services. A first appointment may be provided in any appropriate community setting, in-person (group or individual session), by telephone, or by telehealth.

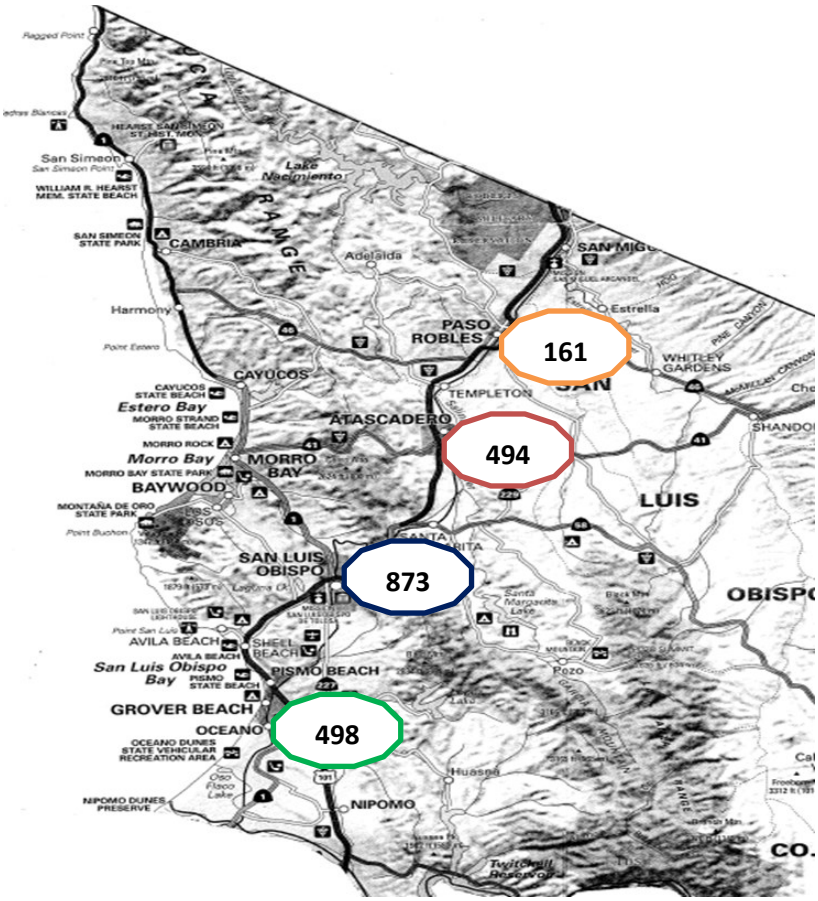
Emergency or Crisis conditions will be responded to immediately and may include calling emergency transportation to an emergency department at the local hospital for medical issues or calling the Mental Health Evaluation Team (MHET) for psychiatric emergencies. All beneficiaries experiencing a medical or psychiatric emergency will be directed to the nearest hospital for services. Urgent conditions require immediate attention but do not require inpatient hospitalization. Post-hospitalization follow-up is an urgent service that occurs within seven (7) calendar days of discharge from acute care (either medical or psychiatric hospitalization). Another urgent service within 7 days is upon discharge from County Jail or Prison or State Hospital. At the time of first contact, each beneficiary will be triaged to identify the presence of an emergency or urgent condition. After hours care can be accessed by calling the 24-hour Access Line, where callers are screened and triaged for risk and appropriate referrals are made. Each regional Drug and Alcohol Services clinic will provide urgent appointments on the next business day following the weekend or holiday.

8f. The geographic location of providers and Medi-Cal beneficiaries, considering distance, travel time, transportation, and access for beneficiaries with disabilities

Based on an analysis of current San Luis Obispo County CenCal Health report (December, 2015), the county's distribution of Medi-Cal beneficiaries is divided into three regional access points: South County (32% of the total beneficiaries), Mid-County/San Luis Obispo (25% of the total beneficiaries), and North County (44% of the total beneficiaries). In our DMC-ODS implementation plan, we are proposing to divide up the North County where the largest number of Medi-Cal recipients is located, into two geographic areas—those associated with Paso Robles and those associated with Atascadero. In addition, the Mid-County/San Luis Obispo area has cities associated with the Atascadero region. Using a re-distribution by cities, we have the following breakdown of Medi-Cal beneficiaries: South County (30%), Mid-County/San Luis Obispo (21%), Atascadero (20%) and Paso Robles (29%). San Luis Obispo County's DMC-ODS Implementation Plan includes four functioning regional clinics associated with this regional distribution. All four regional clinics are aligned along the Highway 101 corridor (see Map) with an average of 20 minutes travel between each regional clinic. The county's regional transit does cover the route up and down the county using Highway 101. Other county health and social services are also aligned in these four regional areas.

The numbers on Diagram 16 of the map distribution indicates the client caseload in the adult treatment clinics. In addition to the adult clinics, the youth treatment services are located on school sites (High School, Continuation School, and Community School) and Family Resource Centers throughout the County.

Diagram 15. San Luis Obispo County Map of Medi-Cal beneficiary SUD Adult caseload distribution



For persons with disabilities, SLOBH county-operated and county contractors will adhere to the following policies and regulations to serve all clients.

- Americans with Disabilities Act of 1990;
- Section 540 of Rehabilitation Act of 1973;
- 45 Code of Federal Regulations (CFR), Part 84, Non-discrimination on the Basis of Handicap in programs or Activities Receiving Federal Financial Assistance;
- Title 24, California Code of Regulations (CCR), Part 2, Activities Receiving Federal Financial Assistance; and
- Unruh Civil Rights Act California Civil Code Section 51 through 51.3 and all applicable laws related to services and access to services for persons with disabilities.

All providers are required to make accommodations to serve persons with physical disabilities, including vision and hearing impairments. In addition, services must be made available to all individuals with mobility, communication or cognitive impairments as required by federal and state laws and regulations. If a provider is unable to meet the needs of a person with a specific

physical disability, they must expedite the person's transition to ensure the individual is successful in accessing needed support and services. Beneficiaries are advised of their right to receive services and any complaints and grievances are investigated and appropriate and timely action is taken to ensure access.

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.

The following Quality Support Team Work Plan has been drafted in accordance with 42CFR 438.206 for Fiscal Year 2016-2017 to ensure timely access to services.

QST Work Plan:
The annual QST Work Plan identifies key areas that will be a focus of the Department's quality improvement efforts for the year. The goal is data-driven, continuous quality improvement with measurable outcome benefits for plan members.

Goal # 1: Maintain a responsive toll free 24/7 Central Access line

Goal # 2: Monitor Service Delivery Capacity

Goal # 3: Increase system capacity to serve Latino beneficiaries

Goal # 4: Provide timely access to services

Goal # 5: Monitor attendance rates for key services

Goal # 6: Maximize consumer satisfaction responses

Goal # 7: Monitor and respond to beneficiary requests

Goal # 8: Monitor and respond to provider requests

Goal # 9: Implement interventions when better care was more appropriate

Goal # 10: Improve clinical documentation

Goal # 11: Conduct effective clinical records reviews

Goal # 12: Develop improved Site Certification procedures

San Luis Obispo County Behavioral Health/Drug & Alcohol Services
Quality Support Team Work Plan Fiscal Year 2016-2017

Goal # 1: Maintain a responsive toll free 24/7 Central Access line	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person/Group**
Monitor the performance of the toll free Central Access line during and after regular business hours <u>Measurable Objectives</u>: All calls will be logged as required (100% success rate) Staff who answer phones will utilize the scripted responses (90% success rate)	1. Implement scripted responses at all clinic locations and in Central Access (1st quarter) 2. Conduct monthly test calls (English and Spanish) to evaluate performance in the following areas: • Language capacity • Informing beneficiaries about how to access mental health services • Informing beneficiaries about how to access urgent services • Informing beneficiaries about how to access the problem resolution and fair hearing process • Log of calls that includes name of beneficiary, date of call, initial disposition 3. Complete quarterly reporting to DHCS (quarterly)	Managed Care Program Supervisor QST staff TMHA Hotline Coordinator

Goal # 2: Monitor Service Delivery Capacity	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person/Group**
Establish goals for the number, type, and geographic distribution of SUD services <u>Measurable Objective</u>: Maintain a network of providers that is sufficient to provide adequate access to services	1. Continue to measure and track access and attendance at each clinic site as a measure of capacity (see Goals 3- 5 for detail) 2. Track wait time from request to screening and from screening to assessment at all sites 3. Track requests for service by beneficiary zip code; analyze for gaps (quarterly)	QST staff Managed Care staff and Program Supervisor

within 14 days of referral or request		

Goal # 3: Assess ability to serve Latino beneficiaries	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person(s)**
Establish a baseline for the number and percentage of clients served who are Latino Measurable Objective: 5% increase in utilization by Latino clients	1. Measure penetration rate (annually) 2. Measure number and percentage of clients served who are Latino (quarterly) 3. Track number of clients receiving three or more services by ethnicity to allow examination of our ability to retain consumers (quarterly) 4. Maintain bilingual staff capacity at all key points of contact, including at the toll free Central Access line	QST staff BH Administration

Goal # 4: Provide timely access to services	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person/Group**
Wait time for screening (routine) Measurable Objective: Screening offered within 14 days of request (80% success rate)	1. Monitor and report wait time for screening for English and Spanish speaking consumers (monthly) 2. Allocate clinic staff so that sufficient screening appointments are available to meet the demand. 3. Recommend corrective action if a site is unable to meet the standard (monthly) 4. Make data-driven staffing recommendations to Behavioral Health Administrator	Managed Care Program Supervisor QST staff BH Administration Clinic Program Supervisors

Goal # 5: Monitor attendance rates for key services	Planned Steps/Activities to Reach the Goal (Reporting Frequency)	Responsible Person/Group
Assessment appointments Measurable Objectives: 85% attendance rate (youth) 80% attendance rate (adults)	1. Monitor and report attendance rate at scheduled intake appointments by site (monthly) to develop a baseline 2. Develop and implement a survey to determine reasons for missed intake appointments	QST staff Clinic Program Supervisors

Goal # 6: Maximize consumer satisfaction	Planned Steps/Activities to Reach the Goal (Reporting Frequency)	Responsible Person/Group
Consumer Satisfaction Survey Objective: 85% of the responses on the survey will be rated "Strongly Agree" or "Agree" when asked about overall satisfaction with services	1. Develop and implement a consumer satisfaction survey 2. Encourage a representative sample of beneficiaries to complete the survey 3. Report promptly to staff at all sites.	QST staff Clinic Support Staff

Goal # 7: Monitor and respond to beneficiary requests	Planned Steps/Activities to Reach the Goal (Reporting Frequency)	Responsible Person/Group
Resolve beneficiary requests at the lowest possible level Measurable Objective: Successfully resolve all beneficiary concerns within	1. Track all consumer requests (second opinion and change-of-provider requests, grievances, appeals, fair hearings) 2. Monitor and report outcome and timeliness of resolution (quarterly)	Patient's Rights Advocate

legal time frame (100% compliance)		

Goal # 8: Monitor and respond to provider requests	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person/Group**
A. Resolve provider appeals at the lowest possible level <u>Measurable Objective</u>: Successfully resolve provider appeals within legal time frame (100% compliance)	1. Track provider appeals and requests 2. Monitor and report outcome and timeliness of resolution (quarterly)	Managed Care Program Supervisor QST staff
B. Make timely authorization decisions <u>Measurable Objective</u>: Provide referrals to Residential Treatment within 24 hours of the request (100% compliance)	1. Track and report the number and percentage of Residential Treatment referrals which are completed within 24 hours of the request 2. Monitor and report outcome and timeliness of resolution (quarterly)	Managed Care Program Supervisor QST staff

Goal # 9: Implement interventions when better care was more appropriate	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person/Group**
Conduct regular review of Incident Reports	1. Review Incident Reports; monitor and report (monthly) 2. Refer Incident Report to Morbidity & Mortality Committee in event of	QST Staff Medical Director

Measurable Objective: Review and respond to Incident Reports within two weeks of report submission (within one day for suspected privacy incidents)	death or serious injury 3. Make recommendations regarding follow-up when better care was more appropriate	Privacy Officer

Goal # 10: Improve clinical documentation	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person/Group**
Provide regular training to improve documentation Measurable Objective: 100% of MHP staff will attend documentation training at least annually	1. Revise and distribute Documentation Guideline update (twice yearly; more often if needed) 2. Establish training schedule to include all clinic and contractor sites 3. Track attendance at face-to-face and completion of E Learning documentation training (annually)	QST staff

Goal # 11: Conduct effective clinical records reviews	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person/Group**
Establish a consistent audit protocol and schedule as part of Utilization Management Program Objective: Identify areas of strength and deficiency in documentation to help guide training and to ensure appropriate access and billing for	1. Establish a monthly audit schedule to include all sites with a focus on high utilizers of services or areas of specific need 2. Analyze and report results (monthly)	QST staff Health Information Technology (HIT) staff

services		

Goal # 12: Develop improved Site Certification procedures	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person/Group**
Identify DHCS site certification standards and incorporate into MHP procedures Objective: Create a standardized set of procedures for certification and tracking of all county operated, contract provider, and out of county provider sites	1. Develop a review and monitoring process that ensures that each site requiring certification remains in compliance with standards 2. Develop a common tool and strategy for identifying out of county providers that need to be certified in order to serve SLO beneficiaries 3. Report progress (quarterly)	QST staff Program Supervisors Contract providers

10. Training Provided. What training will be offered to providers chosen to participate in the waiver? How often will training be provided? Are there training topics that the county wants to provide but needs assistance?
Review Note: Include the frequency of training and whether it is required or optional.

On a quarterly basis, the County provides Drug Medi-Cal training to all of its staff and providers, including the interface between Drug Medi-Cal and the Electronic Health Record (EHR). The Drug Medi-Cal training includes the following elements:

- Screening (Screening Tool, ASAM)
- Assessment (ASI, Diagnostic Review)
- Treatment Plans
- CalOMS
- Progress Notes
- Justification for Continuing Treatment
- Discharge Plan or Discharge Summary
- Sub-units training

The Drug Medi-Cal training is a Live training, with hands-on access to the EHR while sitting in a computer lab with up to 12 other clinicians or staff. The opportunity to ask questions, work through vignettes and examples, and learn-by-doing is provided. An annual refresher course in Drug Medi-Cal regulations is required for each staff person. All new staff are required to attend a week-long training on Medi-Cal documentation standards and demonstrate competency in documentation as well as the operation of the EHR in order to receive a certificate of competency before conducting treatment services on their own.

The County of San Luis Obispo also provides mandatory annual training on: Harassment Prevention, Compliance and Code of Ethics, Fraud, Waste, and Abuse, Privacy and HIPAA Training, Law and Ethics, and 42CFR Training. This is a combination of customized video training and Live training options.

Using the online training software, Relias, the County of San Luis Obispo provides required online training for at least two pertinent clinical issues per year as designated by the SLOBH Cultural Competency Committee. Recent topics have included Veteran's issues, Homelessness, Trauma Informed Care, Bullying, and Cultural Diversity issues.

Lastly, in-person or Live Trainings are also available on an annual basis as we provide training on the evidence based practices which are in use in our County (see section below). In June, 2015, Dr. David Mee-Lee came to San Luis Obispo County to train on ASAM Criteria. These trainings are optional for those who do not directly need the material, but staff can also be designated as required to attend due to their role.

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

Although the County of San Luis Obispo brought in Dr. David Mee-Lee in June 2015 to train on the ASAM Criteria, County staff have changed and due to the integration in several areas (such as Managed Care and Quality Support Team), more training on ASAM Criteria is needed and SLO County staff have been attending training through CIBHS. A train-the-trainer model would be preferred to build internal capacity and meet ongoing training needs to accommodate new staff and providers, to ensure inter-rater reliability for placement decisions, and for utilization management. In addition, we anticipate working together with DHCS and UCLA to come up with a standard reporting mechanism for the ASAM Criteria data elements. This will help to ensure that the inter-rater reliability is consistent.

We have implemented many evidence based practices and they are consistently applied and available in our County (see section below). However, we would benefit from DHCS support and training to provide fidelity assessments for monitoring the evidence based practices.

Currently, Drug and Alcohol Services provides buprenorphine in the detoxification program. Naloxone (an opiate overdose prevention medication) and Antabuse (for alcohol use reduction) are also available on a limited basis. Long-term administration of the newer medications (buprenorphine, acamprosate, and naltrexone) has not been used at Drug and Alcohol Services. We would request technical assistance to implement these new medication protocols. There are currently no other providers in the community utilizing the newer medications. The long-term goal would be to establish physicians in the community who are willing to continue to prescribe these medications when the patient finishes treatment services. Thus ensuring long-term recovery continues as needed.

Financial rate setting, cost reporting, invoicing, financial audits of providers, and other administrative supports training by DHCS would be appreciated by our County.

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

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

- Telephone access line and services in the prevalent non-English languages.

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

- 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.

Monitoring Process:

SLOBH Quality Support Team (QST) will expand to become an integrated Behavioral Health division.

Quality Support Team Program Structure and Description:

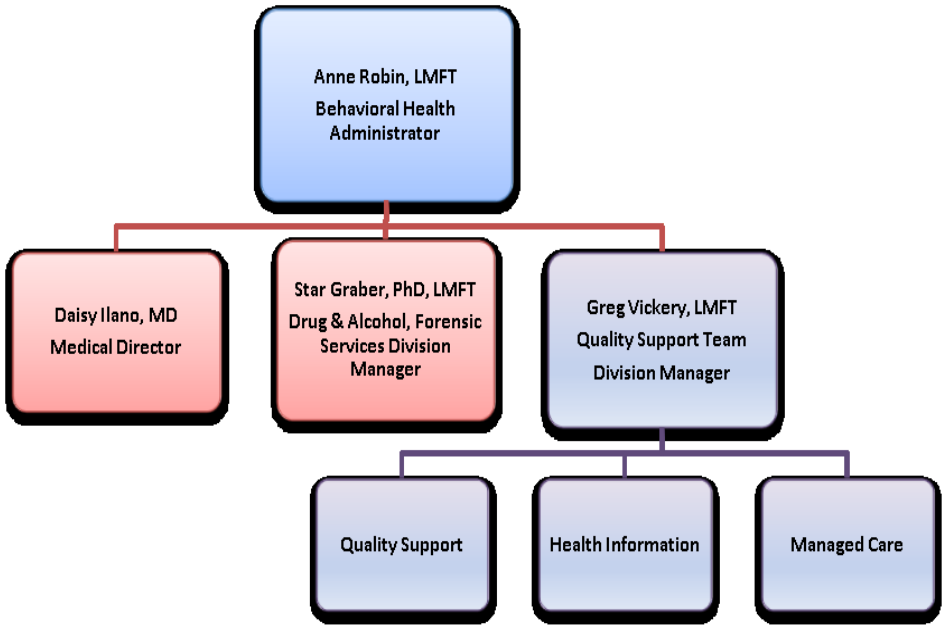
Purpose:

- To define the Quality Support Team's structure and elements
- To assign responsibility for QST activities to team members
- To provide a framework for understanding the Quality Support Team Work Plan, which establishes quantitative measures to assess performance and identifies and prioritizes areas for improvement
- To clarify processes for identifying and implementing improvements to better meet the needs of the MHP's beneficiaries

Organizational Overview:

The chart below shows a very simplified view of the part of SLOBH's Management Team and where QST fits in the structure. The QST Division Manager, Greg Vickery, LMFT, reports directly to the Behavioral Health Administrator and participates on the Behavioral Health Management Team.

Diagram 16. Quality Support Team Overview



QST staff report directly to the QST Division Manager. The following SUD Quality Support Team staff will be added to the existing Mental Health QST. QST staff executes key Quality Management, Quality Improvement, Utilization Review and Utilization Management duties including:

1. Staff: 1.0 FTE ASO I/II (TBA)

- QST Committee: Collect, report and present access, appeal and other data elements tracked by the QST Committee
- QST subcommittees: Organize, monitor and track QST subcommittees, maintain minutes, agendas and records
- Site Certification: conduct site reviews, coordinate with DHCS site reviewers, monitor, track and maintain certification records, maintain ITWS/BHIS files
- Quality of Care concerns: track and record Incident Reports, coordinate follow up requests
- Policy & Procedure: review, draft, coordinate input and approval
- Committee membership: QST Committee, Incident Report Review

2. Staff: 1.0 FTE LPHA Clinician (Julianne Schmidt, LMFT)

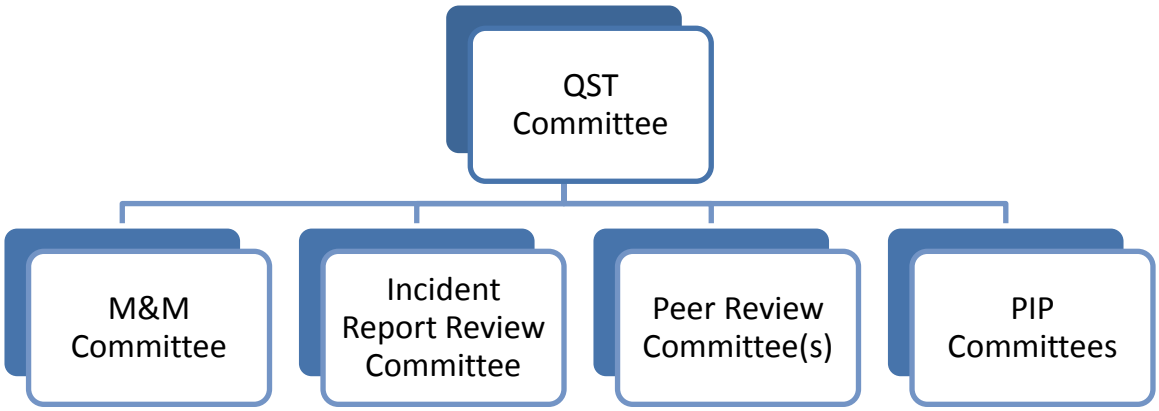
- Outpatient utilization management: review medical records to ensure consistent application of medical necessity criteria, adherence to documentation requirements, proper coding and claiming of services, identification of over or under utilization of services
- Provide staff training to improve documentation and coding

- Acts as the Clinical PIP coordinator and staff representative or coordinator of the following: QST Committee, Morbidity & Mortality, Incident Report Review, PIP, and Peer Review.

QST Committee Structure:

Within FY 2016-2017, SLOBH will integrate the SUD QST Committee with the MHP's Outpatient QST Committee. Initially, however, the two will be separate to allow focus on establishing detailed performance objectives and measures. The QST sub-committee structure is illustrated below.

Diagram 17. Quality Support Team Committee Structure



QST Committee (Outpatient) Membership:

- QST Division Manager (chair): Greg Vickery, LMFT
- BHD Administrator: Anne Robin, LMFT
- Medical Director: Daisy Ilano, MD
- Drug & Alcohol Services Division Manager: Star Graber, PhD, LMFT
- QST staff
- Managed Care Program Supervisor: Amanda Getten, LMFT
- Behavioral Health Advisory Board member
- SLOBH Patient's Rights Advocate: Leah DeRose, LMFT
- SLOBH Ethnic Services Manager: Juan Munoz-Morris
- Compliance Officer: Ken Tasseff
- Contractor/Provider staff
- Consumer/Family members
- Peer/Advocate members:
  - TMHA Peer Advocacy Program Manager
  - Family Advocate
  - Health Navigator

QST Committee Activities:

1. Quality Improvement Plan goals initially will focus on establishing baseline measures and performance standards that will result in a complete QST Work Plan.
2. Approve, and monitor the goals and objectives of the QST Work Plan. When the QST includes the SUD staff, the work plan will be adjusted to ensure substance use disorder activities are incorporated.
3. Monitor key quality indicators (monthly), including:
    - Wait time for assessment and acute care follow up (English and Spanish)
    - Wait time for appointments
    - Attendance at key appointments, including screening and assessment
    - Utilization of MAT and Withdrawal Management services
    - Coordination with physical health care services
    - Responsiveness of Central Access line
4. Monitor key quality indicators (quarterly), including:
    - Notices of Action
    - Grievances, Appeals (beneficiary and/or provider), Fair Hearing requests
    - Change of Provider and Second Opinion requests
    - Peer Review Results (medical services provided by prescribers and nursing staff in Withdrawal Management and Medication Assisted Treatment)
5. Periodic monitoring of beneficiary satisfaction.
6. Review and evaluate results of other quality improvement activities, including the clinical and nonclinical PIPs.
7. Receive reports from sub-committees and recommend necessary actions, including corrective actions when opportunities for more appropriate care are identified.
    a. Morbidity & Mortality Committee is chaired by the Medical Director. This subcommittee meets monthly to review instances of death or serious injury.
    b. Peer Review Committee is chaired by the Medical Director. This sub-committee meets monthly to review the clinical documentation of medical staff to ensure the safety and effectiveness of prescribing practices. A specific SUD Peer Review Committee will be added and chaired by each of the regional Program Supervisors for the SUD clinics. This sub-committee will meet quarterly at a minimum to review the clinical documentation of SUD staff to ensure the implementation of evidence-based practices, correct SUD treatment processes, level of care decisions, and continuity of care are consistent and appropriate for each client.
    c. Incident Review Committee is chaired by the QST Division Manager. Outpatient Incident Reports from Behavioral Health staff and contractors are reviewed to ensure improved care and appropriate follow up.
8. Receive reports from Cultural Competence committee.
9. Review and recommend policy changes and additions.
10. Other quality improvement activities as identified, including making recommendations for training and program development that improve beneficiary care.

Patients' Right Advocate, Beneficiary Complaints, Grievances, and Appeals

San Luis Obispo County Behavioral Health has implemented a problem resolution process that enables each beneficiary to resolve problems or concerns about any issue related to SLOBH's performance of its duties. The PRA will ensure that beneficiary rights are promoted and protected and that the problem resolution process works effectively for SLOBH beneficiaries. The Drug and Alcohol Services Patients' Rights Advocate will be the same as for the Mental Health Services within the Behavioral Health Department. The PRA reports directly to the Behavioral Health Administrator and receives additional support from the QST Division Manager.

The PRA will:

- Ensure beneficiaries are informed of their rights
- Advocate for beneficiaries
- Receive and investigate complaints
- Monitor behavioral health facilities, services, and programs for compliance with patient's rights provisions
- Provide training and education for providers and beneficiaries
- Exchange information with the State Patient's Rights Program

The PRA will ensure that beneficiaries are informed of their rights and have access to the problem resolution processes. Informing materials will be provided to clients at the beginning of services and upon request thereafter. Informing materials will be available in English, Spanish, and alternative formats. The PRA will ensure that the Beneficiary Handbook, Guide to Behavioral Health Services, which contains detailed information about the problem resolution and rights, will be available at all certified sites and through the 24/7 Access Line at 800-838-1831. The PRA will ensure that SLOBH's Client Information Centers contain notices explaining grievance, appeal, and expedited appeal procedures and patient's rights so that the information will be readily available to both beneficiaries and staff. The Consumer Request Forms and postage paid, self-addressed envelopes will be available in each Client Information Center. Clients will be able to obtain, complete and return a Consumer Request Form without having to make a verbal or written request to anyone. The contact information for the PRA and the State Office of Patients' Rights will be posted in all Behavioral Health facilities.

Problem Resolution: The PRA will receive, investigate and resolve complaints received from providers or beneficiaries about violations of patient's rights. The Consumer Request Forms will be tracked, logged, and responded to advocates to beneficiaries and/or representatives regarding requests for Second Opinions, Change of Provider, Grievances, Appeals, and Expedited Appeals. Assistance will be provided to the beneficiary (at their request) with the problem resolution process and will include, but not be limited to, help writing the grievance, appeal, expedited appeal on a Consumer Request Form. The PRA will coordinate prompt resolution of grievances and appeals and will notify beneficiaries of the disposition of the problem. See Attachment H for Patients' Rights Advocate forms and policy and procedures.

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

San Luis Obispo County Behavioral Health will ensure that all providers (including County-operations) are implementing at least two of the identified evidence based practices (EBP's) through the following:

- Incorporating the requirement to implement at least two of the EBP's listed in the Standard Terms and Conditions in all Requests for Proposals and awarded Contracts for the DMC-ODS services.
- Including provisions in all contracts for DMC-ODS services requiring providers to implement at least two specific EBP's in the contract, we well as information on how they will be implementing the EBP's with fidelity to the model.
- Similar to all quality and compliance monitoring, SLOBH will monitor adherence to implementing at least two of the identified EBP's through review and approval of the contract language, mid-year monitoring, which includes a written provider self-audit and on-site monitoring visit and review of progress reports.
- If a provider is found to be out of compliance, SLOBH will offer technical assistance to adhere to requirements, as well as issue a written report documenting the compliance and requiring a Corrective Action Plan be submitted to the County.

For many years, SLOBH has provided a number of evidence based practices in its treatment programs as listed below. This listing does not preclude other EBP's from being added or changed from the listing.

Table 18. Evidence Based Practices for San Luis Obispo County

Name	Purpose
Matrix Model	Substance use disorder treatment, a cognitive behavioral therapy (Adults and Youth)
Seeking Safety	Trauma based treatment, offered for women and men, appropriate for both group and individual settings
Helping Men/Women Recover	Gender specific services for substance use disorder treatment used in group counseling
Moral Reconation Therapy (MRT)	Appropriate for criminogenic factors that often accompany substance use disorders (Adults and Youth)
Motivational Interviewing	A practice of using motivational interviewing for client engagement
Illness Management and Recovery (IMR) and Integrated Dual Disorder Treatment (IDDT)	Co-occurring Disorder treatment services offered in an integrated manner
Recovery Support Services	Recovery Support Services are important to beneficiaries in the recovery and wellness process

Seeking Safety: Seeking Safety combines a present-focused therapy to treat post-traumatic stress disorder (PTSD) with a cognitive behavioral therapy substance abuse treatment approach. Seeking Safety is designed for flexible use in both group and individual format as well as for women, men, and mixed-gender groups and in a variety of settings (e.g., outpatient, inpatient, residential). Key principles include:

- Safety as a goal (assisting clients to find safety in their relationships, thinking, behavior, and emotions);
- Integrated treatment plans that treat both PTSD and substance abuse simultaneously;
- A focus on replacing or rebuilding ideals lost as a result of both PTSD and substance abuse; and
- A focus on cognitive, behavioral, interpersonal, and case management issues.

Seeking Safety has shown positive results in a variety of settings, reducing both trauma-related symptoms and substance use (Najavits, 2002). Two of these studies were randomized controlled trials (Hien, 2004, Najavits, under review). Findings from a not yet published study, funded by SAMHSA, "Women with Co-Occurring Disorders Violence Study," also found positive results for trauma informed treatment. This four-site study saw reductions in mental health symptoms and substance use indicators. Designed by Dr. Lisa Najavits under a National Institute of Drug Abuse grant, the program was developed to treat both substance abuse disorders and PTSD.

Helping Women/Men Recover: At the core of San Luis Obispo's treatment program are the gender responsive addiction treatment Helping Women/Men Recover frameworks. The materials can be used in a variety of settings and the exercises can be adapted for work with individuals. These evidence-based models have been modified to meet the special needs of the target population by lengthening its content, intensifying selected components, and incorporating trauma treatment.

The program is organized into four modules: self, relationships, sexuality, and spirituality. These reflect the four areas that represent triggers for relapse and the areas of greatest change in recovery. The topics take into account the physical, psychological, emotional, spiritual, and sociopolitical aspects of the holistic health model of addiction. It is a comprehensive integrated theoretical that not only incorporates cognitive behavioral techniques, but also affective-dynamic and systems perspectives. It will provide specific gender responsive services for both mothers and fathers in treatment.

Helping Women Recover has demonstrated reduced substance use with criminal justice involved women. In a randomized clinical trial, female inmates who had substantial substance use history were placed into Helping Women Recover or standardized treatment. From baseline to the 12 month follow-up women in the intervention group had a larger decrease in drug use composite scores on the ASI than their counterparts (NREPP, 2010). In addition, a smaller percentage of the intervention group than the comparison group women were re-

incarcerated during the 12 months follow-up period—67% less likely to recidivate. Less substance use and less recidivism are outcomes that we want to achieve in our treatment programs.

Both the Helping Men/Women Recover and Seeking Safety have been found to be effective in low-income and minority populations, and additionally, have already been culturally modified successfully. Both Helping Women/Men Recover and Seeking Safety are long-term group and individual counseling formats. These evidence based practices are available in Spanish language formats should they be needed and are effective with criminal justice populations.

We have selected the Helping Women/Men Recover over other evidence based practices for multiple reasons:

- It uses a cognitive behavioral therapy approach to substance abuse management, which has demonstrated to be gender responsive setting working with both mothers and fathers;
- It has fully developed fidelity measure that will assist us in its implementation;
- Because our County providers currently have received training in the Helping Women/Men Recover, we anticipate expedited enhancement; and
- Its core characteristic—development of individualized treatment—promotes sensitivity to cultural, physical, linguistic, and other needs.

Moral Reconation Therapy (MRT): Moral Reconation Therapy is a systematic treatment strategy that seeks to decrease recidivism by increasing moral reasoning. Its cognitive behavioral approach combines elements from a variety of psychological traditions to progressively address ego, social, moral, and positive behavioral growth. MRT takes the form of group and individual counseling using structured exercises and prescribed homework assignments. The MRT Workbook is structured around sixteen objectively defined steps focusing on seven basic treatment issues: confrontation of beliefs, attitudes, and behaviors; assessment of current relationships; reinforcement of positive behavior and habits; positive identity formation; enhancement of self-concept; decrease in hedonism and development of frustration tolerance; and development of high stage moral reasoning. MRT is an open-ended group format that may meet once a month or up to five times per week. Group size can vary from 5 to more than 20. Homework tasks and exercises are completed outside of group and then presented to group members during meetings. The most important aspect of the treatment is when the participant shares work with the group. The facilitator is trained to ask appropriate questions concerning the exercises and to maintain focus on the participants' completion of MRT's 16 steps.

MRT does not require high reading skills or high mental functioning levels, as participants' homework includes making drawings or writing short answers. The format seems especially appropriate for a drug court treatment program in a self-contained clinical setting.

In one study of the use of MRT, after one year of release from custody, adult male felony inmates who participated in MRT showed a re-incarceration rate that was two-thirds lower

than that of a control group of inmates who had volunteered for the MRT program, but did not receive it due to limited treatment funding. In another study, male and female clients who participated in MRT were rearrested for any offense at a rate of 20% compared with 45.3% for a matched control group. In several other studies, the authors (Little, 2001, 1999) maintain that MRT cuts the expected 1-year recidivism rate in half. Studies show that well-implemented cognitive behavioral interventions can reduce recidivism by as much as 30 percent on average, particularly with moderate to high-risk offenders.

In 2012, "A Meta-Analysis of Moral Reconation Therapy" was published for the International Journal of Offender Therapy and Comparative Criminology. The study considered criminal offending subsequent to treatment as the outcome variable. The overall effect size measured by correlation across 33 studies and 30,259 offenders was significant (r=.16), indicating that MRT has a small but important effect on recidivism. Of all, 20 (62%) of the studies were conducted on incarcerated offenders with the balance on community-based offenders. Only 6% of the studies involved female offenders. However, more research is needed and the impacts would be important not only to proponents of MRT, but also to proponents of gender-responsive interventions.

The Moral Reconation Therapy program was chosen because:

- The target population of this project is medium to high-risk offenders;
- It has been proven to be effective in substance abuse treatment;
- It has been shown to reduce recidivism—a goal of our programs;
- Some SLOBH staff have been trained in MRT treatment protocols; and
- It is based in cognitive behavioral therapy and fits well with the other selected evidence based practices used in the County.

Illness Management and Recovery (IMR): The purpose of this practice is to help people to develop personalized strategies for managing their mental illness and moving forward with their lives. The focus of IMR is to provide people with the information and skills they need in order to make informed decisions about their own treatment. The educational materials in the toolkit are written for schizophrenics, bipolar, and major depression (which are consistent with the population of focus for this project). IMR is used on a weekly basis with consumers either individually or as a group for 3 to 10 months. The interventions include: psycho-education; behavioral tailoring (for consumers who choose to take medication); relapse prevention; and coping skills training. Some of the topics presented are: recovery strategies, practical facts on mental illness, building social support, drug and alcohol use, and copying with stress and problems. These strategies will help the BHTC participants establish a clean and sober lifestyle and to improve the quality of their lives with medication compliance (if applicable).

Most of the research on IMR has focused on persons with schizophrenia which is the top disorder being treated in our Co-occurring Disorders Program (Psychiatric Services, 2002). There is research literature on the efficacy of the various interventions of IMR on other diagnostic populations, particularly Bipolar disorder (CIMH, website).

Integrated Dual Disorders Treatment (IDDT):

Stage of the Individual Consumer	Appropriate Interventions
Pre-contemplation & Engagement	Outreach, practical help, crisis intervention, develop alliance, assessment
Contemplation & Preparation Persuasion	Education, set goals, build awareness of problem, family support, peer support
Action – Active Treatment	Substance abuse counseling, medication treatments, skills training, family support, self-help groups
Maintenance – Relapse Prevention	Relapse prevention plan, continue skills building in active treatment, expand recovery to other areas of life

The program is for all adult consumers (both male and female) with both substance abuse or dependence disorders and mental illness, such as schizophrenia, bipolar disorder, or depression. Issued as a SAMHSA Toolkit in 2003, IDDT features include: assertive outreach; stage-wise comprehensive treatment; treatment goals setting with person-centered interventions for each stage; and flexibility to work within each stage of treatment. Examples of interventions that are linked to the stage of the individual are highlighted above:

Integrated Dual Disorders Treatment will address the goals of treatment in its recovery model. IDDT is consumer driven providing unconditional respect and compassion. The clinician is responsible for helping clients with motivation for treatment and the focus is on the client goals and function, not on adherence to treatment.

Most evidence for this practice is found for adults, with a wide range of ages studied primarily ages 18 – 55, both male and female. IDDT has most evidence with Caucasians, with some evidence for African Americans, and more evidence needed for Latinos. Furthermore, the research for this practice has been focused on patients with dual disorders—mental illness (schizophrenia, bipolar, or depression) and substance abuse or dependence.

Recovery Support Services: Recovery Support Services (RSSs) are non-clinical services that assist individuals and families to recovery from alcohol or drug problems. They include social support, linkage to and coordination among allied service providers, and a full range of human services that facilitate recovery and wellness contributing to an improved quality of life. We will focus on SAMHSA's definition of four major dimensions that support a life in recovery:

- Health—overcoming or managing one's disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and, for everyone in recovery, making informed, healthy choices that support physical and emotional well-being.
- Home—having a stable and safe place to live.

- Purpose—conducting meaningful daily activities, such as a job, school volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society.
- Community—having relationships and social networks that provide support, friendship, love, and hope.

First, recovery support needs span the periods of pre-recovery engagement, recovery initiation, recovery stabilization, and recovery maintenance. As such, these service relationships last far longer than counseling relationships that are the core of addiction treatment, are far more likely to be delivered in the client's natural environment, and often involve a larger cluster of family and community relationships.

Second, recovery support relationships are less hierarchical (less differential of power and vulnerability) than the counselor-client relationship, involve different core functions, and are governed by different accountabilities. As such, the ethical guidelines that govern the addiction counselor are often not applicable to the recovery coach.

Third, individual consumers of peer-based recovery support services differ in the kind of non-clinical support services needed, and it is not uncommon for the same person to need different types of support services at different stages of his or her addiction and recovery careers. This requires considerable care in evaluating support service needs, delivering those services within the boundaries of one's knowledge and experience, and knowing how and when to involve other service roles.

Studies find that when an individual's full array of needs (e.g. food, clothing, housing, transportation) is met, short- and long-term outcomes, including retention in treatment and reduction in substance use are improved. Further, Finney, Noyes, Coutts, & Moos (1998) found that recovery oriented support may foster greater self-efficacy and longer abstinence.

Recovery Support Services was chosen as the evidence based practice because:

- It has been shown to be effective with clients with substance use disorders
- Comprehensive medical and social care will be enhanced through RSSs, especially in working with the new population of heroin addicted individuals
- San Luis Obispo is a rural medium sized County and we do not have access to resources and large nonprofits that other urban areas have, so it can be difficult for our clients to navigate the County's resources. Furthermore, being in a rural medium County, public transportation is not as well-designed as larger Counties, and so providing transportation with Recovery Support Services will be paramount.
- Recovery Support Services will be conducted by peers who can pass their strength, hope and experience to others
- Recovery Support Services are individually based and will provide necessary supports to overcome ethnic and gender disparities.

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)?

Although SLOBH intends to coordinate with neighboring counties, SLOBH is not proposing to implement a formalized regional model at this time. Youth residential treatment and possibly adult residential treatment services will require a regional model through contracts with providers in neighboring counties.

15. Memorandum of Understanding. Submit a signed copy of each Memorandum of Understanding (MOU) between the county and the managed care plans. The MOU must outline the mechanism for sharing information and coordination of service delivery as described in 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).

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

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

San Luis Obispo County has one managed care health plan which is combined with Santa Barbara County, known as CenCal Health. We are in the process of amending the current MOU between the San Luis Obispo County Mental Health Plan and CenCal Health, to incorporate related provisions from the DMC-ODS STCs, which was originally executed on October 28, 2008 and revised on September 24, 2015. SLOBH is working on developing the proposed language for the amended MOU and is in the process of meeting together with CenCal Health for discussions. It is expected that the MOU will be signed by the end of September, 2016. A copy of the MOU will be sent to DHCS when approved.

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).

San Luis Obispo County Behavioral Health has implemented a telehealth pilot project based out of the Mental Health Youth Treatment Services. Based upon the initial success of the pilot, the plan is to expand the services throughout the county. This provides behavioral health services for the rural and hard to reach populations in our County. In addition, the county has a dearth of medical professionals and our plan is to expand telehealth services to provide physician, psychiatrist, and nursing accessibility to the clients in the regional mental health and SUD clinics. Services will include consultative and 'direct' client care including medication screening, assessment, evaluation, monitoring, and management. Consultation and 'direct' client care services for the co-occurring disorder mental health and substance use clients, medication assisted treatment, physical health co-morbidities, and other categories may be conducted using telehealth services.

In lieu of a SUD client coming to a Drug and Alcohol Services clinic or a psychiatrist or nurse providing on-site services at multiple clinic locations, telehealth would be used to centralize the services thus improving client access, minimizing travel time, and maximizing the use of the medical professional's time. The medical professional would operate out of one central site, meet with clients and staff over the telehealth network providing direct client care and consultation to the staff. A Drug and Alcohol Services staff member (LPHA or Licensed Psychiatric Technician or Drug and Alcohol Worker) will be with the client, while the medical professional is on the other end of the camera.

The benefits of video-based telehealth include (Maheu, et al, 2004):

- Increased client satisfaction
- Decreased travel time
- Decreased travel, child and elder care costs for the clients
- Increased access to underserved populations
- Improved accessibility to specialists
- Reduced emergency care costs
- Faster decision-making time
- Increased productivity/decreased lost wages for the clients
- Improved operational efficiency
- Efficacy is on par with in-person care for many groups
- Decreased hospital utilization

We propose using telehealth services through mobile devices (tablets, mobile phones, and laptops) using a secure connection such as U-SEE, which would allow provision of services regardless of the location of the client. Staff could have complex case discussions while each member of the team is in a different location and view presentations together. Equipping

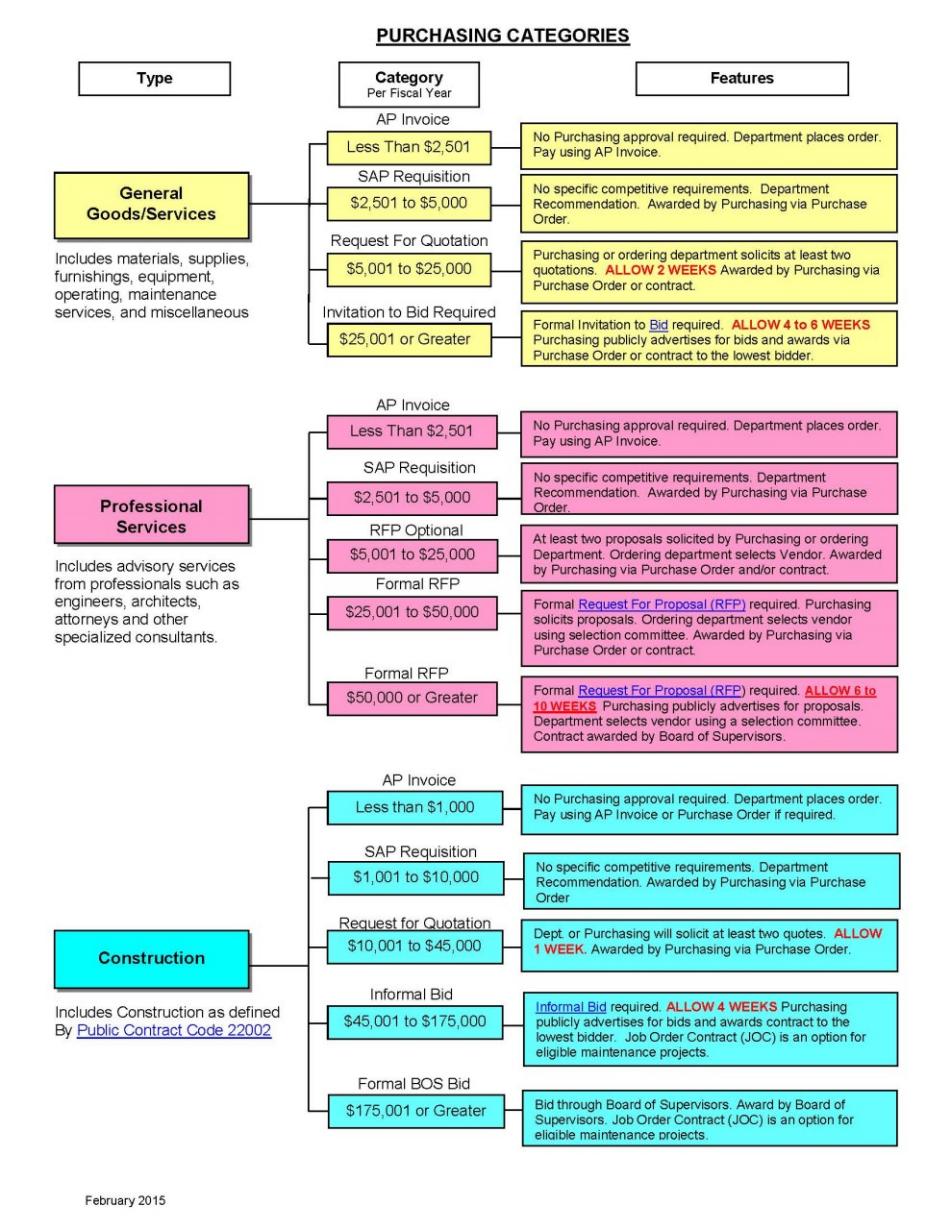
clients with self-care apps on their own mobile devices that could connect them with their case managers beyond 'office hours' and locations or with appropriate recovery support services will also be considered. Technology can offer value for individuals and their families along the entire spectrum of behavioral health services. This may include screening, assessment, prevention, treatment, recovery management, and continuing care (SAMHSA TIP 60, 2015). Additionally, by offering technology assisted care to clients (e.g. encouraging clients to complete online skills training modules), clinicians may increase their time availability for clients with multiple challenges; focus more of their time on the delivery of services that require their clinical expertise and interaction with clients; and enable clients to review repetitive but clinically important content, such as psychoeducational materials, without having to devote extensive time to such activities themselves.

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?

Contracting:

San Luis Obispo County Behavioral Health complies with the San Luis Obispo County policies and procedures for the selection and retention of service providers as described in the County contract manual. These policies and procedures apply equally to all providers regardless of public, private, for-profit or non-profit status. Services contracted under DMC ODS are considered the "Professional Services" category as outlined in the County contracting manual.

Diagram 19. Purchasing Categories



Services under $25,000 can be acquired by a solicitation process that includes a minimum of two firm quotes and a description of how services will be delivered. A formal Request for Proposals (RFP) process may be used but is not required. The provider that best demonstrates

the capacity and capability to deliver quality services, has a strong financial portfolio, and has a realistic implementation plan will be chosen.

For services greater than $25,000 a formal Request for Proposal (RFP) process is required. This process includes the publishing of the project or 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. All RFPs include a sample contract containing all the required terms and conditions.

Once proposals are received San Luis Obispo County Behavioral Health convenes a review panel that may include content experts, other Mental Health and Substance Use Disorder providers, another departmental stakeholder (eg: social services), consumers and or family members. The panel is given criterion to evaluate each proposal and make recommendations to the Behavioral Health Administrator for funding. If necessary in order to make a final recommendation, the panel may choose to interview one of more of the applicants.

Once approved by the Behavioral Health Administrator, a formal recommendation for approval is recommended to either the San Luis Obispo County Purchasing department (contracts under$50,000) or the San Luis Obispo County Board of Supervisors (contracts over $50,000). Once approved by the Board the contract is officially executed. Per County policy the RFP process for contracts above $25,000 may be waived by a justification signed by the Purchasing Department. Situations in which an RFP may be waived include, but are not limited to, emergency situations or those in which an independent contractor is the “sole source” of a particular service in the County.

Contract Term: The County has a 3-year contract term limit. A standard renewal process is in place to request the extension of a contract beyond the 3-year limit. The request requires the review and approval of the Behavioral Health Administrator, the Health Agency Compliance Officer, County Counsel, and, if over $50,000, the by the Board of Supervisors.

Appeals Process: The County has a formal appeals process. This is documented in the contracts manual and in San Luis Obispo County’s standard RFP form that the proposer completes and submits to the County via Public Purchase when proposing to perform services. If a proposer desires to protest the selection decision, the proposer must submit by facsimile or email a written protest within five (5) business days after delivery of the notice about the decision. The written protest should be submitted to the Behavioral Health Administrator in writing, must include the name and address of the Proposer and the Request for Proposals numbers, and must state all the specific ground(s) for the 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 Behavioral Health Administrator will respond to a protest within five (5) 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. The decision of the Behavioral Health Administrator will be final.

Service Continuity: If a current DMC provider is not selected, the County will take responsibility for ensuring the continuity of care for the beneficiary, including working with the beneficiary to secure another alternative service provider, transfer to the newly selected service provider, or appropriate increase or decrease in level of care and transition to that service provider.

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

SLOBH offers or contracts for medically necessary MAT services through Behavioral Health Department staff and contracted office based opiate treatment (OBOT) providers, a NTP program, and a provider network licensed as primary care clinics. Services include: assessment, treatment planning, medication assisted treatment, ordering, prescribing, administering, and monitoring of medications for substance use disorders. Physicians and licensed prescribers in DMC programs will be reimbursed for the ordering, prescribing, administering, and monitoring of medication assisted treatment.

MAT will expand the use of medications for beneficiaries with chronic alcohol related disorders and opiate use. Medications may include: naltrexone, both oral (ReVia) and extended release injectable (Vivitrol), topiramate (Topomax), gabapentin (Neurotin), acamprosate (Campral), and disulfiram (Antabuse). Other medications may be prescribed as indicated for substance use disorders (including FDA approved medications that may become available in the future):

- Opiate overdose prevention: naloxone (Narcan). See Attachment D for naloxone policy and procedures for the County of San Luis Obispo.
- Opiate use treatment: buprenorphine-naloxone (Suboxone) and naltrexone (oral and extended release). Note: Methadone will continue to be available through the licensed narcotic treatment program.
- For tobacco cessation and nicotine replacement therapy as indicated.

An increase in physician time and 1.0 FTE licensed psychiatric technician (LVN/LPT) each for North County and for South County will be needed to increase the availability of MAT to all areas of the county. Patients receiving drug Medi-Cal outpatient treatment services through Drug and Alcohol Services would also be prescribed MAT through the physician (MD) working at the program as need is determined. The patient would then fill the prescription at the pharmacy of their choice. The LVN/LPT would be available at each of the DAS clinics in North County and in South County to monitor side effects, order laboratory testing, provide medication education groups, and document client progress to the medication in the electronic health record, working closely with the program physician to make medication adjustments as needed.

Additionally, SLOBH is currently coordinating care and expanding the availability of MAT outside the DMC-ODS by building the capacity of the entire health system to use these treatments for beneficiaries with a substance use disorder. Behavioral Health Department has a grant funded Opiate Safety Coalition that is training physicians, nurse practitioners, and psychiatrists in primary care and specialty mental health clinics on the efficacy of using MAT, practice guidelines, and medication administration. In addition, the Behavioral Health Department is the expert on naloxone distribution in the County, and we are currently training pharmacies to prescribe this overdose antidote to extend the availability of naloxone into the community. Physician consultation is supporting implementation in areas such as: medication selection, dosing, side effect management, adherence, and drug-drug interactions.

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

All providers shall obtain authorization for residential services prior to referring or admitting a beneficiary. Residential authorization processes are completed to assure beneficiaries access medically necessary services in a timely manner. All authorization and reauthorization are tracked through the EHR on the Behavioral Health Referral Form (see sample in Attachment I). There are four primary pathways that will support beneficiaries in accessing and receiving timely authorization for residential services.

Path 1: Access Line

Beneficiaries are advised to contact the Access Line to inquire about services. When the Access Line screening yields a residential need, an authorization and a BH Service Request for Level 3+ services is created. An appointment is made by the Access Line with the Assessment Coordinator, provided the caller is open to exploring a residential placement. A beneficiary shall be offered an evaluation appointment within 24 hours of the initial call with the Access Line or on Monday morning following a weekend call. Evaluation appointments may be provided face-to-face, by telephone, or by telehealth, and may be provided anywhere in the community.

Path 2: Walk-in Screening

Prospective clients often are referred by family members, friends, clergy, social services and other health providers, already knowing that the beneficiary needs residential placement for treatment or withdrawal management. The Assessment Coordinator will conduct the Screening Tool with the ASAM Criteria. If the results from the screening indicate the likely need for residential treatment the Assessment Coordinator will submit a Behavioral Health Referral Form to the Behavioral Health Managed Care Team for tracking. The Assessment Coordinator will introduce the beneficiary to the Behavioral Health Case Manager who will work to provide the smooth transition to a residential placement. If the client is not eligible for residential level of care, the Assessment Coordinator will facilitate a ‘warm hand-off’ to the provider that best matches the client’s needs (outpatient, intensive outpatient, or ambulatory withdrawal management). If housing is an issue, the Assessment Coordinator and Case Manager will work

to ensure the client is safe, working with Shelter Care providers and Recovery Residences and other temporary housing options.

Path 3: Outpatient Provider Initiated Authorization

Outpatient provider initiated residential authorization requests are made to the regional Assessment Coordinator who will schedule a face-to-face, telephone, or telehealth interview, conducting the ASAM Criteria to determine level of care placement. The Assessment Coordinator will review the client's progress in outpatient treatment, consult with the primary outpatient Specialist, and conduct any other assessment instruments needed. Upon determination that residential treatment is indicated, the regional Case Manager will work with the client to determine the best residential facility available within the timelines. When the outpatient provider makes a residential referral on weekends or holidays or after-hours for evaluation and residential authorization, the client will be referred to the Access Line. The Access Line staff will conduct an ASAM Criteria over the phone and review the client's lack of progress in outpatient treatment. When indicated, the beneficiary shall be granted a preliminary 7-day authorization for residential treatment. The Behavioral Health Referral Form is filled out by the Assessment Coordinator, Case Manager, and/or Access Line and submitted to the Managed Care Team for tracking. Once admitted to care, the residential provider shall request a re-authorization for treatment for continued care at a residential level.

Path 4: Residential Treatment Re-Authorizations

Residential providers shall request a re-authorization, based on the results of the ASAM assessment at least seven (7) days prior to the end of the initial authorization expiration date. This will allow time for the residential provider to transition the client if the request is denied. Upon receipt of a re-authorization request with a treatment summary (including a new ASAM Criteria), Access staff will review the request and based on the review, provide one of the following responses to the requesting residential agency within 24 hours: Approved as Requested; Approved as Modified; Deferred; or Denied.

Maximum Residential Treatment Duration:

Presumptive authorization does not guarantee payment and submission of claims to Medi-Cal are subject to a client's eligibility, services being rendered, and documentation in accordance with Title 22, the ASAM Criteria, and the DMC-ODS STCs. The maximum duration of residential treatment for adolescents is 30 days on an annual basis. For adults, the annual residential services maximum is 90 days per client. A one-time extension of up to 30 additional days on an annual basis may be authorized, when medically necessary. Only two non-continuous 90 day residential episodes may be authorized in a one-year period for adults. Perinatal and criminal justice involved adults may be considered for a longer stay based on medical necessity and with advanced authorization from the Managed Care Team, Access Line, or Assessment Coordinator. The residential treatment authorizations are from 1 day – 30 days, and shall be re-authorized every 30 days maximum. Re-authorizations shall be documented on a client specific Behavioral Health Referral Form, located in the EHR, with appropriate authorization signatures. A copy of the Behavioral Health Referral Form shall be forwarded to the Behavioral Health Managed Care

Team who will work with the Finance Team for appropriate invoice, DMC billing and pay source monitoring. Other non-Medi-Cal funds can be used for extended lengths of stay.

Denials of Services – Appeals Process:
If medical necessity is not demonstrated during the authorizations or re-authorizations process, the residential authorization shall be denied. The provider shall be notified of the denial in writing with the denial reason. The client will be notified of the denial in writing on a standard Notice of Action form. Clients or providers advocating on the client's behalf may appeal the service denial. The client or provider must send a written letter describing why the client/provider disagrees with the service denial, and why the client meets medical necessity for the requested service modality. The letter shall be faxed to the Access Line. A Review Committee will be convened and must make a final determination within seven (7) days of the initial authorization request. The Review Committee's decision will be final.

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.

Residential treatment is biggest barrier to the implementation of the DMC-ODS in the County of San Luis Obispo. Although we currently have a perinatal (women with children) residential treatment provider, contracts with neighboring residential treatment providers or other out of county residential treatment providers will need to be secured and are not currently available upon implementation of the pilot. Outpatient treatment services are currently available in Paso Robles in accordance with the DMC-ODS requirement, however, not to the level of accessibility that we expect. In addition, due to the need to secure a larger clinic in the Paso Robles area and requirements of the existing lease, the full operation of the outpatient treatment clinic in Paso Robles will be implemented in a phase-in plan. Youth outpatient treatment services will be expanded onto school campuses as a priority in September, 2016. The intensive outpatient treatment program for youth and their families is scheduled to commence in January, 2017. See the implementation timeline with deliverables below:

Table 20. Year One Implementation Timeline

Requirement	Deliverable Tasks	Timeline
MOU with CenCal Health	Finalized, signed and approved MOU document sent to DHCS	September 30, 2016
24/7 Access Line	This service is currently available, however, the County is in process of determining other options for providing the overnight call handling	September 30, 2016

Paso Robles expanded outpatient treatment services	New clinic site certified, staff hired, and expansion complete	January 1, 2017
Youth Intensive Outpatient Tx	Staff hired and program implemented	January 1, 2017
Youth Residential Treatment	RFP for in-County or out-of-County youth residential treatment providers	January 1, 2017
Adult Residential Treatment	RFP for in-County or out-of-County residential treatment providers for a variety of adult services	January 1, 2017

County Authorization

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

Anne Robin, LMFT
County Behavioral Health Administrator
County of San Luis Obispo

San Luis Obispo County

7/5/16
Date

Drug Medi-Cal Organized Delivery System

Implementation Plan
For
County of San Luis Obispo

Health Agency

Behavioral Health Department

Attachments

Attachment A. Stakeholder Attendance Sheets

ACA Planning Group Agenda

ACA Planning Group

Coordinated planning for a new health care system

Tuesday, February 16, 2015

3:00 PM to 5:00 PM

SLO City/County Library

Community Conference Room

995 Palm Street (at Osos), SLO

www.SLOpublichealth.org/ACA

Contact: Michelle Shoresman
SLO County Public Health Department
mshoresman@co.slo.ca.us ▪ 805-781-5192

AGENDA

1. Welcome and Introductions
   - Roundtable Updates by Agency Representatives
2. Drug Medi-Cal Organized Delivery System: What's Happening and What's New (Star Graber)
3. Medi-Cal Update
   - DSS Update
   - Enrollment #s (CenCal)
4. Outreach to Undocumented Kids
5. B-HIP Update
6. Covered California Enrollment – Statistics to date
   - Enrollment Issues – Advocacy Needed
7. Other business

REMINDERS

- Next Meeting: Tuesday, ------- , 2015; 3:00–5:00, SLO County Library
- Visit the ACA Planning Group webpage at www.SLOpublichealth.org/ACA to find meeting notes, schedules, presentations and handouts, plus lots of resource links and materials, including brochures, fact sheets, and presentations for consumers and stakeholders.

ACA Planning Group Sign-In Sheet

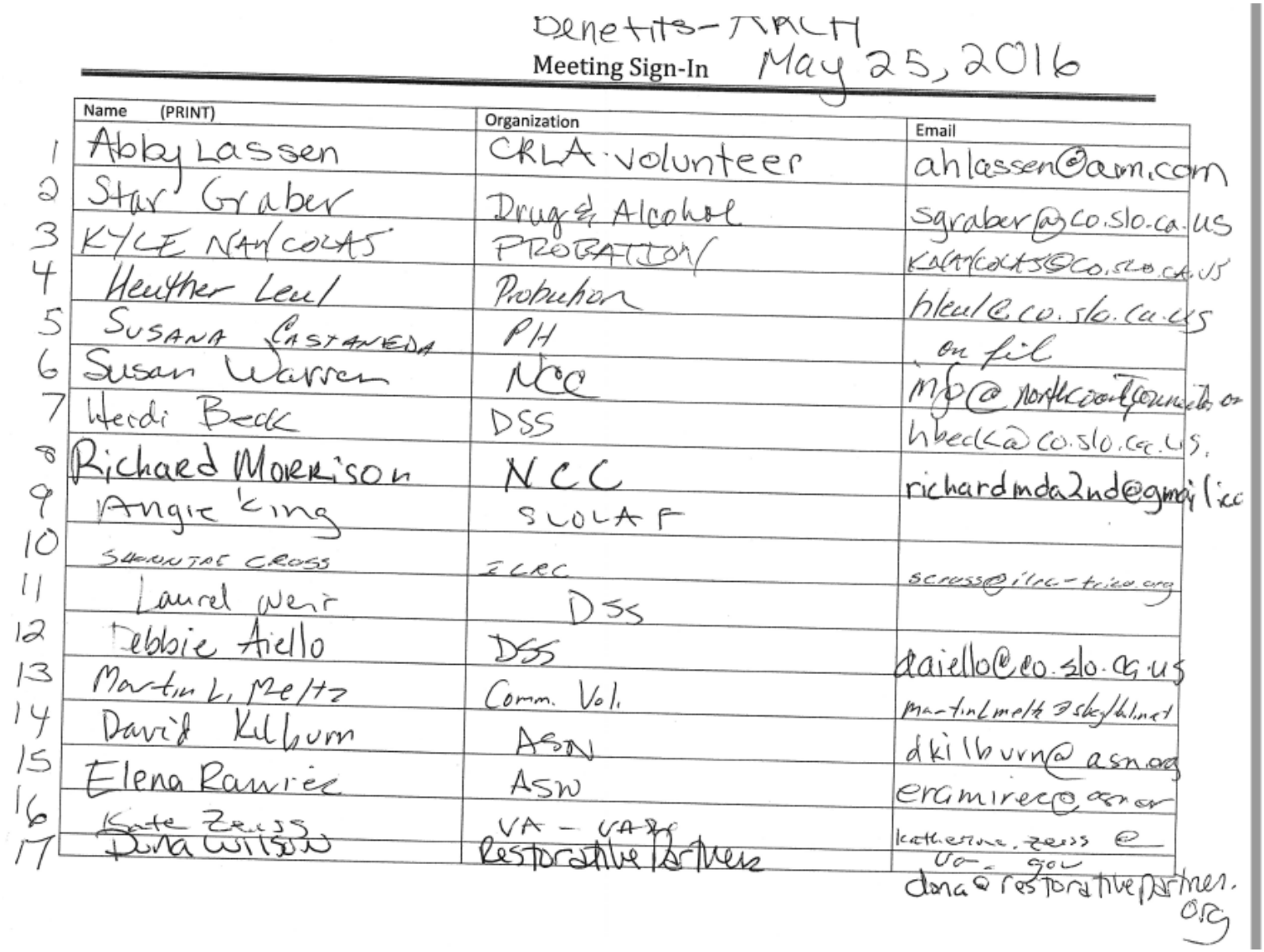
SIGN IN SHEET

2/16/16

ACA Planning Group

PRINT NAME	AFFILIATION	E-MAIL Not necessary if we already have it.
Kip Meredith	Insurance Agent	Kip@MeredithInsuranceCenter.com
Stan Graber	BEHAVIORAL HEALTH	sgraber@co.slo.ca.us
MICHAEL FRAMBERGER	INSURANCE AGENT	FRAMBERGER@CHARTER.NET
JOEL DIRINGER	D A	joel@diringerassociates.com
Abby Lassen	~~Behavioral~~ Benefits ARCH	ahlassen@aim.com
Susan Ross	consultant	
Becca Cassel	First 5 Health Access	
Penny Borenstein	PHD	
Wendy Wendt	First 5	
Mayra Valencia	CAPSLO	mvalencia@capslo.org
Mike Taylor	Health	

ARCH Benefits



Benefits-ARCH

Meeting Sign-In May 25, 2016

	Name (PRINT)	Organization	Email
1	Abby Lassen	CRLA · volunteer	ahlassen@am.com
2	Star Graber	Drug & Alcohol	sgraber@co.slo.ca.us
3	KYLE NANCOLAS	PROBATION	KANCOLAS@CO.SLO.CA.US
4	Heather Leul	Probation	hleul@co.slo.ca.us
5	SUSANA CASTANEDA	PH	on file
6	Susan Warren	NCC	mfo@northcoastfoundation.org
7	Heidi Beck	DSS	hbeck@co.slo.ca.us,
8	Richard Morrison	NCC	richardmda2nd@gmail.com
9	Angie King	SLOLAF	
10	SHANNAE CROSS	ECEC	scross@ilrc-trico.org
11	Laurel Weir	DSS	
12	Debbie Aiello	DSS	daiello@co.slo.ca.us
13	Martin L. Meltz	Comm. Vol.	martinLmeltz@sbcglobal.net
14	David Kilburn	ASN	dkilburn@asn.org
15	Elena Ramirez	ASW	eramirez@asn.org
16	Kate Zeuss	VA - VASH	katherine.zeuss@va.gov
17	Dona Wilson	Restorative Partners	dona@restorativepartners.org

Atascadero Clinic ODS-DMC Stakeholder Presentation Sign-In Sheet

Sign In Sheet

ODS-DMC Stakeholder Presentation

Tuesday January 19, 2016 from 12:30 - 2:30 pm

NAME	AGENCY	EMAIL/PHONE
1. Holl-lee Lawrence	DAS	hlawrence@co... \ 461-6038
2. Kelsey Fermo	DAS	ktermo@co... \ 461-6058
3. Kim Schwab	DAS	kschwab@co / 461-6234
4. Rinda Bartlett Hartley		rbartlettartley@co... 461-6080
5. Clark Guest	DAS	cguest@co.slo.ca.us 461-6080
6. Nathaniel Reynolds	DAS	nareynolds@co.slo.ca.us / 461-6086
7. [illegible]	DAS	eleigan@co.slo.ca.us 458-0832
8. Monica Butler	DAS - Atas.	mbutler@co.slo.ca.us 461-6857
9. Mollie Beek	~~DAS~~ - "	mbeek@co.slo.ca.us 461-6157
10. Dawn Glove	DAS	DGlove@co.slo.ca.us.
11. Justin Hodges	DAS	JHodges@co.slo.ca.us
12. Paterese Reynolds	DAS	pmreynolds@co.slo.ca.us 461-6087
13. Jenny Gustavson-Dufour	DAS	jgustavson@co.slo.ca.us 461-6039
14. Michael Axelrod	DAS	MAxelrod@co.slo.ca.us 4616191
15. Lana Adame	DAS	LAdame@co.slo.ca.us
16.		
17.		

Behavioral Health Board Agenda 2-17-16

Behavioral Health Board Meeting
2180 Johnson Ave., 2nd Floor, Library Conf. Room
San Luis Obispo, CA 93401
February 17, 2016 3:00pm-5:00pm 805-781-4719

1. CALL TO ORDER

2. INTRODUCTIONS AND ANNOUNCEMENTS

3. PUBLIC COMMENTS: CITIZENS ARE INVITED TO MAKE COMMENTS RELEVANT TO BEHAVIORAL HEALTH ISSUES AT THIS TIME. WE ASK THAT YOU LIMIT THE TIME TO THREE MINUTES.

4. APPROVAL OF MINUTES FROM JANUARY 20, 2016 MEETING.

5. ONGOING BUSINESS:

   A) OTHER OPPORTUNITIES FOR TRAINING: RELIAS TRAINING- KEN TASSEFF

6. NEW BUSINESS:

   A) FIREARMS RESTRAINING ORDER PRESENTATION- LEE CUNNINGHAM
   B) IMPLEMENTATION PLAN- GREG VICKERY

7. PRESENTATION: DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM- DR. STAR GRABER

8. ADJOURNMENT.

AUDIO RECORDINGS WILL BE MADE OF BEHAVIORAL HEALTH BOARD MEETING TO ENSURE ACCURACY OF MINUTES.

For questions about this agenda, please call Laura Zarate at lzarate@co.slo.ca.us or 1-805-781-4719.

Compliance Notices:

NOTE: In compliance with the Ralph M. Brown Act (California Government Code 54950-54963) this meeting shall be publicly open to all members of the public, press/media, audio and/or video recording, still or motion picture camera filming, without requiring a sign-in or identification of themselves.

NOTE: In compliance with the American with Disabilities Act of 1990 (42 U.S.C. Sec. 12132), if you need special assistance to access the meeting room or otherwise participate at this meeting, including auxiliary aids or services, please contact Laura Zarate at lzarate@co.slo.ca.us or 1-805-781-4719. Notification of at least forty-eight (48) hours prior to the meeting will help enable the County of San Luis Obispo staff to make reasonable arrangements to ensure accessibility to the meeting.

NOTE: In compliance with the Americans with Disabilities Act of 1990 (42 U.S.C. Sec. 12132), if you need and wish to request appropriate alternate formats to accommodate a person with a disability, please contact Laura Zarate at lzarate@co.slo.ca.us or 1-805-781-4719.

NOTE: In compliance with the California Public Records Act aka CPRA (California Government Code 6250-6270), this agenda and all meeting materials distributed with it and during this public meeting shall be made available upon request and if requested in an appropriate alternate formats to accommodate a person with a disability, please contact Laura Zarate at lzarate@co.slo.ca.us or 1-805-781-4719

You may also view BHB Agenda and Minutes at
http://www.slocounty.ca.gov/health/mentalhealthservices/Behavioral_Health_Board/Behavioral_Health_Board_Agendas___Minutes.htm

Behavioral Health Board Minutes 2-17-16

Behavioral Health Board Minutes
San Luis Obispo County
February 17, 2016
3:00 – 5:00 p.m.
Health Campus Library Conference Room, 2180 Johnson Ave
San Luis Obispo, CA 93401

MEMBERS PRESENT:
Martin Bragg
Aurora William
Clint Weirick
Joyce Heddleson
Marshall Hamilton
David Riester
Jim Salio
Jill Heuer

GUESTS:
Joe Madsen (THMA)
Diane Leenders (ACTTCPA)
Lee Cunningham-Assistant District Attorney

MEMBERS AND ALTERNATES ABSENT:
Frank Mecham
Ian Parkinson
Kelly Kenitz (for Sheriff Parkinson)
Loretta Butterfield
Pam Crabaugh
Jason Reed
Robert Reyes
Karl Hansen
Linda Connolly
Theresa Scott
Vicki Fogleman (for Sup. Mecham)

BEHAVIORAL HEALTH STAFF PRESENT:
Anne Robin
Raven Lopez
Frank Warren
Dr. Star Graber
Ken Tasseff
Greg Vickery

1. **Meeting was called to order @ 3:05 pm by Martin Bragg.**

2. **Introductions and Announcements:**
   - Round-table introduction.
   - Aurora William: It is that time of year for Grant Review -submitted to the County for Community-based Organizations of Prevention Grant Money. If interested in being a reviewer, contact Aurora Williams.
3. **Citizen Comments:**
   None.
4. **Approval of Minutes:** The minutes of the meeting of January 20, 2015 were reviewed and approved M/S/C: Salio/Hamilton.

5. **Ongoing Business:**

   a) **Other Opportunities for Training: Relias Learning- Ken Tasseff:**
      - Behavioral Health purchased Relias for trainings to increase knowledge in Behavioral Health and obtain CEUs. Relias offers a great selection of courses from Cultural Competence to Suicide Prevention and many more. Behavioral Health purchased 500 licenses of which 350 are used for Behavioral Health Department and 150 are reserved for our partners. Out of that 150, some are available for Behavioral Health Board Members interested in enrolling.
        There are mandatory trainings like Privacy and Security Policy, Fraud Waste and Abuse etc. for our employees and Relias allows us to track who has taken these mandatory trainings. We are happy to say we are 100% compliant.

Ken gave a brief overview of how Relias looks, how to navigate it and showed the different trainings available.

6. New Business:

A) Firearms Restraining Order Presentation-Lee Cunningham

- Lee Cunningham presented the following regarding the Law that took effect on January, 2016 that allows family to temporarily retrieve guns or ammunition from person who has it:
  Firearms Restraining Order Presentation.pdf

B) Implementation Plan- Greg Vickery:

Implementation Plan Approved_2015.pdf

Greg Vickery will be at BHB Meeting next month to answer any questions.

7. Presentation: Drug Medi-Cal Organized Delivery System- Dr. Star Graber:

Dr. Star Graber began her power-point presentation at 3:45pm with one handout:

- Drug Medi-Cal Organized Delivery System (DMC-ODS).

May find the DMC-ODS Presentation Here:
DMC ODS February 2016.pptx

The Behavioral Health Board unanimously agrees to support moving forward with the Drug Medi-Cal Organized Delivery System. M/S/C: Salio/Riester

9. Adjournment: Meeting was adjourned at 4:55pm

The next Behavioral Health Board meeting will be Wednesday, March 16, 2016, 3:00pm – 5:00pm in the Library Conference Room, Second floor of Health Campus -Laura Zarate

Criminal Defense Training 1-13-16 Sign-In Sheet

Organized Delivery System, Forensic, & P-36 Training

Criminal Defense January 13, 2016

Name:	Department:	Email:	Signature:
Carlie M Peterson	CCPD	carliempeterson@gmail	
CARRIE WINTER	PD	cwinters@gmi...	
EARL CONAWAY	CPD	earl@conawaylawfirm.com	
MELODIE BEARD	PD	melodie@mwelleranwellercm	
Scott Taylor		scott@taylordefenfirm.com	
CHRIS CUMMINGS	PD	SLO_DEFENDER@YAHOO.COM	
Ann Wilson			
Dan Hilton			
Matt Hanley		hanleym.slocrimlaw@gmail.com	
J MAGUIRE	PD	JMAGUIRE@SLODEFEND.com	
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Amy Broomfield	Paralegal PD		
Kenneth Cima	PD	kmcima@yahoo	
Michael Adams	PD	adam luc 13@ yahoo	
RON CRAWFORD	PD Bar # 71521	RGCRAWDAD@HOTMAIL.COM	

Organized Delivery System, Forensic, & P-36 Training

Criminal Defense January 13, 2016

Name:	Department:	Email:	Signature:
Jay Peterson	CPD	jayapeterson@hotmail.com	
Angela Kowal	PD	amkowal@sbcglobal.net	
JOHN SAEHS		JFSAEHS@aol.com	
	presented by		
	Clark W Guest		

CWS Training 3-2-16 Sign-In Sheet

Organized Delivery System Training

Criminal Justice & Forensics Programs

Child Welfare Services March 2, 2016

DSS: Our Guest Trainees need their own sign in sheet

Name:	Department:	Email:	Signature:
JoAnn Overbey	DSS	joverbey@co.slo.ca.us	JoAnn Overbey
Julie Stefanko	DSS	jstefanko@co.slo.ca.us	
Katy Collier	DSS	kcollier@co.slo.ca.us	Katy Collier
Adelia Avila	DSS	adiello@coca.slo.us	
[illegible]	DSS		
Rosa Lopez	DSS		
Melissa DeRose	DSS		
Mark Henderson	DSS		
Monica Monroy	DSS		
Nancy Kuster	DSS		
Tammy Brown	DSS		Tammy Brown
Belinda Benassi	DSS	bbenassi@co.slo.ca.us	
C. Monroy	DSS		
David Platt	DSS	dplatt@co.slo.ca.us	

Organized Delivery System & Forensic Training—Child Welfare Services March 2, 2016

Name:	Department:	Email:	Signature:
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Sheri Robertson	DSS	srobertson@co.slo.ca.us	
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Patricia Ransome	DSS	Ransomic@co.slo.ca.us	
Angella Holmes	DSS	aholmes@co.slo.ca.us	AHolmes
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Mary Cartier	DSS	MCartier@co.slo.ca.us	
Jim Mudge	DSS	jmudge@co.slo.ca.us	
Leah Tetz	DSS	LTetz@co.slo.ca.us	LeaTetz
	Not everyone signed in as there was a total of 42 present		
			Clark W Grant 3-2-16

District Attorney's Office Training 11-20-15 Sign-In Sheet

Organized Delivery System, Forensic, & P-36 Training

District Attorney's Office November 20, 2015

Name:	Department:	Email:	Signature:
Andrew Baird	DA	abaird@co.slo.ca.us	Andrew Baird
Sandy Mitchell	DA	smitchell@co.slo.ca.us	
Matthew Kennedy	DA	mkennedy@co.slo.ca.us	
Jesse Martinez	DA	jmartinez@slo.ca.us	
Tom Wilson	DA	TWilson@co.slo.ca.us	
Nick Quincey	DA	nquincey@co.slo.ca.us	
Kathleen Philpot-Secrest	DA	Philpot-katee@hotmail.com	
Lindsey Bittner	DA	lbittnera@co.slo.ca.us	
Fabiana Fedo	DA	ffedo@co.slo.ca.us	
Kelly Mandarino	DA	kmandarino	
Greg Devitt	DA	gdevitt	
Ashley Cervera	DA	acervera@co.slo.ca.us	
Nikhil Dandekar	DA	ndandekare co...	
Sheryl Wolcott	DA	swolcott@co.slo.ca.us	
Dan Dow	DA	ddow@co.slo.ca.us	

Clark W Grant

Organized Delivery System, Forensic, & P-36 Training

District Attorney's Office November 20, 2015

Name:	Department:	Email:	Signature:
C. White	DA	CDWhite@co.slo.ca.us	

DMC-ODS Presentation February 2016

Drug Medi-Cal Organized Delivery System (DMC-ODS)

Star Graber, PhD, LMFT
Division Manager
SLO Behavioral Health Department

February 2016

Five years ago in SLO

2011 Substance Use Disorder Treatment

- Evidence based practices (Matrix)
- Three days per week (groups)
- Women & Children POEG & 1 residential
- Criminal justice domination (Prop 36, ADC)
- MH & SUD integration just starting
- No medi-cal, lots of grants, self-pay

This past year Affordable Care Act (ACA) and DMC Certification

Behavioral Health in ACA
Mental Health and Substance Use

- Essential Health Benefits:
  - Required Services – behavioral health treatment is one of ten categories that must be included in all qualified health plans and alternative benefit plan
- Parity:
  - Mental Health and Substance Use Disorder (SUD) treatment must be provided at parity with physical health

Expanded Substance Use Disorder Benefits

- Intensive outpatient treatment (IOT) for all populations
- Residentially-based SUD services for all populations
- Medically necessary inpatient detoxification (hospital based)

SUD Implications of ACA

- Mix of payor sources
- Pre-ACA: 30% medi-cal
  40% self-pay
  10% private insurance
  20% grant sponsored

Post-ACA: 70% medi-cal
10% private insurance
20% self-pay/grant sponsored

SLO BHD Substance Use Disorder Services: Beneficiaries

- Significant changes:
  - Over 135 newly eligible for Medi-Cal
  - Over 300 currently open clients "converted" from unsponsored to Medi-Cal
  - Increased severity of substance use disorders, increased co-occurring disorders, increased opiate and alcohol disorders
  - Intensive Outpatient Treatment services implemented for all County SUD clinics
  - Increased medication services
  - Increased hours for clinic-based Withdrawal Management

SLO BHD Substance Use Disorder

- Drug and Alcohol Services is the primary SUD Medi-Cal provider in County currently
- 17 new Drug & Alcohol Services staff hired in FY2014-15
- Wait list has continued to decrease as staff have been hired
- Expect to continue seeing increase of requests for treatment, expect more severe addiction issues

SUD Wait List

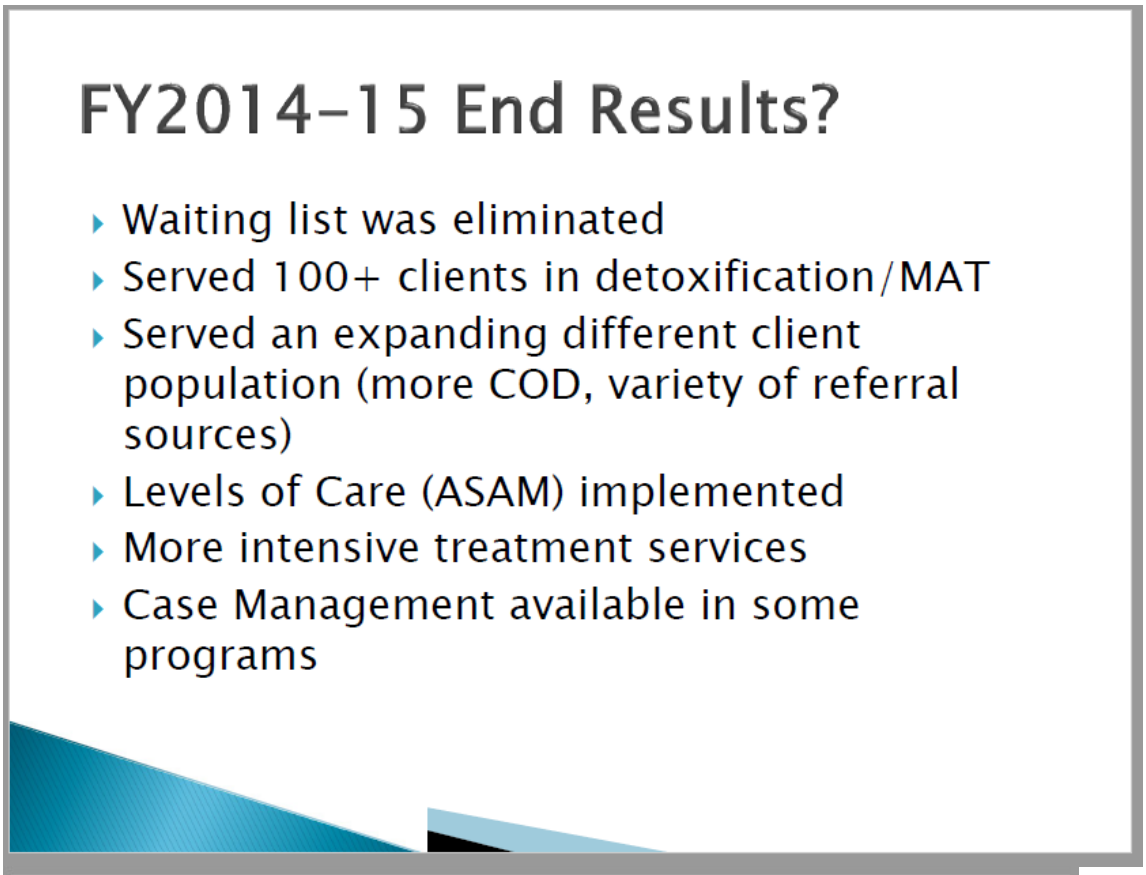
Clinic	Days On 2014	Days On 2015	# Clients On 2014	# Clients On 2015
Atascadero	47	12	55	3
Grover Beach	31	25	24	24
SLO	22	12	8	7
Paso Robles	n/a	0	0	1

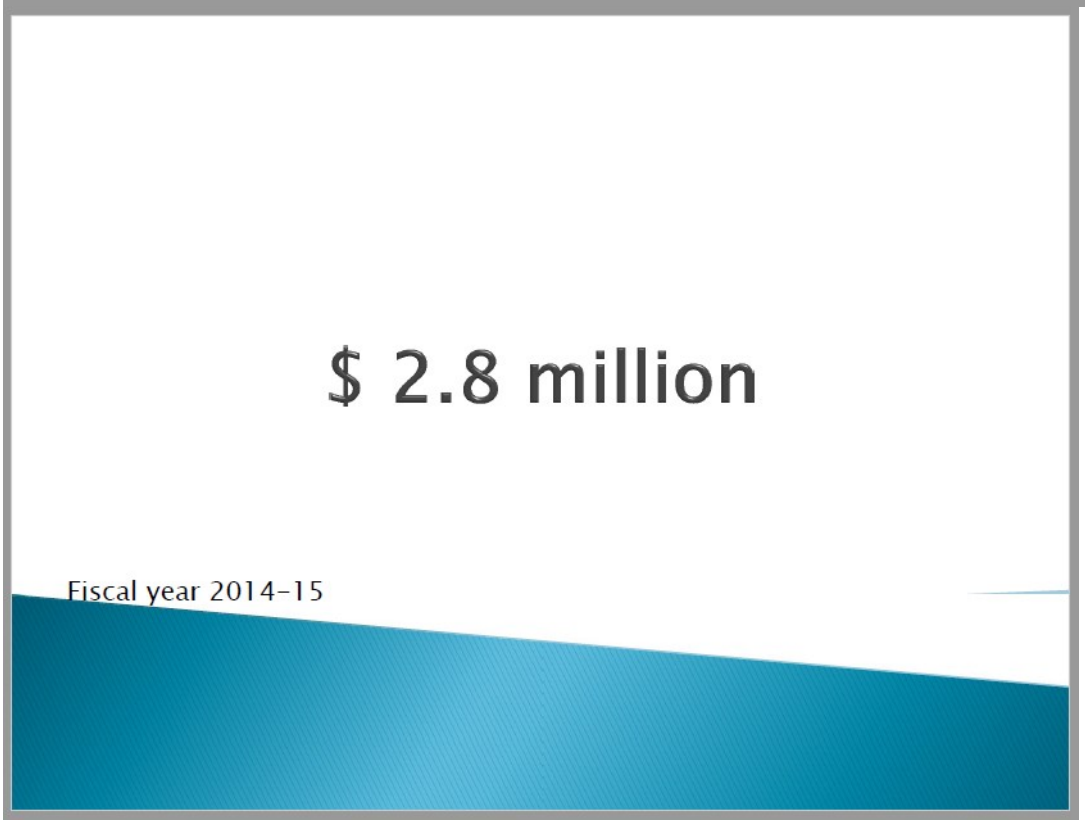
Expanded SUD Treatment

- Intensive Outpatient Treatment (IOT) implemented (4 tracks in 3 clinics)
- Outpatient Treatment expanded slightly
- Court screenings of COD individuals (grant and AB109 funding)
- In-custody COD treatment for inmates at the County Jail (AB109 funding)

Infrastructure Changes

- Added Drug Medi-Cal training continual basis
- Added HIT positions to scour charts, bring to compliance with medical records, and work with billing and finance
- Added ASO position to work with DHCS certification, outcomes, and data related to treatment services
- Added internal Quality Assurance Committee, peer review of charts


FY2014-15 End Results?
Waiting list was eliminated
Served 100+ clients in detoxification/MAT
Served an expanding different client population (more COD, variety of referral sources)
Levels of Care (ASAM) implemented
More intensive treatment services
Case Management available in some programs


$ 2.8 million
Fiscal year 2014-15

Future Organized Delivery System (DMC-ODS)

- San Luis Obispo is a Phase 2 County
- Technical assistance by DHCS
- In person meetings with So CA Counties
- TA phone calls
- Submitted County Budget Plan to opt-in
- Conduct stakeholder process – chance to provide feedback (NOW)
- Write the County's Implementation Plan (April 1, 2016) to Board of Supervisors
- Opt-in Decision

County is responsible for all DMC providers and services

- County intake and assessment coordinators in each regional clinic (gate keeper or authorization function for all SUD DMC services)
- Use of the American Society of Addiction Medicine (ASAM) Criteria for level of care placement determination
- Authorizations for residential treatment within 24 hours

ASAM Criteria

- Placement into the most appropriate, least restrictive level of care, providing safety and security for the patient
- Multi-dimensional assessment around six dimensions (acute intoxication/withdrawal, biomedical, emotional/behavioral, readiness to change, relapse/continued use, and recovery environment)
- Matches patient's severity of SUID illness with treatment levels

Levels of Care for Treatment

ASAM Level of Care	Service	Description
.50	Early Intervention	At risk individuals, do not meet SUD diagnosis
1	Outpatient	Less than 9 hours of service per week for adult, less than 6 hours for youth
2.1	Intensive Outpatient	9 or more hours per week for adults, more than 6 hours for youth
2.5	Partial Hospitalization (not required)	20 or more hours of service per week, not requiring residential care
3.1	Clinically managed, low-intensity residential	24-hour care with trained counselors to stabilize imminent danger, less intense milieu (sober living environment + treatment)
3.5, 3.7	Residential treatment services	24-hour care with trained staff providing treatment on-site
4	Medically managed inpatient	24-hour nursing care and daily physician care for severe unstable problems, counseling available to engage into treatment

Levels of Care for WM

ASAM Level of Care	Withdrawal Management	Description
1-WM	Ambulatory WM without extended on-site monitoring	Mild withdrawal with daily or less outpatient supervision
2-WM	Ambulatory WM with extended on-site monitoring	Moderate withdrawal with all day support and supervision
3.2-WM	Clinically managed residential WM	Moderate withdrawal but needs 24 hr support
3.7-WM	Medically monitored inpatient WM	Severe withdrawal, needs 24hr nursing visits
4-WM	Medically managed intensive inpatient WM	Severe, unstable, daily physician (hospital)

Required Elements of DMC-ODS

- Outpatient (Level 1)
- Intensive Outpatient Treatment (Level 2)
- At least one ASAM level of residential services
- All ASAM levels (3.1, 3.3, 3.5) within 3 years
- Coordination with ASAM levels 3.7 and 4.0
- Withdrawal management (at least one level)
- Recovery Services
- Case Management
- Physician Consultation

Eligibility & Medical Necessity

- Medicaid eligibility must be verified by County
- Reside in the participating County
- Must have one diagnosis from DSM for SUD OR be assessed to be at risk for developing SUD (youth under age 21)
- Must meet ASAM criteria and placement into treatment services

New and Minor Changes

- LPHA language for intake, diagnosis, treatment plans and 6-mo Justifications—LPHA can sign.
- SUD treatment Services can be provided "in any appropriate setting in the community".
- Intake/Screening is covered benefit
- Individual therapy (without restrictions)
- Family therapy (different than collateral)
- Patient education
- Medication services required

Residential Treatment

- Short-term residential (1-90 days), up to six months for criminal justice clients and perinatal services
- Residential services provided in a DHCS licensed facility and ASAM level designation
- Authorization for placement into residential facilities is conducted by the County

Medication Assisted Treatment

- Buprenorphine or Suboxone for opiate users.
- Alcohol dependence: Naltrexone (Vivitrol), Disulfiram (Antabuse), and Acamprosate.
- Ambulatory detoxification services.
- Naloxone (Narcan) distribution program for DMC-ODS beneficiaries.

Additional Medical Services

- Components that will be covered: ordering, prescribing, administering, and monitoring of MAT
- Physician consultation – this is a service for clinical staff and other medical staff (not for the beneficiary)

Case Management

- Counties must coordinate the case management services for SUD clients
- Services provided by LPHA or certified counselor
- Recorded in 15 minute increments

Recovery Services

- Outpatient recovery counseling
- Recovery coaching
- Monitoring via telephone and internet
- Education and job skills
- Family support
- Support groups
- Ancillary services

DMC Organized Delivery System Waiver

- Quality Assurance Activities (Beneficiary Access Number, Beneficiary Handbook). Also Quality Improvement Plan and Committee
- Telehealth allowable
- Utilization Controls (EQRO, Tri-ennial audits)
- Selective Provider Contracting
- Evidence Based Practices—at least 2
- Continuum of Care
- Evaluation to be provided by UCLA

"No person eligible for DMC-ODS services will be placed on waiting lists for such services due to budget constraints"

DMC-ODS: In Summary

No Opt-In	Opt-In
Must maintain current service types and levels	County residents only
Must maintain current DMC rate structure, fee for service set by State	New fee rates based upon the costs per service (set by each County)
None of the new services to be added	New services (residential, case management, recovery services, MAT)
No selective contracting process	Selective contracting with providers
County control over providers minimal	No waiting lists, access time monitored
Existing services at risk due to fiscal impacts	Increased QA
Waiting lists for services	Integration with MH
	Evidence based practices

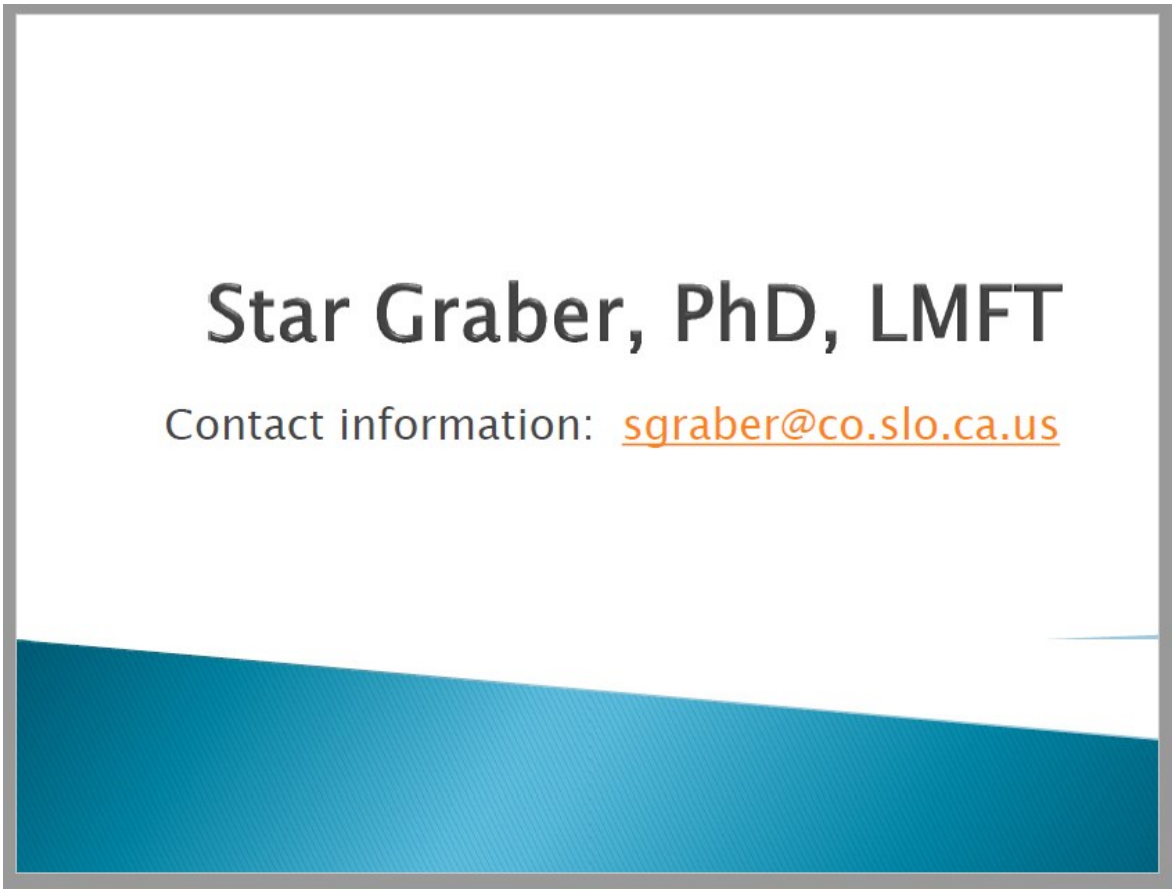
Next Steps DMC-ODS

- Stakeholder process to develop the local plan
- Determine fiscal modelling
- Determine impacts
- Write the County Implement Plan (April 1)
- Request permission to Opt In
- Submit the Plan and get approval from DHCS
- Submit the State-County contract to opt-in
- County budget hearings
- Commence new services (July - Oct 2016)
- Two year process anticipated

Looking Further Forward

- Integrated Health Care (think Emergency Rooms, CHC clinics, primary care physician screening for SUD)
- Care coordination across systems
- Health Information Exchanges (HIE)
- DMC Payment Reforms

Questions and Suggestions


Star Graber, PhD, LMFT
Contact information: sgraber@co.slo.ca.us

FTC Steering Committee Presentation 3-15-16 Sign-In Sheet

Sign In Sheet

DMC-ODS Stakeholder Presentation/FTC Steering Committee

Tuesday March 15, 2016 from 3:30 – 5:00 pm

NAME	AGENCY	EMAIL/PHONE
1. Cherie Vallelunga	Co. Co.	CVallelunga@co.slo.ca.us 781-5435
2. MARK HAAS	DSS	mhaas@co.slo.ca.us
3. Tim Covello	Sup. Ct.	timothy.Covello@slo.courts.ca.gov
4. Desiree Trahan	DSS	Dtrahan@co.slo.ca.us
5. Melissa DePorter	DSS	mdeporter@co.slo.ca.us
6. Kassi Bledsoe	DSS	KBledsoe@COSLO.ca.us
7. Kim Schwab	DAS	Kschwab@co.slo.ca.us
8. IRMA PEREZ	DAS	
9. Gail Wechsler	CASA	~~Gail~~ gwechsler@SLOCASA.org
10. Sandy Wortley	Bryans House	saswort2a@gmail.com
11. Debra Barriger	COCO	dbarriger@co.slo.ca.us
12. Megan Jenkins	GR/DAS	majenkins@co.slo.ca.us
13.		

Grover Beach Drug and Alcohol Presentation 2-2-16 Sign-In Sheet

Sign In Sheet

ODS-DMC Stakeholder Presentation

Tuesday February 2, 2016 from 12:00 - 1:30 pm

	NAME	AGENCY	EMAIL/PHONE
1.	Nat Read	DAS-GroverBch	nread@co.slo.ca.us 473-7080
2.	Elba Vasquez	Drug & Alcohol Services (POEG) Worker 1	evelazquez@co.slo.ca.us 540-8364
3.	Ricardo López	Drug & Alcohol Services	rslopez@co.slo.ca.us/602-6998
4.	Gloria Lopez	DAS/Clerical	gllopez@co.slo.ca.us/473-7080
5.	Candance McGuinness	DAS - GB	cmcguinness@co.slo.ca.us/473-7186
6.	[illegible] CANTU	DAS GB	HCANTU@CO.SLO.CA.US/473-7024
7.	Robert Gurrola	Drug & Alcohol Services	rgurrola@co.slo.ca.us 805 473-7084
8.	Robert Ortega	DAS	rortega@co.slo.ca.us 788-2524
9.	LEN BROCK	DAS/DUI	lbrock@co.slo.ca.us 473-7146
10.	CATHLEEN RAFFERTY	DAS	8680266 crafferty@co.slo.ca.us
11.	Elexia Estrada	DAS GB	eestrada@co.slo.ca.us 473-7085
12.	Deanna Franklin	DAS GB	dfranklin@co.slo.ca.us 473-7003
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15.	Kristina Paramore	DAS EIB	kparamore@co.slo.ca.us 473-7087
16.	Colin Quennell	DAS-GB	cquennell@co.slo.ca.us. 473-7004
17.			
18.			
19.			

CWS Inter-Agency Presentation 4-21-16 Sign-In Sheet

Levels of Care & Organized

Delivery System Training Interagency Meeting at Child Welfare Services on April 21, 2016

Name:	Department:	Email:	Signature:
Tina Lehman	Kinship Center	tina-lehman@senecacenters.org	
Sandra Jimenez	DSS	sjimenez@co.slo.ca.us	
Lily Holzner	Cuesta College	lily_holzner@cuesta.edu	
Michelle Lave	DSS	mlave@co.slo.ca.us	
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Alondra Ortiz	Catholic Charities	aortiz@catholiccharitiescentralcoast.org	
Vivian Soul	TMHA	VSoul@T-MHA.org	
Laura Gaiser	TMHA	lgaiser@t-mha.org	
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Shannon Fissori	DSS	SFissori@co.slo.ca.us	
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KERRY WILSON	HASCO	KWilson@hasco.org	
Courtney Wagner	MH	cpwagner@co.slo.ca.us	
Melinda Sokolowski	CAPSLO	msokolowski@capslo.org	
Mariana Gutierrez	CAPSLO/SLCUSD	mgutierrez@slcusd.org	

Levels of Care & Organized

Delivery System Training Interagency Meeting at Child Welfare Services on April 21, 2016

Name:	Department:	Email:	Signature:
Patti Jo	ALPHA	Patti@slocalpha.org	PJ&
MIMI FELICIANO HIX	CUESTA COLLEGE FACULTY/TESS	MFELICIA@CUESTA.EDU	
Romi Ramirez	TAPP-CAPSLO	RomiRamirez@capslo.org	Romi Ramirez
Jane P.	LINK	jpomeroy@linkslo.org	JP
Laura Morgan	MH/STAFF	lmorgan@co.slo.ca.us	Laura Morgan

Teresa & Clark

SLO County Superior Court Judges Presentation 4-27-16 Sign-In Sheet

Levels of Care & Organized

Delivery System Training San Luis Obispo County Superior Court Judges on April 27, 2016

Name:	Department:	Email:	Signature:
LINDA HURST	judge	linda.hurste slo.courts.ca.gov	
JACKIE DUFFY	JUDGE	Jacquelyn.Duffy@ slo.courts.ca.gov	
Roger PICQUET	"	roger.picquet email.com	
HUGH MACLEAN	"	hfmacl/n@ charter.net	
Michael Powell	CEO	michael.powell@ slo.courts.ca.gov	
Mike Duffy	Judge	michael.duffy@ slo.courts.ca.gov	
D HARMAN	JUDGE	dodie.harmen@ slo.courts.ca.gov	

Teresa Pemberton
and
Clark Guest

Paso Robles Drug and Alcohol Presentation 3-29-15 Sign-In Sheet

Sign In Sheet

DMC-ODS Stakeholder Presentation/Paso Robles Clinic

Tuesday March 29, 2015 from noon – 1:30 pm

	NAME	AGENCY	EMAIL/PHONE
1.	Joan Fusco LCSW	DAS-PR	jfusco@co.slo.ca.us
2.	Corinne Yozamp	DAS-SLO	cyozamp@co.slo.ca.us
3.	Emily Maddox	DAS-PR	emaddox@co.slo.ca.us
4.	Roger Peters	DAS-PR	rpeters@co.slo.ca.us
5.	Alisha Dozier	DAS PR	adozier@co.slo.ca.us
6.	Annika Michetti	DAS PR	AMichetti@co.slo.ca.us
7.	Alicia McAllister	DAS-PR	Amcallister@co.slo.ca.us
8.			
9.			
10.			

North County Connection Presentation 6-2-16 Sign-In Sheet

Sign In Sheet

DMC-ODS Stakeholder Presentation/Recovery Support Services

Thursday, June 2, 2016 10:00 am at North County Connection

	NAME	AGENCY	EMAIL/PHONE
1.	Jesse Warren	North County Connection	462-8600
2.	Kathleen Martin	VASH, Veterans Affairs Supportive Housing	805-305-6174 Kathleen.martin7@va.gov
3.			
4.	Becky Torres	ATC	becky@aregistreatmentcenters.com
5.	Kevin Reeder	ECHO/TFS	Kreeder.echo.cm@gmail.com
6.	Danni Herget		
7.	Loretta Hudson	North County Connection	Lorettahudson20@att.net
8.	PAM STANLEY	CATC - ALMOST :)	PAM@PAMSTANLEY.NET
9.	Crystal Barrett, MA	CAL SOBER RECOVERY	crystalbarrettMA@gmail.com
10.	Ron Morrill	NCC	Ronme760@Gmail.com
11.			
12.			

San Luis Obispo Drug and Alcohol Presentation 1-12-16 Sign-In Sheet

Sign In Sheet

ODS-DMC Stakeholder Presentation

Tuesday January 12, 2016 from Noon- 1:30 pm

NAME	AGENCY	EMAIL/PHONE
1. GARY GIBSON	SLO/DAS	gagibson@co.slo.ca.us
2. Robert Otten	SLO/DAS	rotten@co.slo.ca.us
3. Joshua Woodbury	SLO/DAS	JWoodbury@co.slo.ca.us
4. Griel Mendoza	SLO/MHS/DAS	gcmendoza@co.slo.ca.us
5. Cindy Nelson	SLO/DAS	CKnelson@co.slo.ca.us
6. JChanna Fanger	SLO/DAS	jfanger@co.slo.ca.us
7. Kathy Bailey	SLO/DAS	KBailey@co.slo.ca.us
8. CORINNE YOZAMP	SLO DAS	cyozamp@co.slo.ca.us
9. Betty Gillespie	SLO DAS	bgillespie@co.slo.ca.us
10. Brenda Lopez-Weichinger	SLO DAS	Bweichinger@co.slo.ca.us
11. ROGER PETERS	SLO/DAS/MHS	rpeters@co.slo.ca.us
12. Katie Grainger	SLO/DAS	kgrainger@co.slo.ca.us
13. Tina Wise	SLO/DAS	Twise@co.slo.ca.us
14. Cynthia Caldeira	SLO/DAS	ccaldeira@co.slo.ca.us
15. Amanda Corcoran	SLO/DAS	acorcoran@co.slo.ca.us
16. Susan Hale	SLO/DAS/MH	shale@co.slo.ca.us.
17. Robert Ortega	SLO DAS	rortega@co.slo.ca.us
18. Erin Roberts	SLO/DAS	elroberts@co.slo.ca.us
19. STEVE BERG	SLO/DAS	SBERG@CO.SLO.CA.US
20. RODGER ANDERSON	SLO/DAS	rjanderson@co.slo.ca.us

Sign In Sheet

ODS-DMC Stakeholder Presentation

Tuesday January 12, 2016 from Noon- 1:30 pm

NAME	AGENCY	EMAIL/PHONE
1. Jennifer Woodward	DAS SLO	jwoodward@co.slo.ca.us
2. IRMA PEREZ	DAS SLO	iperez@co.slo.ca.us
3. KEN LOYA	DAS SLO	kloya
4. Sean Myers	ditto	
5.		
6.		
7.		

Attachment B. Behavioral Health Service Request Form – Access Line (sample) and Initial Screening Tool

Behavioral Health Service Request Form Sample

Name: MH CLIENT, FICTIONAL 01 Case#: 400001 Page: 1 of 5
Type: MH Service Request Date: 05/12/2016
Printed on 05/24/2016 at 03:42 PM (Draft)

San Luis Obispo County Behavioral Health Department
SERVICE REQUEST

Contact Date: 10/28/2015 Contact Time: 4:00 p.m.
Caller (if not client): Caller's Phone (if caller is not client):
REFERRAL SOURCE: Family
LEGAL STATUS: Not Applicable Legally Responsible Person:
Responsible Person's Phone: Relationship to Client:

CLIENT DEMOGRAPHICS

Client's Date of Birth: 01/01/1988 Age (today): 28
Client's Gender: Male SSN: 555-00-0001
Client's Physical Address: 11 FICTION WAY
City/State/Zip: SAN LUIS OBISPO CA 93401
Client's Mailing Address: 11 Fiction Way
City/State/Zip: SAN LUIS OBISPO CA 93401
Does client have a home phone? ◉ Yes ○ No ○ Unknown
Home Phone: 555-5551 Special calling instructions:
Does client have a work phone? ○ Yes ◉ No ○ Unknown
Work Phone: Special calling instructions:
Does client have a cell or another phone? ○ Yes ◉ No ○ Unknown
Other Phone: Special calling instructions:

INSURANCE INFORMATION

Does client have Medi-Cal? ◉ Yes ○ No ○ Unknown County? San Luis Obispo
Does client have other insurance? ○ Yes ◉ No ○ Unknown Ins Carrier?
Personal Physician:
Physician's Phone: Physician's Fax:
Primary Language: Spanish
Language Preferred (Individual): Spanish
Language Preferred (Caretaker): Spanish
Interpreter Needed? ◉ Yes ○ No Free Interpreter Offered? ◉ Yes ○ No

CALL NARRATIVE/CONTACT ATTEMPTS:

Risk of harm to self or others? ○ Yes ○ No ○ Unknown
Discharged from hospital? ○ Yes ○ No If so, date of discharge:

Name: MH CLIENT, FICTIONAL 01 Case#: 400001 Page: 2 of 5
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Released from Jail? O Yes ◉ No Date of Release:

Urgency Level:

DISPOSITION:

Was an Assessment offered within the wait time standard?

O Yes O Assessment offered; wait time exceeds standard O No Assessment offered

Was Assessment appointment accepted?

O Yes O Client chose a delayed appointment O Assessment declined

Wait if next available had been accepted (days)

Assessment Date: Time: Wait Time (Days) 0

Assessment Location: Assessing Therapist:

Form MHSR; Version 1.08; 08/11/2015

Risk Factor and Functional Impairment Ratings Scales

Risk Asssment:
Review the Help Text descriptions (from the Adult Needs and Strengths Assessment (ANSA), copyright by Praed Foundation) and select the items that most closely match the client's current level of risk. Describe 'Severe' items in the comment box below and specify safety plan.

Referral Decision Support:
Severe/Significant/Acute: Refer to SLO Mental Health for routine, crisis, or acute specialty mental health services.
Moderate: Evaluate in context of levels of impairment. **May** qualify for specialty mental health services (SMHS).
Mild: Risk factor does not indicate a need for SMHS.
None: Risk factor does not indicate a need for SMHS.

Rate Overall Level of Danger to Self
O None O Mild O Moderate O Severe/Significant/Acute

Rate Overall Level of Danger to Others
O None O Mild O Moderate O Severe/Significant/Acute

Rate Overall Level of Self Injurious Behavior
O None O Mild O Moderate O Severe/Significant/Acute

Risk Factors Comments/Safety Plan:

Functional Impairment/Life Domain Functioning: Review Help Text descriptions; select the items that most closely match the client's current impairments. Describe the client's impairments in the comment box below (required for ratings of severe and moderate, optional for mild or none).

Referral Decision Support (if impairment is due to mental illness):
Severe/Significant: Refer to SLO County Mental Health.
Moderate: Refer for non-specialty mental health services unless there is a reasonable probability of significant deterioration or failure to progress developmentally in this area of functioning (Describe reasonable probability below).
Mild: Impairment does not indicate a need for SMHS. Consider referral for non-specialty mental health services.
None: Impairment does not indicate a need for SMHS. Consider referral for non-specialty services.

Rate Overall Level of Self Care/ADL Impairment
O None O Mild O Moderate O Severe/Significant/Acute
If Impaired, Select Primary Reason:

Rate Overall Level of Employment Impairment
O None O Mild O Moderate O Severe/Significant
If Impaired, Select Primary Reason:

Rate Overall Level of Family Impairment
O None O Mild O Moderate O Severe/Significant
If Impaired, Select Primary Reason:

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Rate Overall Level of Residential Impairment
O None O Mild O Moderate O Severe/Significant
If Impaired, Select Primary Reason:

Rate Overall Level of Social Impairment
O None O Mild O Moderate O Severe/Significant
If Impaired, Select Primary Reason:

Rate Overall Level of School Behavior Impairment
O None or N/A O Mild O Moderate O Severe/Significant
If Impaired, Select Primary Reason:

Funtional Impairment Comments:

Referred for non-specialty mental health services? O Yes O No

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Signatures

(Text Printing Suppressed)

Signature	OBC	E	Signature Line Heading	Name	Date	Time
Pending	☐	S	Approved Category of Staff			
Pending	☐	S	Staff Processing			

Behavioral Health Initial Screening Tool

Name: MH CLIENT, FICTIONAL 01 Case#: 400001 Page: 1 of 8
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Printed on 05/24/2016 at 03:48 PM (Final Approved on 04/25/2016 at 04:11 PM)

County of San Luis Obispo Behavioral Health Department

Substance Abuse

Initial Screening Demographics

1. Who has asked you to come here?

○ Prop 36 ○ CWS ○ PCP ○ MH ◉ Drug Court ○ Deferred Entry of Judge ○ Probation
○ AB109 ○ Self ○ Other

2. Are you pregnant? ○ Yes ◉ No ○ Unknown

If yes, estimated Due Date:

Number of children 0-5 years? 0 Number of children 6-17 years? 0

3. Do you have an open CWS Case? ○ Yes ◉ No ○ Unknown

Child 2 months or younger: ○ Yes ○ No

4. Are you a veteran? ○ Yes ○ No

Medical

5. Have you had a physical in the last 12 months? ○ Yes ○ No Date of last physical

6. Do you have Medi-Cal? ◉ Yes ○ No ○ Unknown County? San Luis Obispo

Do you have other insurance? ○ Yes ◉ No ○ Unknown Ins Carrier?

7. Are you currently taking any medications? If so what?

blah blah blah

Housing

8. Current Living Arrangements House/Apt/Mobile Home

9. Describe current living situation: (optional)

10. Length of time in current living situation

○ Less then 30 days ◉ 1 - 6 Months ○ 6 - 12 Months ○ More than 1 year

11. Housing Status

○ Literally Homeless ◉ Imminently losing housing ○ Unstably housed/at risk of homelessness ○ Stably housed

12. Is client satisfied with living situation?

○ Very Satisfied ○ Satisfied ◉ Neutral ○ Unsatisfied ○ Very Unsatisfied

SAIS1 1.06; 03/30/2016

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County of San Luis Obispo Behavioral Health Department

Substance Abuse

Initital Screening

Substance Use

Section B Questions for Alcohol and Drug Use

Interviewer: Ask the next 3 questions. Check the box next to each question answered "Yes".

☒ 4. Have you ever had any problem related to your use of alcohol or other drugs?

☒ 5. Has a relative, friend, doctor, or other health worker been concerned about your drinking or other drug use or suggested cutting down?

☒ 6. Have you ever said to another person, "No, I don't have an alcohol or drug problem," when around the same time you questioned yourself and felt, maybe I do have a problem?

Drug Use History:

Comments:

blah blah blah

Type of Substance

Substance taken in larger amounts or over a longer period than was intended?	◉ Yes	○ No
Persistent desire or unsuccessful efforts to cut down or control the substance use?	○ Yes	◉ No
Great deal of time spent in activities necessary to obtain the substance?	○ Yes	○ No
Craving, or a strong desire or urge to use the substance?	◉ Yes	○ No
Failure to fulfill major role obligations at work, school or home?	○ Yes	◉ No
Use despite social or interpersonal problems?	◉ Yes	○ No
Recreational activities are given up or reduced because of substance use?	○ Yes	○ No
Recurrent substance use in situations in which it is physically hazardous?	○ Yes	○ No
Use despite knowlege of having physical or psychological problem caused by the substance?	◉ Yes	○ No
Tolerance?	○ Yes	○ No
Withdrawal?	○ Yes	○ No
Use substance for 12 months or more?	◉ Yes	○ No

KEY: Mild 2-3 symptoms, Moderate 4-5 symptoms, Severe 6 < symptoms

○ Mild ◉ Moderate ○ Severe

More than ONE substance that meets criteria? ○ Yes ◉ No Type of Substance

Substance taken in larger amounts over a longer period than was intended?	○ Yes	○ No

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Persistent desire or unsuccessful efforts to cut down or control the substance use?	O Yes	O No
Great deal of time is spent in activities necessary to obtain the substance?	O Yes	O No
Craving, or a strong desire or urge to use the substance?	O Yes	O No
Failure to fulfill major role obligations at work, school, or home?	O Yes	O No
Use despite social or interpersonal problems?	O Yes	O No
Recreational activities are given up or reduced because of substance use?	O Yes	O No
Recurrent substance use in situations in which it is physically hazardous?	O Yes	O No
Use despite knowledge of having physical or psychological problem caused by the substance?	O Yes	O No
Tolerance?	O Yes	O No
Withdrawal?	O Yes	O No
Use substance for 12 months or more?	O Yes	O No

KEY: Mild 2-3 symptoms, Moderate 4-5 symptoms, Severe 6 < symptoms

O Mild O Moderate O Severe

More than TWO substances that meet criteria? O Yes O No Type of Substance

Substance taken in larger amounts or over a longer period than was intended?	O Yes	O No
Persistent desire or unsuccessful efforts to cut down or control the substance use?	O Yes	O No
Greate deal of time is spent in activities necessary to obtain the substance?	O Yes	O No
Craving, or a strong desire or urge to use the substance?	O Yes	O No
Failure to fulfill major role obligations at work, school, or home?	O Yes	O No
Use despite social or interpersonal problems?	O Yes	O No
Recreational activities are given up or reduced because of substance use?	O Yes	O No
Recurrent substance use is situations in which it is physically hazardous?	O Yes	O No
Use despite knowlege of having physical or psychological problems caused by the substance?	O Yes	O No
Tolerance?	O Yes	O No
Withdrawal?	O Yes	O No
Use substance for 12 months or more?	O Yes	O No

KEY: Mild 2-3 symptoms, Moderate 4-5 symptoms, Severe 6 < symptoms

O Mild O Moderate O Severe

More than THREE substances that meet criteria? O Yes O No Type of Substance

Sustance take in larger amounts over a longer period than was intended?	O Yes	O No
Persistent desire of unsuccessful effort to cut down or control the substance use?	O Yes	O No
Great deal of time is spent in activities necessary to obtain the substance?	O Yes	O No
Craving, or a strong desire or urge to use the substance?	O Yes	O No

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Failure to fulfill major role obligations at work, school, or home?	O Yes	O No
Use despite social or interpersonal problems?	O Yes	O No
Recreational activities are given up or reduced because of substance use?	O Yes	O No
Recurrent substance use in situations in which it is physically hazardous?	O Yes	O No
Use despite knowledge of having physical or psychological problem caused by the substance?	O Yes	O No
Tolerance?	O Yes	O No
Withdrawal?	O Yes	O No
Use substance for 12 months or more?	O Yes	O No

KEY: Mild 2-3 symptoms, Moderate 4-5 symptoms, Severe 6 < symptoms

O Mild O Moderate O Severe

SAIS2 Version 1.02; 04/06/2016

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County of San Luis Obispo Behavioral Health Department

Substance Abuse

Initial Screening

Mental Health

Section A. Questions for Mental Health

Interviewer: Ask the next 3 questions. Check the box next to each question answered "Yes".

☐ 1. Have you ever been worried about how you are thinking, feeling, or acting?

☒ 2. Has anyone ever expressed concerns about how you were thinking, feeling, or acting?

☒ **3. Have you ever harmed yourself or thought about harming yourself?**

☒ Check box if any of questions 1-3 are checked and continue to Section A1

Interviewer: If none of the above questions are checked, go to the next tab Section B

A1. Additional Screening Questions for Mental Health

Over the last 2 weeks, how often have you been bothered by the following problems?

a. Feeling nervous, anxious or on edge

○ Not at all ○ Several Days ◉ More than half the days ○ Nearly every day

b. Not being able to stop or control worrying

○ Not at all ○ Several Days ◉ More than half the days ○ Nearly every day

c. Little interest or pleasure in doing things

○ Not at all ○ Several Days ◉ More than half the days ○ Nearly every day

d. Feeling down, depressed, or hopeless

○ Not at all ○ Several Days ◉ More than half the days ○ Nearly every day

e. Thoughts that you would be better off dead or of hurting yourself in some way

○ Not at all ○ Several Days ◉ More than half the days ○ Nearly every day

Summary

BLAH BLAH BLAH

SAIS3 version 1.00; 04/07/2016

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County of San Luis Obispo Behavioral Health Department

Substance Abuse

Initial Screening

Trauma

Section C. Questions for Trauma/Domestic Violence

☒ 7. Have you ever experienced violence or trauma in any setting (including community or school violence; domestic violence; physical, psychological, or sexual maltreatment/assault within or outside of the family; natural disaster; terrorism; neglect; or traumatic grief?)

C1. Additional Screening Questions for Trauma/Violence

Interviewer: If one or more questions are checked in Section C, ask the next 2 questions.

a. Have had nightmares about it or thought about it when you did not want to? ○ Yes ○ No

b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it? ○ Yes ○ No

c. Were constantly on guard, watchful, or easily startled? ○ Yes ○ No

d. Felt numb and detached from others, activities, or your surroundings? ○ Yes ○ No

8. Have you been accused of a sex offense? ○ Yes ◉ No

9. Are you a registered sex offender? ○ Yes ○ No

SAIS4 version 1.03; 04/13/2016

County of San Luis Obispo Behavioral Health Department

Substance Abuse

Initial Screening

Conclusions

Summary of Text Box with Recommendations:

Meets the definition of medical necessity? O Yes O No

Narrative with diagnostic criteria:

blah blah blah

☐ Emergency: Must have second contact within 0-5 days. (see help text)

☐ Urgent: Must have contact between 7-14 days (see help text)

☐ Routine: 14 + days (see help text)

Identify the Level of Care:

O Level Detox O Level .5 (Early Intervention) O Level I (Outpatient) O Level II (Intensive Outpatient) O Level II

Intake Assessment Appointment

Primary Specialist Assigned:

Summary and Dispostion:

blah blah blah

SAIS5 version 1.00: 04/13/2016

Signatures

(Text Printing Suppressed)

Signature	OBC	E	Signature Line Heading	Name	Date	Time
Electronic Signature	☐	S	Staff	EMILY MADDOX	04/25/2016	04:11 PM

Professional Description: DAS Program Supervisor
Credentials: SLO County

Attachment C. Medication Assisted Treatment Program: Buprenorphine

Medication Assisted Treatment Policy and Procedure Manual

Medication Assisted Treatment Program: Buprenorphine

Policy and Procedure Manual
San Luis Obispo County
Drug and Alcohol Services

The Policy and Procedure Manual has been reviewed and approved.

_____ Date_____
Anne Robin, LMFT
Behavioral Health Department Administrator

_____ Date_____
Daisy Ilano, M.D.
Behavioral Health Department Medical Director

_____ Date_____
Star Graber, PhD, LMFT
Division Manager, Drug & Alcohol Services

_____ Date_____
Medication Assisted Treatment Team Leader
Katie Dolezal, Nurse Practitioner

Written: November 1997
First Revision: August 2001
Second Revision: December 2007
Third Revision: April 2008
Fourth Revision: April 2009
Fifth Revision November 2013
Sixth Revision December 2015

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MISSION STATEMENT

To provide opiate replacement therapy and withdrawal management services to residents of San Luis Obispo County who wants to enter recovery with cost effective and comprehensive substance abuse services that can be provided through Medical Assisted Treatment Program (MAT) and community linkages. By doing so, the program will foster health, self-reliance and responsible behavior of individuals; help them recover from substance abuse and benefit our communities.

GOAL STATEMENT

The goals of the Medication Assisted Treatment Program is to reduce the impact of continued drug and alcohol use on the individual and society and assist the person to develop a clean and sober life.

Objective A: To decrease mortality and morbidity from the effects of alcohol, opiates, and methamphetamine abuse as demonstrated by 60% successful completion of the Medication Assisted Treatment (MAT) Program as defined by the following:

1. Remaining in the MAT program for 6 months
2. Incur no new legal charges
3. Be evaluated for concurrent psychiatric needs and treated if appropriate
4. Develop at least one source of community sober support
5. Begin process of obtaining employment or other meaningful activity.

Objective B: To demonstrate and document a 70% rate of concurrent treatment services with the MAT Program at the appropriate level of treatment based upon the individual's needs.
Objective C: The MAT program will service 150 individuals per year.
Objective D: The MAT program will maintain an average length of stay of 90 days in order to achieve stabilization of detoxification symptoms in clients.
Objective E: The rate of re-admission to detoxification services within one year will be less than 10%.

STAFF GOALS AND OBJECTIVES

Goals

The goal of the staff is to provide optimal level of care consistent with current practice to clients requesting opiate replacement therapy, stabilization, or withdrawal management assistance. The care will be provided at the San Luis Obispo Drug and Alcohol Service (DAS) office, with the support of the client's friends/family with the following outcomes:

1. Emerge with a commitment to a life of abstinence from opiates;
2. Accept that one has a chronic, progressive disease and understand the nature of the disease; and
3. Process of recovery that will ensure a clean and sober life.

Objectives

1. An active client caseload will be maintained in MAT with forty (40) clients as the maximum caseload between active detoxification phase, short-term maintenance, and long-term maintenance for buprenorphine medication.
2. Client monitoring for support and prevention of any medical complications during the withdrawal

management process

3. Education provided to clients and their designated support persons to assist the client through successful opiate addiction recovery
4. Referrals will be provided during and after treatment to enhance recovery
5. Clients to attend concurrent outpatient or intensive outpatient treatment groups or other recovery services during the buprenorphine medication assisted treatment program.
6. Referrals will be provided to those who are unable to enter the outpatient Medication Assisted Treatment program due to exclusion criteria, including being prescribed opiates or immediate need, such a being placed on wait list, or circumstances that inhibit their immediate needs being met.

CLINICAL SUPPORT FOR THE M.A.T. PROGRAM

The Medical Director for the County Behavioral Health Department or designee will serve as the supervising physician of the Medication Assisted Treatment Program.

The clients and/or their support person will be referred to primary and emergency medical care services as needed and appropriate. No primary or emergency care will be provided onsite by Drug and Alcohol Services staff. Clients will be responsible for the cost of any recommended medical services and will be advised as such.

CONSULTATION WITH PRIVATE PHYSICIAN AND PAIN MANAGEMENT PATIENTS

Private physicians may be informed of the nature of the Medication Assisted Treatment Program and the use and contents of protocol orders. Upon admission to the withdrawal management program and with a signed authorization for release of information, the private physician will be informed of the status of mutual client during the treatment process. The client may also request that the staff consult with the private physician even prior to the treatment process. .

If a potential MAT client is currently being prescribed an opiate or its derivative, and has expressed intent to discontinue such use, the client will be referred back to their current prescriber to continue their medical plan of care. Pain management patients, or other opiate maintained patients, must show written proof of discharge before potential admission to the County's MAT program.

MAT STAFF

Nurse Practitioner (NP) must possess the following qualifications:

1. A current California license as a Registered Nurse.
2. A graduate of an accredited Nurse Practitioner Program, if hired as a Nurse Practitioner.
3. Minimum of one year of experience in using interviewing and teaching skills, and evaluating health history and physical assessment.
4. Knowledge of physiology of addition and withdrawal management process; or be willing to learn.
5. A current furnishing license.
6. A certification from California Board of Registered Nursing as a Nurse Practitioner.
7. A valid California driver's license.

Licensed Psychiatric Technician (LPT) must possess the following qualifications:

1. A current California license as a Psychiatric Technician.
2. A valid California driver's license and be able to transport clients in a safe manner.
3. Minimum of one-year experience in using interviewing and teaching skills, and physical assessments.
4. Knowledge of physiology and chemical withdrawal management process.

Case Manager must possess the following qualifications:

1. A current Certification as a Alcohol and Drug Counselor as recognized by the State Department of Health Care Services OR a license track (post-Master's intern) or licensed professional of the healing arts (LMFT, LCSW or LPCC).
2. Minimum of two years of working with people with substance use disorders.
3. Willingness to learn the knowledge of physiology, chemical withdrawal management process, and the needs of individuals and families who are going through chemical withdrawal and medication assisted treatment.
4. Must be able to facilitate group counseling services, conduct individual counseling services, and provide education (both individually and in groups).
5. Must possess a valid California driver's license and be able to transport clients in a safe manner.

Behavioral Health Clinician must possess the following qualifications:

1. A license track (post-Master's intern) or licensed professional of the healing arts (LMFT< LCSW, OR LPCC).
2. Minimum of two years working with people with substance use disorders.
3. Willingness to learn the knowledge of physiology, chemical withdrawal management process, and the needs of individuals and families who are going through chemical withdrawal and medication assisted treatment.
4. Must be able to conduct screenings, assessments, diagnosis, treatment planning, discharge planning in compliance with medi-cal paperwork standards.
5. Must be able to facilitate group counseling services and conduct individual counseling services in accordance with evidence based practices.
6. Must possess a valid California driver's license, and transport clients in a safe manner.

MAT STAFF RESPONSIBILITY

Clients seeking help for opiate use disorders-moderate to severe may have a heightened sensitivity to the perceived judgments of others. Staff members must address the clients with empathy and respect as well as reinforcing self-esteem and supporting client's follow-through with treatment.

Staff must observe the following client-staff boundary guidelines:

1. Maintain a professional relationship with client at all times.
2. Do not allow clients to be overly familiar or friendly.
3. Avoid discussion of personal matters with clients.
4. Do not accept gifts or favors from clients.
5. Respect client's confidentiality.
6. Follow other Health Agency/Behavioral Health Department and Drug and Alcohol Services Code of Conduct.

The Medication Assisted Treatment Program Staff consists of the Medical Director or designated physician, Nurse Practitioner, Psychiatric Technicians, Clinicians, and Case Manager Specialists who will be responsible for the following:

1. Review of requests for an assessment of a client for medication assisted treatment as they arrive; triage for prescribed opiates, pregnancy, recent methadone use, and physiological dependence on other substance, such as benzodiazepines.
2. Review of client's health status with the client at intake.
3. Review of current substance use, amount of use, length of time of use, and history of withdrawal signs and symptoms as well as current withdrawal symptoms during the assessment process.
4. Continuous assessment and review of signs and symptoms of withdrawal management, medication compliance, relief of cravings, and/or other recovery needs to determine if medications are adequately addressing client's needs.

REFERRAL PROCESS

1. All referrals will be directed to the MAT Program staff. All potential clients must have attended walk-in clinic or be an active treatment or recovery client of Drug and Alcohol Services Division and have received a tentative diagnosis of opiate use disorder. Screening for admission to the Buprenorphine MAT program can be completed by the Nurse Practitioner, Licensed Psychiatric Technician, or Medical Doctor. If the client is found to be ineligible, an appropriate referral will be made to another agency and an attempt will be made to facilitate treatment linkage.

2. If the MAT staff receives a request for withdrawal management from substances other than opiates, the client will be given appropriate referral(s). If the client is in need of immediate medical attention, they will be referred to the nearest medical facility.

SCREENING PROCESS

Eligibility Criteria

A potential client will be interviewed to determine if one is eligible for the program based on the following criteria.

1. An expressed desire to stop using opiates and all other drugs of abuse, including marijuana and alcohol.
2. Daily opiate use history of greater than six months.
3. Minimum age of 18 years old; or approval by the Medical Director. A referral to an alternate treatment program/facility will be made for any person under the age of 18 years who have not been cleared for admittance to the MAT Program
4. Has the ability to understand and voluntarily accepts the treatment plan.
5. Absence of severe and unstable medical/psychological conditions that would preclude participation in individual and groups processes.

Medical Conditions of Exclusions

The following conditions could make the potential client ineligible for admission into the Outpatient Withdrawal Management or Medication Assisted Treatment Program due to the increased possibility of complications:

1. Active infectious cutaneous disease
2. Unstable angina
3. Uncontrolled hypertension
4. History of recurrent seizure disorder within last two years with the last episode within the past week and without anti-seizure medication
5. Head trauma within past 6 weeks
6. Significant recent exposure to extreme environmental temperature change
7. Unstable diabetes mellitus with recent hypoglycemic episodes, diabetic ketoacidosis, blood sugars over 400
8. Pregnancy*
9. Nursing mother
10. Active or chronic homicidal ideation and attempts including violent behavior or threats to staff
11. Methadone dosage of greater than 30 mg a day**.
12. Significant /Severe psychiatric comorbidity
13. HIV treatment without coordination with prescriber of HIV treatment
14. Active or chronic suicide ideation and attempts
15. Client experiencing:
    a) vomiting more than 5 times in 24 hours / unable to keep fluids down
    b) labored breathing
    c) intractable diarrhea
    d) decrease in urination despite adequate hydration
    e) increased feelings of paranoia
    f) lesions at risk for becoming systemic or not responding to treatment

Medical clearance may be obtained for those with the above listed conditions and may possibly be accepted to the program. It is recommended that a co-management of the client be in place after the medical clearance has been obtained.

* A potential client who is pregnant and requests a buprenorphine treatment will be referred to a methadone clinic for treatment or a private prescriber.
**All clients who are using greater than 30 mg of methadone will be referred to a methadone clinic for methadone treatment; high levels of opiate use *may* be referred to a methadone clinic.

PAYMENT FOR WITHDRAWAL MANAGEMENT AND MAT SERVICES

In accordance with the Drug and Alcohol Services fee policy, all clients will be required to comply with the current cost of the MAT program. The payment will be based on a sliding fee scale according to gross monthly income and family size. Payment will be required on the first treatment day. Medi-Cal will be accepted per San Luis Obispo County Treatment Policy and Procedures.

ADMISSION PROCESS

Intake

1. After the walk-in has been completed and the Drug and Alcohol Services Assessment Coordinator and/or Specialist has approved the referral, the client will be triaged by the MAT Program team, usually the NP (see DAS general policy and procedure for details regarding walk-in clinic process)
2. MAT staff, either MD, NP, or their designee shall run a history of prescription drug use using the CURES system (Controlled Substances Utilization Review and Evaluation Systems). The results will guide MAT staff regarding recent prescribed opiates or other medication as related to admission to the Buprenorphine MAT program, referral to another provider, or discussion regarding status of medical interventions/pain management.
3. Upon acceptance into the Buprenorphine MAT program, clients will be advised to cease opiate use immediately, minimal opiate-free time is approximately 24 hours.
4. Admissions for the current week are not available on Fridays unless the client has experience with buprenorphine and/or is currently on therapy.
5. The Drug and Alcohol Services Assessment Coordinator (AC) /Specialist will be notified of the client's acceptance to the program, if applicable
6. If client is placed on wait list for the MAT program, the AC or Specialist will assign the subunit ending in '90 under their name
    a) MAT staff will review the wait list approximately once a week
    b) Will admit per wait list date or triaged to be at greater need , ie homeless, caring for children
    c) When admission becomes available, the PT or case manager will attempt to make contact with the client and notify the AC or specialist of doing so.
7. Clients may be admitted twice in a twelve-month period.
8. A request for a third admission in the same year will be reviewed by the MAT program team.
9. A client cannot be readmitted within a 90-day period of the last admission unless reviewed and approved by the MAT program team.
10. Current level of commitment to recovery and past compliance with referrals will be evaluated for re-admission requests.

Induction Appointment

1. Induction appointment starts with a discussion regarding client's commitment to full participation in the program, including cessation of all illicit drugs (including alcohol and marijuana) and participation in group therapy and/or individual counseling (as deemed necessary due to client's mental health status).
2. Determine if client is voluntary or mandated.
3. If clients is not currently on color code testing, obtain baseline urine screen for drugs of abuse, add buprenorphine if client states it was recently taken
4. Obtain a urine pregnancy test for women of childbearing age who do not have an IUD or tubal ligation.
5. Per industry accepted standards, the Clinical Opiate Withdrawal Scale (COWS) will guide induction to buprenorphine therapy.
6. COWS scores equal to or great than 16 will be inducted to buprenorphine treatment
7. COWS scores less than 16, the client will be invited to return for re-assessment at the next available appointment.
8. Complete the MU Health Assessment and Medical Conditions Review.
9. Inquire about HIV and Hepatitis C status; refer for testing as appropriate.
10. Assess physical health and recent physical exam and refer as appropriate.
11. Refer for immediate Primary Care intervention for immediate medical need as determined by above assessment.
12. Open subunit per clients DAS center of choice and buprenorphine MAT designation:
    a) Withdrawal management:
        i. 5006: Atascadero Clinic
        ii. 5106: Paso Robles Clinic
        iii. 5206 Grover Beach Clinic
        iv. 5406: San Luis Obispo Clinic
        v. 5706 South Street Clinic
    b) Short Term Replacement therapy (often AB109 clients)
        i. 5010: Atascadero Clinic
        ii. 5110 Paso Robles Clinic
        iii. 5210 Grover Beach Clinic
        iv. 5412 San Luis Obispo Clinic
        v. 5710 South Street Clinic
    c) Long Term Replacement therapy (maintenance clients)
        i. 5011: Atascadero Clinic
        ii. 5111 Paso Robles Clinic
        iii. 5211 Grover Beach Clinic
        iv. 5411 San Luis Obispo Clinic
        v. 5711 South Street Clinic
13. Client to complete first Quality of Life questionnaire.
14. The following forms will be signed by the client and witnessed by the MAT program staff prior to admission to the program (See Appendix):
    a) Client Treatment Agreement
    b) Pharmacy Consent
    c) Medication Consent
    d) Criminal justice release to jail medical staff if client has legal history

e) Transportation consent

15. Set up appointment with AC for second assessment if this has not already been completed.
    a) MAT clients must finish their admission to DAS treatment system by completing the following:
16. CalOMS
17. ASI Lite/ASAM Level of Care
18. Diagnostic Review
19. Other optional assessment tools as clinically indicated (SASSI-3, Motivational scales, Mental Status Exam, Beck Depression Inventory & PTSD Scale or others as appropriate)
20. Program Contracts
21. Consents for Release of Information
22. Treatment plan which will include the following:
    a) physical, mental health, medical, educational, psychosocial, recovery, and referral issues.
    b) client's substance abuse related problems and plan to cease use of opiates
    c) client commitment to remaining alcohol and drug free
    d) treatment group options such as MRT, Seeking Safety, and others
    e) availability of individual counseling and psychiatric services
    f) crisis response
    g) drug testing
    h) discharge
    i) other services for clients specific needs, such as legal issues, family intervention, etc.
23. The Treatment Plan will be signed by the client, MAT staff, and medical director

Documentation Requirements

Health Evaluations:

All clients will have their current Behavioral Health Questionnaire reviewed by the MAT Nurse Practitioner or Psychiatric Technician at the time of admission to the program. The evaluation will include:

1. current health problems
2. current mental status
3. history of health problems
4. history of mental illness
    a) All clients will have a physical exam within the past 12 months and the medical records obtained from the primary physician, or the client will be encouraged and referred to get a physical exam through the next treatment plan period (three months)
    b) Clients with active outstanding medical conditions will be referred for immediate primary care management by the Nurse Practitioner; if health reviewed by PT, they will consult with the NP.

Health Referrals:

Client will be given appropriate referrals, as guided by the Health Questionnaire, for medical treatment and laboratory tests in order to bring them current on health issues. This includes, but is not limited to:

1. Physical exam
2. Lipid profile
3. HIV test
4. CBC with differential
5. CMP
6. PPD/chest X-ray
7. Liver panel
8. Pregnancy test
9. HBC/HCV/HIV
10. Mental health assessment
11. Pap smear/birth control

Medical Records

All clients admitted to the MAT Program will have a medical record consistent with Drug and Alcohol Services Outpatient Treatment documentation. The file will contain the following information and will be kept confidential per Behavioral Health policy. All forms are per Behavioral Health Department treatment unless otherwise noted or specific to MAT program and found in appendices. Every client contact will be recorded using the appropriate document and maintained, and preserved, as part of client's permanent record. Given type of buprenorphine therapy, appropriate forms will be utilized as needed (See Appendix).

1. Application for Outpatient Treatment Services for all BHD clients (Demographics)
2. SA History and Physical Exam
3. Buprenorphine Progress notes
4. Opiate Withdrawal Record: Induction (COWS)
5. Informed Consent for Medication
6. Client Treatment Agreement
7. Pharmacy Consent
8. Medication Consent
9. Criminal justice release to jail medical staff if client has legal history
10. Transportation consent
11. Authorization(s) to Exchange Information- as needed, DAS general form
12. Medical Release for program entrance-as needed

BUPRENORPHINE MEDICATION ASSISTED TREATMENT

Standard of Care for Opiate Recovery

Opiate Replacement Therapy is the accepted as standard of care for individuals who have been taking opiates daily, regardless of route, for more than two years. Buprenorphine therapy is used to promote opiate addiction recovery by decreasing/ceasing opiate addiction related symptoms. For individuals taking daily opiates who experience withdrawal symptom when they cease, buprenorphine is provided to ease/cease those symptoms. If a client had been a daily opiate user, longer than two years per ASAM level of care, they are offered opiate replacement therapy regardless of time opiate free. Buprenorphine replacement therapy is used to decrease/cease opiate craving that are severe enough to negatively impact a client's life goals and potential for remaining opiate free.

Prescription Process

The following delineates the process in which the Medical Director or other "X" waivered physician may provide suboxone therapy.

1. The Medical Director or other "X" waivered physician will attend a weekly meeting with the MAT staff to review all current clients for the upcoming week. Prescriptions for buprenorphine therapy will be written out and signed by the Medical Director or other "X" waivered physician.
2. The prescriptions will be given to the MAT medical staff, NP and/or PT, and will be kept in a double locked medical cabinet or locked briefcase when visiting sites other than San Luis Obispo. No staff other than MAT medical staff, NP and PT, will have access to the buprenorphine prescriptions.
3. The prescriptions are based upon client's level of therapy; intake of buprenorphine mg, attendance and participation in treatment and drug testing results. The prescription is reviewed and given to the client to be filled at the pharmacy of their choice. At induction, the appropriate level of buprenorphine intervention is unknown until assessed by MAT medical staff. For this first appointment, buprenorphine prescriptions will be called in the pharmacy of client choice. At the next MAT meeting, the "X" waivered physician will be notified of a new client admission, their history, their buprenorphine needs, and a hard copy prescription may be written.
4. The MAT medical staff will retain the white copy,
    a) enter the prescription into the medication log
    b) return to the medical director or other "X" waivered physician for quality assurance and control.
5. In urgent circumstances, buprenorphine prescriptions may be called into a pharmacy but will be followed by a hard copy at the first opportunity.

Additional pharmaceutical support will be at the discretion of the Nurse Practitioner and/or the supervising physician on an as needed basis. All other medications prescribed by the Nurse Practitioner will be in accordance with the Standardized Procedures agreement between the Nurse Practitioner and her/his supervising physician.

Withdrawal Management and Replacement Therapy

Withdrawal Management: Buprenorphine Induction phase

1. After the client has completed the walk-in process, been assessed as appropriate, and agrees to requirements of the MAT program, clients may begin buprenorphine therapy.

a) Short Acting Opiates: If a client is using a short acting opiate such as heroin or norco and their COWS score is 16 or greater (see index for form), they will be offered buprenorphine therapy.
b) Long Acting Opiate: If a client has been taking a methadone dose of 30 mg for equal to or longer than 14 days, has been methadone free for 72 hours or more, and their COWS score is 16 or greater (see index for form), they will be offered buprenorphine therapy.

2. The first prescription of buprenorphine is provided. The lowest possible dosage will be used to achieve desired clinical effect. Factors that contribute to dosage choice include:
   a) length of time addicted to opiates,
   b) past buprenorphine usage and dosing (including illicit use),
   c) route of administration,
   d) street value of daily usage,
   e) other factors as appropriate.
3. Dosages will not be provided greater than 16 mg a day. Clients will be given no more than 4-7 days of buprenorphine at one time to monitor for:
   a) adverse effects,
   b) for positive efficacy,
   c) to verify client has completed their follow up assessment,
   d) to decrease potential for diversion,
   e) to verify and/or coordinate group participation.

Buprenorphine Replacement Therapy: Induction phase

Rationale: Opiate replacement therapy is offered to all clients assessed at being at high risk for relapse to potentially deadly opiates. A client is at highest risk for death by overdose if opiate naïve and relapse to a full agonist such as heroin. Replacement therapy is designed to attenuate/alleviate cravings for opiates, allowing the individual to focus on developing their recovery skills.

If a client is opiate naive for longer than one month, they will start with 0.5 mg and will be titrated up according to clinical response, usual indicator is severity of craving for opiates. At the start of treatment, replacement therapy clients will be seen weekly to gauge clinical response. At weekly intervals, the client's dosage will be increased by an appropriate percentage to their current dose not to exceed 4 mg a visit. Maximum dosage for replacement therapy is 16 mg a day.

Buprenorphine Stabilization Phase

When the client experiences no withdrawal symptoms, no uncontrollable opiate cravings, minimal side effects, and is not using additional opiates, then the client's dose can be considered stabilized.

The primary goal of Stabilization is to find the minimum dose needed to achieve the desired clinical effect. Withdrawal management clients will have minimal opiate withdrawal symptoms and replacement therapy clients will have craving reduced to manageable levels.

The MAT staff will continue to monitor the client and evaluate the client's progress and medical/mental health status during buprenorphine treatment.

Monitoring by the MAT staff will consist of assessment of:

1. buprenorphine response

2. compliance with plan of care
3. group attendance
4. cravings

The MAT staff will work in conjunction with the appropriate DAS staff to monitor the clients' compliance with their respective programs. When stabilized, frequency of visits will be dictated by level of client case management need and client preference. Substance use urine testing, including buprenorphine, is performed at treatment appropriate intervals using dip test. This allows the option of discussing the results with the client. Laboratory urine testing may also be used. Breathalyzer is used as clinically appropriate.

Maintenance Phase

The goal of the Maintenance Phase is to prevent emergence of opioid withdrawal symptoms and to suppress the client's cravings for opiates,

Once the client is considered in the Maintenance Phase, the client may be assessed for appropriate referral to an outside provider for continued treatment or may remain with DAS for continued monitoring and treatment. Once the transfer to an outside provider has been completed, the case may be closed for MAT services. The client will also be given the option to continue with DAS buprenorphine therapy treatment if client is also willing to continue in DAS group or individual support. The clients will be required to develop outside community support in addition to continuing recovery support through Drug and Alcohol Services. Buprenorphine replacement clients will be maintained on their replacement dosage until they are completed with their DAS program or until they request a taper to discontinuation. Maintenance clients will be seen minimally twice monthly.

Buprenorphine Tapering/Discontinuation Process

Taper

A taper should only be considered once a successful treatment period is completed. Buprenorphine treatment is designed to suppress cravings and withdrawal so a client can have the opportunity to make changes in behavior, routine, living situation and thinking without chronic and often debilitating cravings. If this is not done first, the taper will likely be shortly followed by relapse

The purpose of a taper is to gradually reduce tolerance, thus distributing withdrawal symptoms over a longer period of time. This slow process minimizes the discomfort experienced on any single day. **Every client's taper will be individualized according to their needs, desires, and tolerance.** The taper will be adjusted to the body's ability to adapt to each decrease, as measured by opiate withdrawal symptoms. Dose decreases of 25% separated by at least 10 days, or 2 mg per 7 days are examples of tolerable taper schedules

Starting from 16 mg, given the half-life of buprenorphine, a 2 mg per 4-5 days taper of often tolerated. Between 16 and 2 mg, a dosage decrease of 2 mg per 5-14 days is scheduled depending on client urgency to discontinue therapy. When dosage is 2 mg, the taper schedule is even more individualized per client tolerance of discomfort. At 0.5 to 1 mg a client is suggested to start skipping days; the half-life of buprenorphine makes this process usually tolerable. The last step in tapering, if needed, is to add hours to the time of day taken until 72 hours is reached. By 72 hours after last minimal buprenorphine dose if the client is withdrawal symptom free, they will most likely remain as thus. If withdrawal symptoms emerge and are not tolerable, take 0.5 mg to 1 mg and wait another 72 hours; repeat this process until all symptoms are resolved

Protracted Withdrawal

As defined by SAMHSA, a protracted withdrawal is strictly defined as the presence of substance-specific signs and symptoms common to acute withdrawal but persisting beyond the generally expected acute withdrawal timeframes. A broader definition of protracted withdrawal is defined the experiencing of the above symptoms and of *non*-substance-specific signs and symptoms that persist, evolve, or appear well past the expected timeframe for acute withdrawal. This includes the cessation of suboxone as daily opiate replacement therapy. Education should be provided to the client who intends to, or has already, tapered off suboxone therapy. MAT staff will improve the client's chances for long-term recovery by normalizing the probability of experiencing protracted withdrawal and help them develop realistic attitudes toward recovery.

Symptoms of protracted withdrawal include:

1. anhedonia/decreased ability to experience pleasure*
2. anxiety*
3. dysphoria (i.e., feeling down or emotionally blunted)*
4. insomnia
5. fatigue
6. difficulty concentrating
7. impaired executive control (e.g., impulse control, solving problems)
8. cravings

*very high frequency

The MAT staff will support a client's recovery process by offering support and understanding, monitoring them regularly, and intervening early when a client appears to be heading for relapse.

Interventions include:

1. Assess for co-occurring disorders, such as depression.
2. Ask about sleep problems; make a differential diagnosis to determine whether a client's sleep problems likely stem from protracted withdrawal or are the result of other causes.
3. Prescribe medications as needed to control symptoms past the acute withdrawal stage.
4. Advise clients to be active; physical and mental exercises, which improve sleep, promote positive emotional states, reduce stress and nervousness, help clients avoid triggers, and distract clients' attention from symptoms.
5. Advise clients to be patient; healing can be slow but progresses every day of recovery.
6. Encourage clients to join mutual support groups and increase healthy social interactions.

Case Management

All MAT clients taking buprenorphine medication assisted treatment will be offered case management services. The purpose of case management is to create the optimal environment for reaching their goals by supporting a client's needs in addition to recovery support.

Although case management and substance use disorder treatment are presented as separate and distinct aspects of the treatment continuum, in reality, they are complementary and, at times, thoroughly blended. Case management principles as applied to substance use disorders are as follows:

1. Case management offers the client a single point of contact with the health and social service systems;

2. Case management is client-driven and driven by client need;
3. Case management is grounded in an understanding of clients' experiences and the world they inhabit, the nature of addiction and the problems it causes, and other problems with which clients struggle;
4. Case management aims to provide the least restrictive level of care necessary so that client's life is disrupted as little as possible;
5. Case management involves advocacy and is community-based, and;
6. Case management is pragmatic. It begins "where the client is" by responding to tangible needs such as shelter, clothing, transportation, or childcare. Entering treatment may not be an immediate priority but meeting survival needs is part of the engagement process. This client-centered perspective is maintained as the client moves through treatment, however, the Case Management Specialist must keep in mind the difficulty in achieving a balance between help that is positive and help that may impede treatment engagement.

Medical Intervention

The following parameters are to be observed for each client in the program:

1. In the event the client requires immediate or emergency medical care during the withdrawal management process, the MAT staff will make every effort to assist the client in obtaining medical or psychiatric care.
2. If the client is in distress during clinic hours, the MAT staff will attempt to facilitate linkage with a medical or psychiatric care facility. If the distress occurs outside of clinic hours, the client may leave a message on the staff's voice mail regarding the distress and their attempts to remedy the situation. A follow up will then be carried out as to the disposition of the client's care.
3. The Medical Director or designee may be asked to determine the client's eligibility to continue with the MAT based on the physical status of the client.

Discharge/Transfer From the MAT Program

After buprenorphine therapy is completed, the client will be encouraged to remain an active treatment client. However, the client may be dis-enrolled from the MAT program for any of the following reasons:

1. Client completes the MAT program and wishes to be discharged.
2. Client is medically/psychologically unable to continue per previous parameters.
3. Client is absent for multiple appointments without prior notification.
4. Client does not participate in the second assessment appointment to complete medi-cal admission process.
5. Client does not attend the required treatment groups on a consistent basis.
6. Client continues to use illicit drugs and/or alcohol as evidenced by two or more positive drug urine testing or by client self-report.
7. Client admits or is found to be diverting the medication prescribed. Or client does not test positive for buprenorphine which would indicate the client has not taken their medication as prescribed for two or more drug test results.
8. Client loses the prescription two times during treatment.

No client will be left to experience opiate/suboxone withdrawal when they are involuntarily discharged from the MAT program. The client will be referred to a community provider and given a prescription that will continue their therapy without interruption. If possible, the MAT staff will assist the client in making their appointment to ensure the client leaves the program with continued care in place.

APPENDIX

Appendix Forms:

MAT Work Flow Process

Admission Packet (Health Questionnaire)

Client Handbook

Clinical Opiate Withdrawal Scale (COWS)

Client Treatment Agreement

Buprenorphine Progress Note Template

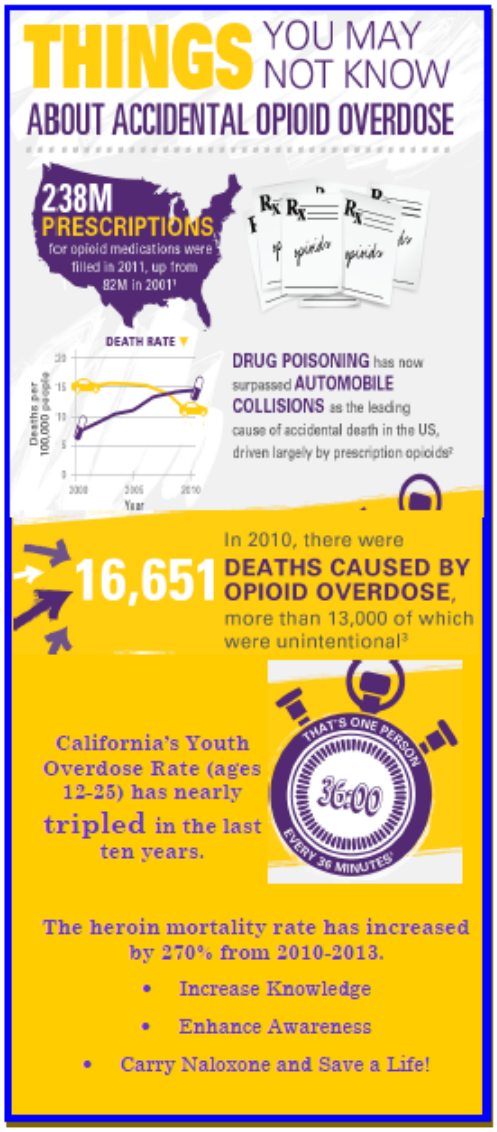
Informational Sheets (flyers)

Risk, Evaluation, and Mitigation Strategy (REMS)

Checklist and Background resource materials

Attachment D. Naloxone Policy and Procedures

Naloxone Brochure for General Public Information



Know your rights!

California state law encourages Naloxone prescribing and distribution.

CA AB635,
The Overdose Treatment Act
Effective 1/1/14

- Licensed healthcare prescribers can issue standing orders and prescribe Naloxone to patients and laypeople.
- Lay persons can possess and administer Naloxone to others during an overdose.

CA AB472,
9-1-1 Good Samaritan Law
Effective 9/17/12

- Witnesses of an overdose who seek medical help by calling 9-1-1 are provided legal protection from arrest and prosecution for minor drug and alcohol violations (like being under the influence at the time).

This is great! How do I get Naloxone?

- Speak to your local medical provider. Naloxone is **FREE** with Medi-Cal, and CVS Pharmacies across the County are carrying the intranasal Naloxone version.
- SLO Bangers Syringe Exchange has intramuscular Naloxone for FREE and upon arrival. They are open Wednesdays, 5:30-7:30PM at the Public Health Department. Call (805) 458-0123 for more info.
- SLO County Drug and Alcohol provides free education sessions and prescribes Naloxone. Call Katie Grainger (805)781-4756 for info.
- CVS in SLO's Marigold Center carries Naloxone over the counter; no prescription is needed. Just walk in and request it.
- **Pricing:** Naloxone is FREE with Medi-Cal, and costs $5 with insurance. Those without any insurance pay $40.69 out of pocket.

NALOXONE for opioid safety

Even though America is only 5% of the world's population, we consume 80% of the world's prescription opioid medication.

This brochure will tell more about accidental opioid overdose, risk factors, and how to acquire Naloxone and potentially save someone's life.

Accidental opioid overdose is preventable

...however, the majority of prescription opioid users do not think they are at risk. Having a conversation about Naloxone and preventing overdose is the first step in saving lives.

Patients prescribed opioids (including high-risk persons with a history of overdose) reported their risk of "overdose" was 2 out of 10.

Perception of risk (2 out of 10) is lower than the reality (8 out of 10).

So what is an opioid?

Drugs derived from, or similar to, opium

- Heroin
- Morphine (named after Morpheus - Greek god of sleep)
- Methadone
- Oxycontin (long acting oral opioid)
- Oxycodone (Percocet)
- Hydrocodone (Lortab, Vicodin)
- Fentanyl
- Many others

NOT Opioids:

Cocaine or crack
Methamphetamines
Benzodiazepines (Xanax, valium, Ativan, Klonopin)
Phenergan
Seroquel
Neurontin
Muscle Relaxers (Soma, Flexeril)
Alcohol

However, many overdoses contain one or more of the drugs on the right, in combination with opioids. Naloxone is still to be administered.

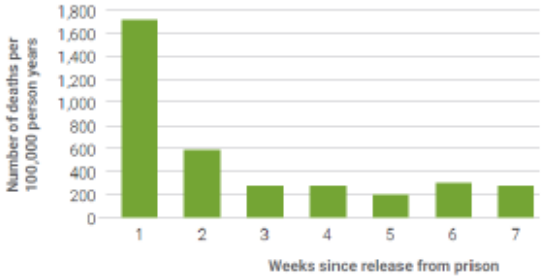
What factors put me at risk of an overdose?

Factors that increase risk of overdose:

- Reduced Tolerance: period of abstinence (such as going through detox, drug and alcohol treatment, or having a baby), change in prescription dose, release from prison or jail.
- Genetic predisposition (such as having a history of respiratory conditions—asthma, COPD, or sleep apnea)
- Combining multiple use of substances (legal or illegal) such as opioids with benzodiazepines, alcohol, or cocaine. **Over 75% of overdoses that occur are because of a mixture of two or more substances.**
- Variation in strength and content of 'street' drugs, or high dosage of opioid medication.

Overdose Mortality Rate by Week Since Prison Release

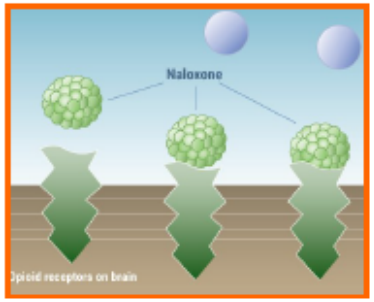
An example of overdose risk if opioids are discontinued and restarted[5]



When a patient reduces or stops opioid use, there is an increased risk of overdose death if opioid use increases again.

What is Naloxone?

- Naloxone, also called by its brand name "Narcan," is a safe, effective medication that can save a life by stopping an opioid overdose.
- This opioid antagonist has a higher affinity to the opioid receptors than opioids like heroin or oxycodone, so it knocks other opioids off the receptors for 30-90 minutes. This reverses the overdose and allows the person to breathe.
- The medication can be safely administered by laypersons via intramuscular or intranasal routes, with virtually no side effects.
- Naloxone is not a controlled substance, is non-addictive, and has no potential for abuse. There is no high effect.



Places to acquire Naloxone are listed on the back of this brochure. Naloxone is FREE with Medi-Cal!

Naloxone Standing Order with Public Health Department and SLO Syringe Exchange

San Luis Obispo County Public Health Department	Page 1 of 2
STANDING ORDER	Effective Date: 3/16/15

NALOXONE

I. PURPOSE

The purpose of this standing order is to allow distribution of the medication Naloxone for reversal of symptoms of opioid overdose, specifically respiratory depression or unresponsiveness. Use of Naloxone (Narcan) is in accordance with California Civil Code Section 1714.22 wherein licensed health care providers may prescribe and distribute naloxone to individuals at risk for opioid overdose and their family members or friends.

II. SCOPE

A. This Standing Order should be used in conjunction with the San Luis Obispo County Behavioral Health Department, Drug and Alcohol Services Division Policy and Procedure, each named "*Opiate Overdose Prevention Project (Naloxone)*".

B. This Standard Order is for particular use by trained "Overdose Prevention Educators" who are defined as staff or volunteers of the County Syringe Exchange Program (SEP).

C. This standing order authorizes Overdose Prevention Educators to distribute Naloxone to SEP participants for administration on behalf of the SEP participant or related person when symptoms of opioid overdose are present.

D. Though naloxone may be delivered intramuscularly via syringe or nasally via a spray, only injectable naloxone will be used by the SEP.

III. CLINICAL PHARMACOLOGY

Naloxone prevents or completely or partially reverses the effects of opioids including respiratory depression, sedation and hypotension. Naloxone is an essentially pure opioid antagonist, i.e., it does not possess the "agonistic" or morphine-like properties characteristic of other opioid antagonists. When administered in usual doses and in the absence of opioids or agonistic effects of other opioid antagonists, it exhibits essentially no pharmacologic activity. Naloxone has not been shown to produce tolerance or cause physical or psychological dependence. In the presence of physical dependence on opioids, naloxone will produce withdrawal symptoms. However, in the presence of opioid dependence, opioid withdrawal symptoms may appear within minutes of naloxone administration and subside in about 2 hours. The severity and duration of the withdrawal syndrome are related to the dose of naloxone and to the degree and type of opioid dependence. While the mechanism of action of naloxone is not fully understood, in vitro evidence suggests that naloxone antagonizes opioid effects by competing for the μ, κ and σ opioid receptor sites in the central nervous system, with the greatest affinity for the μ receptor.

IV. MEDICATION DISTRIBUTION

A. Eligibility criteria for Trained Overdose Responders who may receive an Overdose Rescue Kit:

1. Current adult opioid users, adult individuals with a history of opioid use, or someone with frequent contact with opioid users (including parents, guardians, friends or other contacts);
2. Risk for overdose or likelihood of contact with someone at risk;
3. Able to understand and willing to learn the essential components of overdose prevention; and

4. Willing to complete training every three years.

B. Contraindications

Naloxone is contraindicated in patients known to be hypersensitive to naloxone hydrochloride or to any of the other ingredients in Naloxone.

C. Precautions

1. No more than two administrations of naloxone should be given; this is despite slower response in the face of certain other drugs, including buprenorphine. Naloxone will not harm, nor will it be effective when respiratory depression is due to non-opioid drugs.
2. Pregnancy is not a known contraindication to naloxone, but it is a Category C drug and thus pregnant women should be counseled that there have been no adequate or well-controlled studies in pregnant women.
3. Breastfeeding – it is not known whether naloxone is excreted in human milk and lactating women should be advised accordingly.
4. Geriatric patients – clinical studies are not available to determine if persons over aged 65 respond differently to naloxone, but clinical experience has not noted any such differences.

D. Adverse Reactions

Abrupt reversal of opioid effects in persons who are physically dependent on opioids may precipitate an acute withdrawal syndrome which may include, but is not limited to, the following signs and symptoms: body aches, fever, sweating, runny nose, sneezing, piloerection, yawning, weakness, shivering or trembling, nervousness, restlessness, irritability, diarrhea, nausea, vomiting, abdominal cramps, increased blood pressure, and/or tachycardia.

E. Distribution

Trained Overdose Responders will be given an Overdose Rescue Kit containing two vials of naloxone 0.4 mg/ml with prescription labels; two 3 ml syringes with 25g 1" needles; a prescription card; instructions for use; and other accompanying material (see Procedure).

This standing order shall remain in effect for all patients of the San Luis Obispo County Syringe Exchange Program until rescinded.

By Order of Licensed Physician:  Date: *3/16/15*

Penny Borenstein, M.D.
Health Officer

DOCUMENT HISTORY			
Status: Initial/ Revised/Archived Description of Revisions	**Author**	**Approved by**	**Effective Date**
Initial Release	S. Graber, P. Borenstein	Penny Borenstein	3/16/15

Naloxone Opiate Overdose Prevention Project Procedures: Agreement Between Public Health, Drug and Alcohol Services, and SLO Syringe Exchange

Procedures Manual Drug and Alcohol Services Division San Luis Obispo County		
Section: Division: Date originated: Policy contact:	**Drug and Alcohol Services** **Treatment Services** 5/7/2014 Star Graber, PhD, LMFT, Division Manager	Policy No.: Page 148 of 305 Revised date: 3/16/2015
Subject: **Opiate Overdose Prevention Project (Naloxone) Procedures**		

PROCEDURES: These procedures for use of Naloxone are to be implemented under the accompanying "Opiate Overdose Prevention Project (Naloxone) Policy" with all the citations, references, definitions, and staff titles contained therein.

A. Medication Stock:

1. The Project Director will routinely monitor and maintain adequate inventory of naloxone consistent with projected demand, with expiration date at least 9 months out (preferably 12 months).
2. The Project Director will order naloxone in accordance with needed inventory under the medical license number of the Medical Director for the specific program.
3. Mail receiver(s) will take receipt of the ordered naloxone hydrochloride 1-cc vials of concentration 0.4mg/ml, and will notify Drug and Alcohol Services (DAS) medical staff of package receipt.
4. DAS medical staff will inventory the shipment and log: number doses received; lot #; and expiration date.
5. The Medical or Project Director will ensure that naloxone is stored safely in accordance with the manufacturer's guidelines.

B. Standing Orders:

See attached Standing Orders which include:

- Opiate Overdose Prevention Project Standing Order for Injection Naloxone

The Project Director will ensure that all standing orders for naloxone are signed and current at all times.

C. <u>Materials</u>:

All of the below materials will be placed in an overdose prevention bag (bright red labeled "Overdose Rescue Kit") as purchased by DAS from appropriate vendor(s).

Overdose kit written materials:

1. Naloxone vial prescription labels, to appear as:

NAME:_____ Date:_____ **Naloxone 0.4mg/cc; 1cc**

2. Prescription card:

TRAINED OVERDOSE RESPONDER ***This is to certify that:*** _____ has been trained in overdose prevention and rescue by the

3. Literature on *The California Overdose Treatment Act* AB635 which protects prescribers from "liability…(when) they prescribe, dispense, or oversee the distribution via a standing order of naloxone…and individuals to possess and administer naloxone in an emergency".

4. Instructions for preventing an overdose (call 911, rescue breathing, and injecting naloxone).

5. Information on the *9-1-1 Good Samaritan Law* that provides immunity protection for those who call 911 in the event of an overdose.

6. Treatment information and contact phone numbers.

Naloxone:

1. Medication will be purchased from Hospira pharmaceutical company using the established contract agreement.
2. Orders will be placed for a reasonable supply of naloxone hydrochloride 1-cc vials of concentration 0.4mg/ml.

D. <u>Education and Training</u>:
Overdose Prevention Educator:

1. Drug and Alcohol Services will train designated Behavioral Health staff, and approved community providers and volunteers who are in contact with the populations at risk of opiate overdose.
2. Drug and Alcohol Services will maintain signed and dated approval form by a Medical or Project Director for each Overdose Prevention Educator.
3. The educational program components will include at a minimum:
   - Risk factors for opiate overdose: loss of tolerance, mixing drugs, and using alone;
   - Recognizing signs and symptoms of overdose: no response to sternal rub, shallow/no breathing, bluish lips or nail beds;
   - Calling 911;
   - Rescue breathing and position; and
   - **Directions for administration of injectable naloxone:**
     a) Pop off the orange cap from the vial of naloxone, exposing the rubber seal.
     b) Open one intramuscular syringe with needle and twist the needle component to secure it to the syringe.
     c) Draw the entire contents of the 1cc vial of naloxone into the syringe.
     d) Inject the naloxone into the muscle of the upper arm, upper thigh, or upper, outer

quadrant of the buttocks.

e) Resume rescue breathing until the overdosing person begins to breathe on their own and shows signs of responsiveness.
f) Administer second dose (1cc) of naloxone if there is no response after approximately 2-3 minutes.
g) Remain with the person until he or she is under care of a medical professional, e.g., physician, nurse or emergency medical technician.
h) Do not administer naloxone to a person with known hypersensitivity to naloxone.

- Post-overdose directions: follow-up

a) Seek medical assistance and stay with the individual until the medical assistance arrives

b) Stay with the person to ensure that the naloxone is working, if not administer a second dose

c) When the person revives, do not continue using drugs with him or her, be sure that they are under the care of a medical professional, prior to leaving.

Trained Overdose Responder (TOR):

1. TORs must meet all of the following criteria:
   - Current adult opioid users, adult individuals with a history of opioid use, or someone with frequent contact with opioid users (including parents, guardians, friends or other contacts);
   - Risk for overdose or likelihood of contact with someone at risk;
   - Able to understand and willing to learn the essential components of overdose prevention; and
   - Willing to go through training every three years.

2. TOR Training: An Overdose Prevention Educator will ensure that appropriate data is collected either by prior knowledge or by questionnaire (see TOR questionnaire, next document). The Educator will then provide the potential TOR participant an educational program (10-15 minutes) regarding overdose prevention and response inclusive of all the components provided to the Overdose Prevention Educator in D.3 above.

3. Upon completion of the program, the potential TOR will be assessed by the trainer on their understanding of the information and their comfort with the basic components of overdose response.

E. Overdose Rescue Kit dispensing:

Upon participant completion of overdose prevention training and documentation of competency, the TOR will be provided with the following naloxone kit containing at a minimum:

- Two 1-cc Naloxone Hydrochloride (concentration .4mg/ml) vials;
- Two 3ml syringes with 25g 1" needles (supplied by agency other than Behavioral Health);
- Overdose kit written materials; and
- Step-by-step instructions for administration of naloxone (as discussed above).

F. Documentation and Reporting:

1. The TOR will be strongly encouraged to report all used or lost naloxone vials to the provider from which they received the naloxone kit. Though this is anecdotal information, it will be crucial to estimating the effectiveness of the program and will be reported to Drug and Alcohol Services via quarterly reports.
2. Drug and Alcohol Services will be the secure repository for collected data regarding overdose rescue kit materials. The data collected will minimally include: provider source, name, gender, race/ethnicity, drug of choice, and use of naloxone per kit number and/or lot number.
3. Drug and Alcohol Services will collect program data and report to the Behavioral Health Administrator (or designee), Medical and Project Directors, on a bi-annual basis or sooner as requested.
4. Drug and Alcohol Services will keep all client identifying information in a locked cabinet and destroy after six years.

Attachment E. Case Management Specialist Manual

Case Management Specialist Manual

Case Management Specialist Manual

San Luis Obispo County
Behavioral Health

January 2016

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SECTION I: CASE MANAGEMENT OVERVIEW

This manual has been designed to provide San Luis Obispo County Behavioral Health (SLOBH) with a comprehensive understanding of case management and its role addressing the needs of the public sector client in the drug and alcohol service delivery system.

Mission Statement for Case Management

"The mission of San Luis Obispo Drug and Alcohol Services Case Management is to assist individuals and families with Behavioral Health needs to identify and utilize community resources in order to achieve quality, long term wellness and recovery."

Case management stresses comprehensive assessment, service planning and resource coordination to address multiple aspects of a client's life. Comprehensive substance abuse treatment often requires that a client move between levels of care or systems. Case management facilitates such movement and when fully implemented, will enhance the scope of addictions treatment as well as the continuum of recovery.

The two primary goals of case management are:

(1) to increase client retention in and completion of treatment in order to move clients toward recovery and self-sufficiency; and,

(2) to increase client access to core services such as primary health care, psychiatric care, stable and secure living environment, positive recovery support networks, vocational training, and employment.

The Federal Treatment Improvement Protocol (TIP) 27: Comprehensive Case Management for Substance Abuse Treatment

The federal government has researched and defined case management as it relates to substance use disorders in number 27 of its Treatment Improvement Protocol series titled "Comprehensive Case Management for Substance Abuse Treatment." Broadly, TIP 27 describes four basic models of case management to include:

- Broker/Generalist
- Strengths Perspective
- Assertive Community Treatment
- Clinical/Rehabilitation

The Substance Abuse and Mental Health Services Administration (SAMHSA) describes case management as a coordinated approach to the delivery of health, substance abuse, mental health, and social services, so that clients are linked with appropriate services to address specific needs and achieve stated goals. Research suggests that case management is effective as an adjunct to substance abuse treatment for two important reasons:

- a principle goal of case management is to keep clients engaged in treatment and moving toward recovery, and we know that retention in treatment is associated with better outcomes; and

- a client may be more likely to succeed in treatment when other problems he/she has are addressed concurrently with substance abuse treatment.

Sample definitions of case management include:

- planning and coordinating a package of health and social services that is individualized to meet a particular client's needs (Moore, 1990);

- a process or method for ensuring that consumers are provided with whatever services they need in a coordinated, effective, and efficient manner (Intagliata, 1981);

- helping people whose lives are unsatisfying or unproductive due to the presence of many problems which require assistance from several helpers at once (Ballew and Mink, 1996);

- monitoring, tracking and providing support to a client, throughout the course of his/her treatment and after (Ogborne and Rush, 1983);

- assisting the client in re-establishing an awareness of internal resources such as intelligence, competence, and problem-solving abilities; establishing and negotiating lines of operation and communication between the patient and external resources; and, advocating with those external resources in order to enhance the continuity, accessibility, accountability, and efficiency of those resources (Rapp et al, 1992); and

- assessing the needs of the client and the client's family, when appropriate, and arranges, coordinates, monitors, evaluates and advocates for a package of multiple services to meet the specific client's complex needs (National Assn. of Social Workers, 1992).

SAMHSA quoted The Center for Substance Abuse Treatment's (1998) definition of case management as: "The administrative, clinical, and evaluative activities that bring the client, treatment services, community agencies, and other resources together to focus on issues and needs identified in the treatment plan". SAMHSA's definition of Resource Coordination includes case management, client advocacy, and establishes a framework of action for each client to achieve specified goals. It involves collaboration with the client and significant others, coordination of treatment and referral services, liaison activities with community resources and managed care systems, client advocacy, and ongoing evaluation of treatment progress and client needs."

Applying Case Management to Substance Abuse Treatment

Although case management and substance abuse treatment are presented as separate and distinct aspects of the treatment continuum, in reality, they are complementary and, at times, thoroughly blended. Case management principles as applied to substance abuse treatment are as follows:

- case management offers the client a single point of contact with the health and social services systems;
- case management is client-driven and driven by client need;
- case management is grounded in an understanding of clients' experiences and the world they inhabit, the nature of addiction and the problems it causes, and other problems with which clients struggle;
- case management aims to provide the least restrictive Level of Care (LOC) necessary so that the client's life is disrupted as little as possible;
- case management involves advocacy and is community-based; and
- case management is pragmatic. It begins "where the client is" by responding to tangible needs such as shelter, clothing, transportation or childcare. Entering treatment may not be an immediate priority but meeting survival needs is part of the engagement process. This client-centered perspective is maintained as the client moves through treatment; however, the Case Management Specialist must keep in mind the difficulty in achieving a balance between help that is positive and help that may impede treatment engagement.

The TIP 27 Functions of Case Management

- Engagement - Identify and fulfill a client's immediate needs and reduce barriers that impede treatment.
- Assessment - Determine a client's eligibility and appropriateness for both substance abuse and other services.
- Planning, Goal Setting, and Implementation - Identify goals in all relevant life domains using the strengths, needs, and wants from the assessment process.
- Linking, Monitoring, and Advocacy - Refer client to needed resources, evaluate progress, and support a client's need for services related to his/her service goals.

Disengagement - A process that involves physical and emotional separation between a client and the Case Management Specialist once he/she can function independently.

SECTION II: THE FUNCTIONS OF CASE MANAGEMENT

Primary Functions of Case Management

The primary functions of case management (CM) are intake, assessment, and allocation of appropriate resources.

Intake

The primary requirement of intake is to determine eligibility for case management services. This is an important step in the process as this is the usually the first contact between the Case Management Specialist (CMS) and client. Initial referrals come from the SLOBH clinics and programs.

Given that intake is often the most critical contact with a client, lack of skill and proper training may render the screener incapable of obtaining needed information which may lead to inappropriate decisions regarding the need for care and may also prevent the client from following through with recommendations.

The SLOBH will make training available to Case Management Specialists.

Standards:

The SLOBH has written Employee Task and Standards (T&S) for Case Management Specialists. The T&S are clear guidelines for the following areas:

- Group Process/ Education
- Group Rosters
- Individual Rosters
- Charting Documentation/ Progress Notes
- Absences
- Re-admission to treatment
- Case Management Plans
- Leave of Absence
- Collaboration
- Progress Reports
- Discharge/ Termination
- Caseload, Productivity and Efficiency
- Staff Meetings and Individual Supervision

See Appendix for full Task and Standards.

Assessment

The activities encompassed in the function of assessment serve to coordinate all aspects of the client's involvement in SLOBH. This function, which is primarily focused on the determination of needed resources. The assessment also explores the client's situation in the life domains of: Housing, Child Care, Educational/Vocational, Employment, Basic Needs, Transportation, Substance Use Recovery, Legal, Healthcare, Family/Relationships, and Life Skills. While treatment focuses on activities that help clients to recognize the extent of their substance abuse problems, the assessment function of case management explores a client's strengths and needs (treatment and support) and refers him/her to available community resources. Throughout the client's involvement in CM, the Case Management Needs Assessment (CMNA) tool provides an ongoing review of the client's need for drug and alcohol treatment and supportive services. In this way, the client is afforded the optimal opportunity to develop sufficient coping strategies to be able to support a self-directed recovery program.

If a client is actively involved in treatment, the need for CM services should continually be evaluated throughout treatment experience. In this way, the client receives Behavioral Health treatment and supportive services at the most appropriate level until he/she has developed sufficient coping strategies. The CMNA should begin at the opening of CM assignment and updated at time of justification for ongoing services as well as at closing.

Case Management

CM services are designed for those individuals who present with multiple needs and lack the skills to meet those needs. The two primary goals of case management are: 1) to increase client retention in and completion of Behavioral Health treatment in order to move clients toward recovery and self-sufficiency and 2) to increase client access to core services such as psychiatric care and secure living environments. The underlying principle of CM services is to increase an individual's level of self-sufficiency based on the client's needs in one or more of the following domains:

Housing
Child Care
Educational/Vocational
Employment
Basic Needs
Transportation
Substance Use Recovery
Legal
Health Care
Family/Relationships
Life Skills

In most cases, treatment/recovery and CM services are concurrent experiences for the client. However, it is possible at times for a client to be involved in CM services but not actively involved in Behavioral Health treatment/recovery, e.g. waiting for appointments or a transition in level of care.

Although the need for CM services may be identified during a drug and alcohol assessment, the need for support services can arise at any time during the course of treatment/recovery as clients experience major life changes. For this reason, it is imperative that referrals to CM services not be restricted to the assessment stage.

Primary Activities of Case Management

- Engagement - This is the process of establishing rapport between the Case Management Specialist and the client. This step is essential in that it creates a foundation for working together. Clients who are experiencing difficulties need to feel confident and comfortable in expressing their concerns to a Case Management Specialist. Engagement goes beyond informing clients about the available community resources, it is intended to identify and meet the client's immediate needs. Maintaining rapport with the client is critical in order to keep the client engaged in recovery services.

- Evaluation of the Client's Strengths and Needs - This is the process by which a client's needs are examined through the administration of the CMNA. The role of the Case Management Specialist is to encourage a client to recognize his/her own assets and how he/she can apply them in positive ways to attain the goals in the case management plan. It is also important to help the client identify those behaviors that may create barriers to obtaining his/her goals.

- Case Management Planning and Goal Setting - This includes the development of a client-driven case plan to address the specific needs identified through the completion of the CMNA. The Case Management Specialist will assist the client in developing a written case plan and in determining the sequence in which to address the areas of need. Case plan goals should be realistic, measurable, and mutually acceptable. The action steps are designed to work toward achieving goals and must be observable and time limited.

- Linking - This is the process by which Case Management Specialists should refer clients to available resources that best meet individual needs and support the completion of goals specified in the case plan. It is important to maintain a balance between linking the client to services and doing too much for the client.

- Monitoring - The process by which the Case Management Specialist evaluates the progress toward the completion of goals identified in the case plan. Monitoring can include regular administration of the CMNA, review and adjustment of the case plan, and the assessment of available community resources.

- Advocacy- The process of being a proponent for the client in helping remove obstacles that may prevent the client from obtaining necessary services. Advocacy is geared toward, but not limited to; achieving the goals identified in the case plan and may include acting as an intermediary between the client and another agency or entity.

- Coaching - The process of skill building through educating the client on appropriate behaviors and interactions. Techniques used in coaching include modeling, rehearsing interviews, and role- playing difficult or problematic situations with clients.

- Discharge Planning – A process that occurs over the course of a client's involvement in CM services during which he/she begins to rely less on the Case Management Specialist and more on his/her own abilities.

Referral to Case Management

Referrals come from SLOBH clinics and programs.

Admission to Case Management

Admission to CM services should not be restricted based on level of care for Behavioral Health treatment.

Levels of Case Management

High/Medium/Low

- High
  - 25% of caseload
  - Intensive first two weeks
  - 3+ contacts per week with client
  - Transportation frequent/ black out period, modeling behavior, community reintegration
  - Crisis
  - Clients with special needs
  - New goal
- Med
  - 50% of caseload
  - 1-2 contacts per week
  - Working on current goals
  - Linkages
- Low
  - 25% of caseload
  - <1 contact per week
  - Most goals completed or nearing completion
  - Warm handoff

Case Plan

The Case Plan constitutes the core of the CMNA effort. It should be viewed as a road map to assist the client in addressing service needs. Case Management Specialists and clients must work together to develop individualized case plans that include realistic and measurable goals. The overall purpose of the case plan is to establish a well-documented plan of action for meeting goals. Ideally, after identifying areas of need, a client will determine how to best utilize his/her strengths and assets to achieve actions steps and goals in each of the areas of concern. Clients should be encouraged to take an active role in service planning so that they will feel empowered and invested to work on goals they have developed themselves rather than those developed solely by the Case Management Specialist. An important role of the Case Management Specialist in the CMNA process is to encourage, assist, and support the client in identifying his/her strengths and needs and to be a resource person whose professional training can help the client access the appropriate services.

Given that most clients involved in CM services are also engaged in Behavioral Health treatment, it is important to remember that the intent of a case plan is not to replace or duplicate a treatment plan. It must serve as an adjunct or supplement to a treatment plan and the focus should be on accessing and utilizing services available to meet a client's needs. This does not mean that a client's needs with regard to the Substance Use Recovery (SUR) domain should be overlooked. A typical goal of the SUR domain may be "client will address substance use issues" followed by action steps such as "comply with all recommended treatment".

The needs identified in the case plan should then be prioritized to consist of those that the client is most willing to address; however, there are instances when the client needs the service but is not interested in working on that domain at that point in time. For instance, based on the results of the CMNA a client may have a need in the SUR domain: however, from the client's perspective this is not something he/she is ready to address. The Case Management Specialist should defer addressing this domain in the case plan and be able to demonstrate through documentation that the needs in this domain continue to be discussed. Once the client is comfortable and engaged in case management services, the Case Management Specialist may utilize motivational skills to work on those domains that the client was previously unwilling to address.

The case plan must identify opportunities to empower the client in accessing community resources. When the Case Management Specialist is designated as being responsible for something in the action step, it must be limited to specific activities such as linking, monitoring, advocating, or coaching. The Case Management Specialist should not put himself/herself in a position to become a resource to meet the client's needs directly, but function as a support to increase the client's self- sufficiency.

The case plan should be reviewed at each meeting with the client to ensure that progress is being made on identified goals. The case plan may need to be amended due to significant changes in life circumstances or a crisis situation occurring for the client. Documentation is required to demonstrate the circumstances and the resolution of the crisis situation.

Case Management Notes

While notes should be as concise as possible, they must adequately describe the nature and extent of each contact. It is beneficial to structure notes in a specific format such as FIO (Focus, Intervention and Outcome). This allows the Case Management Specialist to focus on what the content of the note should include:

- ✓ **F** (Focus) – Domain in life area being addressed
- ✓ **I** (Intervention) – Action that occurred. Assisting client to identify or achieve client needs
- ✓ **O** (Outcome) – Follow through on intervention

The Case Management Specialist is required to electronically sign and final approve case management note entries in a timely manner.

Confidentiality

Case Management Specialists adhere to the laws, regulations, and guidelines of confidentiality set in place by HIPAA (Health Insurance Portability and Accountability Act of 1996), Federal Regulations Title 42, State Regulation Title 9, and Drug and Alcohol Services policy and procedure. Case Management Specialists will complete the 42 CFR Training as required within 6 months of being hired.

Protecting client's confidentiality allows for:

- Creating a trusting/healing environment for client's to share their personal information without fear of unauthorized disclosure.
- Maintaining an agency of high professional conduct and integrity.
- Remaining a resource in the community for clients to receive professional treatment.
- Protecting ourselves, our staff, and our agency from potential legal action due to breach of laws or regulations regarding confidentiality.

Establishing Client Confidentiality

Informing clients of their privacy rights should be done as early as feasible to begin the building of a professional and trusting relationship. Case Management Specialists are expected to respect and guard the confidences of each client and community member who seek information and/or services. The client in the therapeutic relationship may be more than one person, which may include family members for the client and all involved parties. Case Management Specialists are required to explain to the client the nature of confidentiality and possible limitations of the client's rights to confidentiality and review with the client the circumstances where confidential information may be requested and where disclosure of confidential information may be legally required.

Upholding Confidentiality

To uphold and protect client's privacy Case Management Specialists will:

- Follow SLOBH procedure for signing Informed Consent/Release of Information (ROI) forms. All ROIs will be signed by clients prior to discussing information with other agencies, entities or outside parties. ROIs should be updated as necessary. Hard copy ROIs must be entered and scanned into the Electronic Health Record per Quality Assurance.

- Exercise exceptions to confidentiality when needed. Examples may include medical emergencies, a Judge's order to release information to a court, unreported abuses of a child, dependent adult or elder, or in the event of the client being a danger to self or others.

- Store, safeguard, and dispose of clients records in ways that maintain confidentiality. All documents with client information must be carried in a locking briefcase and stored in an approved locking cabinet.

- Consult supervision when confidentiality or client's privacy is in question.

- Share client information with written authorization only. ROIs signed by the client should specify the designated party, what information is permitted to be disclosed and the purpose of the disclosure. The information to be released or received must relate to the purpose of the consent. Information shared beyond the scope of the ROI can be considered a breach of client confidentiality.

- Only share client information with other staff members for treatment coordination and follow applicable Federal and State regulations.

As a professional standard, a client's information is shared when relevant to the present situation within the case. Historical information on the client or other related parties, although appears useful, may serve to contaminate the objectivity of the current treating staff. Before disclosing historical information to other staff members, is it important that we ask ourselves the questions:

- Does the information need to be disclosed for the client to receive complete care?
- Would the information be in the best interest of the client?
- What would the client's reaction be to knowing their past information was shared without their consent?

If we determine the information is relevant to the current case, it is suggested that we consult with our supervisor and proceed in the disclosure with discretion.

When working with clients with communicable diseases, we will seek supervision in effort to ensure upholding of laws and statuses of confidentiality specific to the communicable disease.

- NOTE: The Health Insurance Portability and Accountability Act (HIPAA), under 45 C.F.R., contains confidentiality requirements that may supercede the requirements of 42 C.F.R. One clear example involves the need to obtain a client's revocation of his/her consent "in writing" under HIPAA.

SECTION III: APPENDICES

Checklist

- Task and Standards
- Approved Abbreviations for Treatment Documentation
- Case Management Needs Assessment
- Budget: Housed
- Community Resources For Assistance
- SLE Checklist
- Residential/SLE Placement Procedure
- SLE FAQs
- Gradual Self Sufficiency Payment Plan for SLE's
- Transitioning to Self-Pay Letter
- Open and Closing SLE AZ Assignments
- DL 937 Verification for Reduced Fee Identification Card
- SLE Complaint Form
- Sober Living, Residential Treatment, and Outpatient Services Information
- SLE Daily Bed Rates Chart
- Treatment Schedule
- Revocation of Consent Form
- Consent for Release of Confidential Information Form (General)
- Verification of Income Form

Task and Standards

Drug & Alcohol Services
Employee Task & Standards
Case Management Specialist Assignment

Case Management Mission Statement:
The mission of San Luis Obispo Behavioral Health Case Management is to assist individuals and families with behavioral health needs by identifying and utilizing community resources in order to achieve quality long term wellness and recovery.

TASK ⇨	**Group Process/Education**
Standard Annual Evaluation Area: **Accuracy** **Job Knowledge** **Interpersonal Skills** **Creativity** **Alertness** **Acceptance of Supervision** **Personal Appearance**	✓ Groups will be conducted according to program curriculum and agency standards. Case Management Specialists should inform the Program Supervisor immediately should the groups become full/depleted. Based upon monthly audit of group rosters, the following standards should be held: Min Max CM Groups 2 12 CM Education Groups 2 12 ✓ Groups will be conducted in a professional, ethical manner and according to the Group Guidelines and Treatment Manual. For groups, which utilize a guest speaker, the Case Management Specialist will facilitate the confidentiality statement for the guest speaker and forward to the Program Supervisor. ✓ Groups will only be conducted within the scope of the certificate or licensure of the Case Management Specialist.
TASK ⇨	**Group Rosters**
Standard Annual Evaluation Area: **Accuracy** **Job Knowledge** **Alertness** **Drive**	✓ Clients will sign roster at each group or Case Management Specialist will mark absence with notation. Rosters will be completed with all required information (topic, time start & ending, Case Management Specialist signature). Case Management Specialist will turn in roster at the end of the workday to the designated location. For IOT services, the client must sign in and sign out for each three hour block of time.
TASK ⇨	**Individual Rosters**
Standard Annual Evaluation Area: **Accuracy** **Job Knowledge** **Alertness** **Drive**	✓ Rosters need to be completed in a timely manner, including absences (excused or unexcused). Client signatures must be obtained. All required information needs to be reflected on the roster and Case Management Specialist must sign. Case Management Specialist will turn in roster at end of workday to the designated location.
TASK ⇨	**Charting Documentation/Progress Notes**
Standard Annual Evaluation Area: **Accuracy** **Quantity of Work** **Acceptance of Supervision** **Job Knowledge** **Alertness** **Creativity**	✓ Charting of all relevant group, IOT, and individual sessions shall be documented by the end of the workweek in which the session occurred. ✓ Group Notes should include **Focus** for case management session, Case Management Specialist **Interventions**, **Content** of session, and reflect client **Progress** towards treatment and case management goals, and medication response if applicable. All progress note documentation must have signature and date and final approval. ✓ For Case Management non-group progress notes, the format is **Focus, Intervention and Outcome.** What is the focus of the case management activity, what are the interventions that the Case Management Specialist performed, and what is the outcome. All case management notes must have Case Management Specialist signature, date, and final approval. Time for all activities are to be

	recorded. ✓ When ethical issues are present (e.g. suicide, CWS reporting) the progress notes should be more detailed to cover a trail of information and to document actions taken. Notes regarding ethical issues should be documented by the end of the same day. Case Management Specialist will contact the Program Supervisor in all ethical circumstances by the end of the same day. ✓ Progress notes should be legible and complete, using only standard abbreviations. ✓ Upon review of charts using Quality Assurance Standards, errors should be less than 10% of caseload. Corrections need to be made within 5 days and documented on Quality Assurance Checklist and forwarded to Program Supervisor.
TASK ⇨ Absences	
Standard **Annual Evaluation Area:** **Accuracy** **Quantity of Work** **Acceptance of Supervision** **Job Knowledge** **Alertness** **Creativity**	✓ Absences should be documented in the client chart and on the roster, whether excused or unexcused. Excused or unexcused absences are at the discretion of the Case Management Specialist, with informed consideration for Treatment Specialist, unless specified by program guidelines. Case Management Specialist will address attendance as a therapeutic issue with the client. ✓ Outreach upon client absence, shall be at the Case Management Specialist's discretion, with consideration for Treatment Specialist, and is encouraged in the cases of concern about client safety and child welfare. Outreach may be by phone call or letter co-signed by Program Supervisor, and documented within the client chart. ✓ Case Management Specialist will facilitate termination procedures for case management assignments when the client has failed to call or show within five contacts or two weeks to case management specific appointments and/or treatment appointments. The Case Management Specialist will inform the Treatment Specialist of the client's failure to show for assigned case management activities.
TASK ⇨ Re-admission to treatment	
Standard **Annual Evaluation Area:** **Accuracy** **Acceptance of Supervision** **Job Knowledge** **Alertness** **Creativity**	✓ Returning clients may attend Walk-in session. Walk-in Specialist will determine the current appropriate treatment placement and documentation that needs to be updated. Case Management Specialist will refer any returning clients to the Walk-in clinic.
TASK ⇨ Case Management Plans	
Standard **Annual Evaluation Area:** **Accuracy** **Acceptance of Supervision** **Job Knowledge** **Alertness** **Creativity**	✓ Case Management Specialist shall develop a case management plan with the client, which compliments the treatment plan, including case management goals, objectives, and with expected completion dates. Case management plans are to be completed in conjunction with the treatment plan. Case management plans are to be completed prior to the deadline in cases where case management has been deemed necessary. A case management plan is to be in place within 30 days of walk-in/intake, and every 90 days thereafter plans shall be individualized reflecting each client's own recovery plan. All case management plans must have Case Management Specialist signature, date, and final approval. ✓ Clients will sign their case management plan to indicate their understanding and involvement in the case management plan development.
TASK ⇨ Leave of Absence	
Standard **Annual Evaluation Area:**	✓ Case Management Specialist may facilitate client's leave of absence from 7 up to 90 days. Case Management Specialist will fill out the Leave of Absence Request form, as prompted by client or if situation is deemed advisable by circumstances

Accuracy **Quantity of Work** **Acceptance of Supervision** **Job Knowledge** **Alertness** **Creativity**	that have come to the Case Management Specialist's attention. Program Supervisor shall approve the Leave of Absence request for absences of more than 30 days. The relevant Case Management Specialist or Treatment Specialist will facilitate termination procedures when the client has failed to call or show within ten days after Leave of Absence expires.
TASK ⇨	**Collaboration**
Standard **Annual Evaluation Area:** **Accuracy** **Acceptance of Supervision** **Job Knowledge** **Alertness** **Creativity** **Interpersonal Skills** **Personal Appearance**	✓ Case Management Specialists will participate in collaborative case management efforts on behalf of the client with other involved agencies with appropriate Releases of Information. All interactions will be professional and timely. Case Management Specialist will document the efforts into the client record. Case Management Specialist will inform the Program Supervisor promptly of any difficulties in the collaborative process.
TASK ⇨	**Progress Reports**
Standard **Annual Evaluation Area:** **Accuracy** **Quantity of Work** **Acceptance of Supervision** **Job Knowledge** **Alertness** **Creativity**	✓ Progress reports are to be issued at the client's request on the standard form with appropriate Release of Information signed prior to report being issued. Program Supervisor must co-sign all outgoing documentation for staff under supervision. Progress reports to be completed in a timely manner according to the client's need. A copy of the report is to be inserted in the client's record. Progress reports must be stamped with the Confidentiality Statement. ✓ No personalized letters of recommendation or personalized progress reports shall be issued.
TASK ⇨	**Discharge/Termination**
Standard **Annual Evaluation Area:** **Accuracy** **Quantity of Work** **Acceptance of Supervision** **Job Knowledge** **Alertness** **Creativity**	✓ Discharge from case management services and related case management assignments will occur upon successful completion of case management goals. Case Management Specialist will process all closing paperwork within 30 working days, relative to case management services. Case Management Specialist will ensure appropriate follow-up linkages and referrals, which may include a return to Drug & Alcohol Services. The Case Management Specialist will facilitate final progress reports within twenty days related to case management services and assignments. ✓ Termination from case management services will occur if the client has failed to show or call within five case management and/or treatment contacts or two weeks. Case Management Specialist will relay information to Treatment Specialist so that a termination letter can be issued, which will include three referrals for other services. The Case Management Specialist will relay information when appropriate to Treatment Specialist so that the client will be made aware in writing, at least 10 days prior to the effective day of the intended termination action, of their right to request a return to treatment and subsequent case management services. The Case Management Specialist will facilitate final progress reports within the twenty days related to case management services and assignments.
TASK ⇨	**Caseload, Productivity and Efficiency**
Standard **Annual Evaluation Area:** **Accuracy** **Quantity of Work** **Acceptance of**	✓ Caseloads will be determined by program needs, client acuity level, and program regulations. Case Management Specialist will monitor the client caseload per Department Policy and Procedures. At the individual session with the Program Supervisor, the Case Management Specialist will review/ update the client caseload on a regular basis and as needed. The caseload capacity will be determined by the Program Supervisor in accordance with Department standards and as negotiated with the Case Management Specialist due to Specialist's assigned job duties.

Supervision **Job Knowledge** **Alertness** **Creativity** **Drive**	
TASK ⇨	**Staff Meetings and Individual Supervision**
Standard Annual Evaluation Area: **Acceptance of Supervision** **Supervision Required** **Drive** **Job Knowledge** **Alertness** **Creativity** **Interpersonal Skills** **Personal Appearance** **Attendance**	✓ Case Management Specialists will meet with their Program Supervisor individually as deemed necessary, at a minimum of once per quarter. Consult with the Program Supervisor as to the manner of scheduling individual time. ✓ Case meetings will include discussions on walk-in/new referrals to the program, client issues, staff announcements, procedural updates, and other items necessary for team development. ✓ Case Management Specialists will come prepared for all meetings and participate in the development of new ideas and better ways of doing things within program requirements. Case Management Specialists will be aware of department and program goals and establish their own personal work goals within this context.

Approved Abbreviations for Treatment Documentation

1. A = before
2. B.I.D. = 2 times per day
3. C or w/ = with
4. Dx = diagnosis
5. Fx = fracture
6. HS = at bedtime
7. Hx = history_
8. P = after
9. R/O = rule out_
10. S = without
11. QD = daily
12. Q.I.D. = 4 times per day
13. R/S = Rescheduled
14. Tx = treatment
15. Thx = therapist
16. Ct = client
17. P.O. = probation officer
18. Psych = psychiatric (as in "psych eval")
19. Eval = evaluation
20. Spx = Specialist
21. CM = Case Manager
22. NP = Nurse Practitioner
23. DAS = Drug and Alcohol Services
24. AOD = Alcohol and other Drugs
25. Alc or ETOH = Alcohol
26. FTS = Failure to Show
27. N/S = No show
28. N/A = Not applicable
29. Ex = Excused
30. MI = Motivational Interviewing
31. Dx = Diagnosis
32. SUD = Substance Use Disorder
33. MH = Mental Health
34. BHD = Behavioral Health Department

Case Management Needs Assessment

Client Name:

_____

Anasazi #:

_____

Date of Service(s):

_____

Case Management Services Provided:

- ☐ Childcare # kids _____
- ☐ Consumer assistance and protection
- ☐ Criminal justice / legal services
- ☐ Criminal Thinking (CBT)
- ☐ Education
- ☐ Employment
- ☐ Family Counseling
- ☐ Food
- ☐ Hep-C/HIV/AIDS – related services
- ☐ Leisure & Social
- ☐ Material goods
- ☐ Mental health care/counseling
- ☐ Other health care/dental/eye
- ☐ Outreach
- ☐ Permanent Housing Placement
- ☐ Personal enrichment
- ☐ Substance abuse services/testing
- ☐ Temporary housing (SLE)
- ☐ Transportation # times _____
- ☐ Trauma Services
- ☐ Other _____
- ☐ Other _____

Details:

_____

_____

_____

External Referrals:

- ☐ CAPSLO _____
- ☐ CASA
- ☐ Child Development Center
- ☐ Chrysalis
- ☐ Community Counseling
- ☐ Community Health Clinic
- ☐ County Mental Health
- ☐ Department Social Services
- ☐ Family Care Network
- ☐ Food Banks
- ☐ Hep-C/HIV/AIDS – related services
- ☐ Housing Authority
- ☐ Kinship Center
- ☐ Liberty Tattoo
- ☐ Martha's Place
- ☐ Mobile Crisis Team
- ☐ Non-Profit Charities
- ☐ Occupational Therapy
- ☐ Other health care/dental/eye
- ☐ Physical Therapy
- ☐ Senior Services
- ☐ Sober Living Environment (SLE)
- ☐ Sober Schools
- ☐ Social Security
- ☐ Transitions (T-MHA)
- ☐ Vet's Services / VASH
- ☐ Vocational Rehab / One-Stop
- ☐ Other _____
- ☐ Other _____

Details:

_____

_____

Case Management Intake

Client Name: _____

Anasazi #: _____

Family Size (#): _____

Family Income (total): $_____

- Note level based off family size

Education Level:

| Grade 0-8
| 9-12/Non-Graduate
| High School Grad/GED
| 12+ Some Post-Secondary
□ 2 or 4 yr. College Graduate

Health Insurance:

| Yes
□ No

Disabled:

| Yes
□ No

Family Type:

|_| Single Parent / Female
|_| Single Parent / Male
|_| Two-Parent Household
|_| Single Person
|_| Two Adults - No Children
|_| Other _____

Housing:

| Own
| Rent
| Homeless
| Other _____

Other Family Characteristics:

| Farmer

| Migrant Farmworker
| Seasonal Farmworker
| Veteran
| Active Military

295 & Planned Services

Source(s) of Family Income:

TANF

_ SSI

_ Social Security
Pension

_ General Assistance

_ Unemployment Insurance
Employment + Other Source

_ Employment Only

Other _____

Benefits:

□ WIC
| Food stamps
| Rental/SLE Assistance
| Medicare/Medical/Homeless Health
| Other _____

Planned Services at Intake:

Consumer assistance and protection

Criminal justice / legal services

_ Criminal Thinking (CBT)

_ Day care

Education

_ Employment
Family Counseling

Food

Hep-C/HIV/AIDS - related services

_ Leisure & Social

_ Material goods
Mental health care/counseling

_ Other health care/dental/eye

Outreach

_ Permanent Housing Placement
Personal enrichment

_ Referral to other service(s)
Substance abuse services/testing

_ Temporary housing (SLE)

_ Transportation

_ Trauma Services

Other _____

_ Other _____

Budget: Housed

Name: _____ **Date:** _____

Case Manager: _____ **Open Date:** _____

Monthly Income:

Sources:	*Amounts:*		
_____	_____	**Gross Income**	$0.00
_____	_____	**Deductions**	$0.00
_____	_____	**Expenses**	$0.00
_____	_____	**Discretionary**	$0.00
Subtotal	$0.00		
Deductions:			
Taxes	_____		
_____	_____		
_____	_____		
Subtotal	$0.00		

Monthly Expenses:

Rent	_____
Household Expenses	_____
Gas	_____
Electric	_____
Water	_____
Trash	_____
Cable/Internet	_____
Phone	_____
Transportation:	
Car Payment	_____
Registration	_____
Insurance	_____
Gas / Oil	_____
Repairs / Maintenance	_____
Bus Pass	_____
Personal:	
Work / School Expenses	_____
Food	

Community Resources for Assistance

MAXINE LEWIS MEMORIAL SHELTER: 781-3993(calls answered in afternoon/evening only); mlminfo@capslo.org
750 Orcutt St. (at Broad St.), SLO

- Admittance between 6-7 pm. No one admitted after 7 p.m. No private transportation is available, only city bus service.
- Breakfast and dinner provided. Showers available. No alcohol, drugs or violence.

PRADO DAY CENTER: 786-0617 or pradoinfo@capslo.org
43 Prado Rd., SLO

- Open 8:30am - 4:30 pm daily. Breakfast: 8:30-9:30 am.; Lunch (hot meal) 12-1 pm.; bag lunch 11-11:15 am at front gate
- A rest area for individuals & families: showers, laundry, restrooms, storage, telephone, newspaper, children's area
- Professional and volunteer support services
- Homeless Case Management: Open Assessment: Tue (& Wed) 1-4pm or call/email Mary Lou Zivna for apt mzivna@capslo.org
- Medical van: Mon, Wed, Fri: 9:30am-3:30pm; Dental van: last Wed, Thur, Fri of month: 8:30am-3:30pm

CAPSLO ENERGY: 541-4122 X14 Short St, SLO

- HEAP utilities assistance (not emergency assistance)

GRASS ROOTS II: 544-2333; for emergencies, call 471-7732.
11545 Los Osos Valley Road A-1, SLO: Open Mon, Wed, Fri 9am-12 or by appointment

- Food, clothing, furniture & household items, housing information, legal referrals, crisis counseling available

FOOD BANK COALITION OF SAN LUIS OBIPSO COUNTY: 238-4664

HOTLINE: 211: 24 hours a day/365 days a year: information and referrals; Crisis counseling; Senior information and counseling

SOCIAL SECURITY ADMINISTRATION: 544-5251 3240 S. Higuera St., SLO 9am – 4 pm Mon - Fri

SOCIAL SERVICES DEPARTMENT: 781-1600 3433 S. Higuera St., SLO 8 am – 5 pm Mon - Fri

ASSISTANCE LEAGUE: 782-0824: make an appointment

- Clothing for children K-6 grades: 2 outfits, shoes and socks. Bring a referral from the school secretary or nurse

CATHOLIC CHARITIES: 706-8566
3592 Broad St., Suite 104 SLO: Open Monday - Friday by appointment only

- Pathway to Stability by referral only
- Immigration Legal Assistance: 706-8565

GOD'S STOREHOUSE: Grace Church: 1350 Osos St., SLO: Open Saturday from 9:00am-11:00 am to low-income families

GOODWILL WAREHOUSE AND DONATION CENTER: 544-0542

GREEN PASTURES: 543-5451
First Presbyterian Church of San Luis Obispo: 981 Marsh St., SLO (corner Morro & Marsh)

- Open Wednesday 1:00 - 3:45 pm (lottery drawing for 10 clients at 1 pm)
- Provides emergency resources and practical help

MERCY CHURCH: 543-2888
710 Aerovista Place, SLO: 2nd Tuesday 5-6:30 pm: food bank, clothes & shoes
Meadow Park parking lot: Saturday 10-10:30 am

MOUNTAINBROOK COMMUNITY CHURCH: 543-3162
1775 Calle Joaquin, SLO: food pantry with bread every day open Monday and Thursday 4 – 5 pm

SLO NOOR CLINIC: 439-1797 1428 Phillips Lane, Suite B-4, SLO
free primary care clinic Friday & Saturday 1-5 pm; eye clinic last Thursday of every month 8 am-12pm

SAINT VINCENT DE PAUL SOCIETY: 544-7041

- Open Tuesday 2-3:30 pm Prado Day Center 43 Prado Road: ID's, Birth Certificates, Notary; glasses, medications by referral only
- Open Thursday by appointment only (call and leave call back number) at the Mission 751 Palm St: rental assistance (eviction notice), rental deposits, utilities (shut off notice), other financial needs (case by case basis)

SALVATION ARMY: 544-2401
815 Islay St., SLO: Open Tuesday – Friday 10:00 am –2 pm
The Clothing Closet is open Tuesday & Thursday (Nov & Dec; > Dec: Tues-Fri) 10:00 am – 1:30 pm

- Food and Clothing are available to individuals & families once a month
- Utility assistance, eviction prevention

WOMEN'S SHELTER: 544-2321 Call 781-6400 if you need help; Call 911 if there is an emergency

- Provides services for women and children seeking refuge from domestic violence

ZION LUTHERAN CHURCH: 'Harvest Bag' 543-8327
1010 Foothill Blvd., SLO: Sign up at church before 4 pm on Tuesday

- Pick up food on Wednesday 8: 15 and 10:30 am (or by special arrangement); if unable to pick up, call by 9:45 am

SERVICES AVAILABLE IN NORTH COUNTY:
ECHO OVERNIGHT SHELTER: 462-FOOD (3663)
First Baptist Church, 6370 Atascadero Ave., Atascadero: Dinner at 5 pm

FOOD PANTRY:
Assembly of God Church, 5545 Ardilla Ave., Atascadero: 466-2626: Thursday 1-2 p.m.
Assembly of God Church, 925 Bennett Way, Templeton: 434-2616: Wednesday 3-6 p.m.
Grange Hall, 5035 Palma, Atascadero: 1st Wednesday 10:30 a.m.-noon

HOT MEAL:
Paso Robles People's Kitchen, next to 2nd Baptist, 1945 Riverside Ave, Paso Robles M-F 11:30 am-12:30pm, 5-6pm
Refuge Church, 6955 Portola Rd, Atascadero: 466-3354: sign-in 5:30-6pm

LOAVES AND FISHES:
Atascadero: 5411 El Camino Real, 461-1504 M-F 1-3 pm
Paso Robles: 2650 Spring St, 238-4742 M-F 2-4 pm; TTh 5:30-7:30 pm

SALVATION ARMY:
5411 El Camino Real, Atascadero: 466-7201: Tue-Thur 1-3 pm
711 Paso Robles Street, Paso Robles: 238-9591: Tue-Fri 10 am – 1:30 pm

WOMEN'S RESOURCE CENTER: 461-1338
1030 Vine Street, Paso Robles

SERVICES AVAILABLE IN SOUTH COUNTY:
5 CITIES CHRISTIAN WOMEN EMERGENCY FOOD: 473-3368
192 South Ninth Street, Unit B, Grover Beach

5 CITIES HOMELESS COALITION: Grover Beach 574-1638 http://5chc.org/

CAPSLO CASE MANAGEMENT: 473-8210 (Larry Feldt, So. County Supvr)
Open Assessment: Wed 2-4 1616 Manhattan, Grover Beach

CHILDREN'S RESOURCE NETWORK: call for appointment 709-8673 or
www.childrensresourcenetwork.org: Teen's Closet: clothing for children up to 18

FOOD PANTRY: 305-1465: Mon, Tues, Thur, Fri 10 am- 1pm
Nipomo Community Baptist Church, 545 Orchard Ave, Nipomo

HARVEST BAG: 489-4223 Wed 7:00 am – 9:00 am at Soto Park

SALVATION ARMY: 481-0278:1550 W. Branch St. AG (M-W 10-1:30 pm , Friday 12-3)

- Food, utility assistance, eviction prevention, emergency assistance

ST. PATRICK'S CATHOLIC CHURCH OUTREACH FOOD PANTRY:

Servicing people living in 5 Cities and Nipomo only

501 Fair Oaks Ave, Arroyo Grande 489-2680 X31: Food distrib: Tues, Wed, Thur 4 – 5 pm

- Emergency assistance (call for appointment): rent, utilities, gas and clothing vouchers

SLE Checklist
Items to Consider When Placing Clients in SLE's

- ☐ Discuss with Treatment Team the possibility and justification for placing client in SLE
- ☐ Help to identify the best fit for SLE placement for client
- ☐ Contact SLE and see if they have any open beds. SLE Contact Info located at S://SLE's/Sober Living Information. Arrange with House Manager/ Executive Director a time for client's induction at SLE.
- ☐ Open up client's AZ SLE subunit assignment, dated to when they first entered the SLE. For instructions on opening AZ SLE assignments, go to S://SLE's/Open and Closing SLE AZ Assignments
- ☐ Complete the BH Referral Form in AZ. Step by step instructions on filling out the Referral Form process located at S://SLE's/SLE Referral Form Procedure
  - ☐ Make sure to fill out all boxes in BH Referral Form
  - ☐ Give brief explanation as to why client needs SLE, and how they are demonstrating compliance in program
  - ☐ Clearly outline what program client is in, what funding source to be billed to (AB109, ADC, GFS, DSS, MIOCR), days requesting funding for the calendar month (i.e. month of July 2015, OR client entered SLE on July 24th, asking for payment July 24- July 31, 2015), as well as percentage of funding (100%, 75%, 50%, 25%).
  - ☐ Electronically sign and add all necessary signatures for approval.
- ☐ Go over SLE agreement with client and make sure they are aware of current month and following month's SLE payment agreement between client and County.
- ☐ Fax over BH Referral Form to SLE client is staying at. (Complete form and faxing over to SLE within five days of client entering SLE)
- ☐ If any changes occur to SLE plan, please update the BH Referral Form accordingly, email SLE Contract Manager letting them know of the change, and inform SLE of the change (if they don't already know).
  - ☐ Changes can include: client leaving SLE early, funding agreement changes, etc.
- ☐ Otherwise, if no changes, then repeat the BH Referral Form process for the following month. You will have to complete a new form for client's SLE stays each calendar month.
  - ☐ Payment plan (general guideline for all DAS clients at SLE's) is located at S://SLE's/Gradual Self Sufficiency Payment Plan
  - ☐ If client is 30 days out from becoming self-pay, send them a transition letter, located at S://SLE's/Transition to Self Pay Letter
- ☐ Lastly, once client leaves SLE, make sure to close them out of their SLE AZ assignment with the correct discharge status. For information on closing out SLE AZ assignments, go to: S://SLE's/Open and Closing SLE AZ Assignments
- ☐ If you ever run across any client complaints about an SLE, there is a general procedure with how to address complaints:
  - ☐ Bring complaint up to house manager/executive director to be resolved
  - ☐ If issue is not resolved or you think it is a violation of SLE standards, fill out the complaint form, located at S://SLE's/SLE Complaint Form. Save form under specific SLE on S://SLE's/(SLE house)/Complaints, and email to SLE Contract Manager.

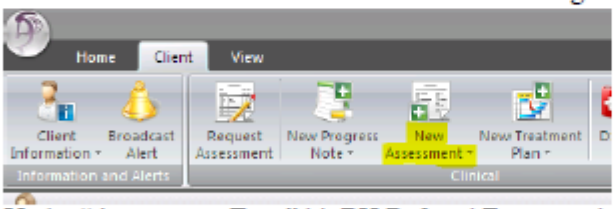
Residential/SLE Placement Procedure

- Present your recommendation to program specific team meeting (i.e P36, ATCC, ADC, FTC) for team approval.

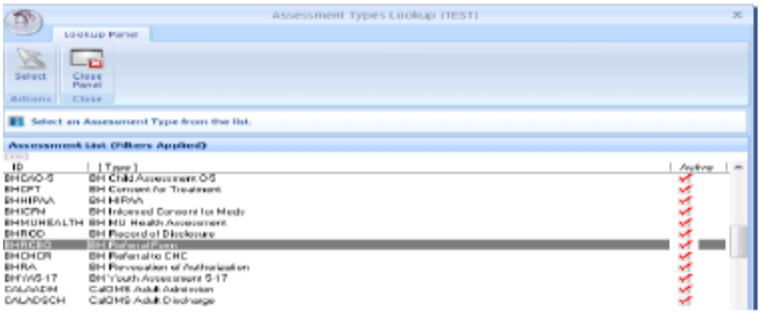
- Counselor can help identify the best fit for client, which programs have open beds, how long the wait list is.
    - We can only pay for a residential that has a contract with DAS (see list below).
        - Bryan's House
        - Captive Hearts
        - Casa Solana
        - Good Samaritan – Project Preemie and Recovery Point
        - Gryphon
        - House of Serenity
        - JC House
        - Middle House
        - Next Step
        - Restoration House
        - Sowing Seeds Saving Souls Ministries

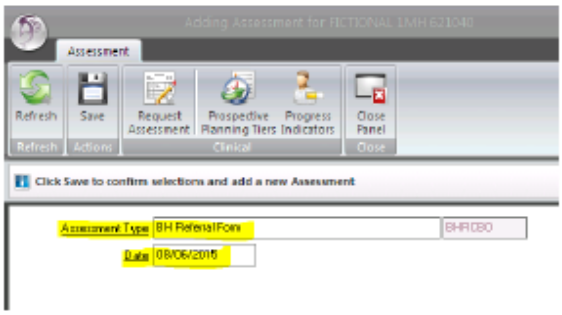
- Client is responsible for contacting the residential program and setting up an interview with the program.

- Counselor completes the BH referral form in Anasazi Clinician's Home Page.
    - As an internal control, this form should be processed **every month** for each client in a facility in order for payment to be processed on their behalf. Payment will be postponed until this process has been completed.
    - Go to New Assessment in AZ Clinician's Home Page:

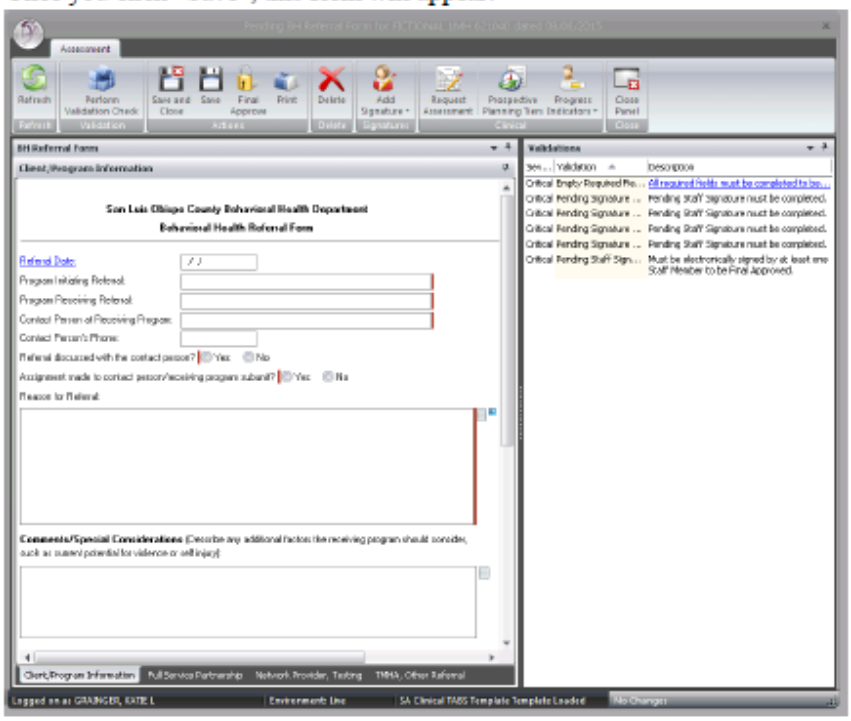


    - Under "Assessment Type" hit BH Referral Form, as shown in screenshot below:





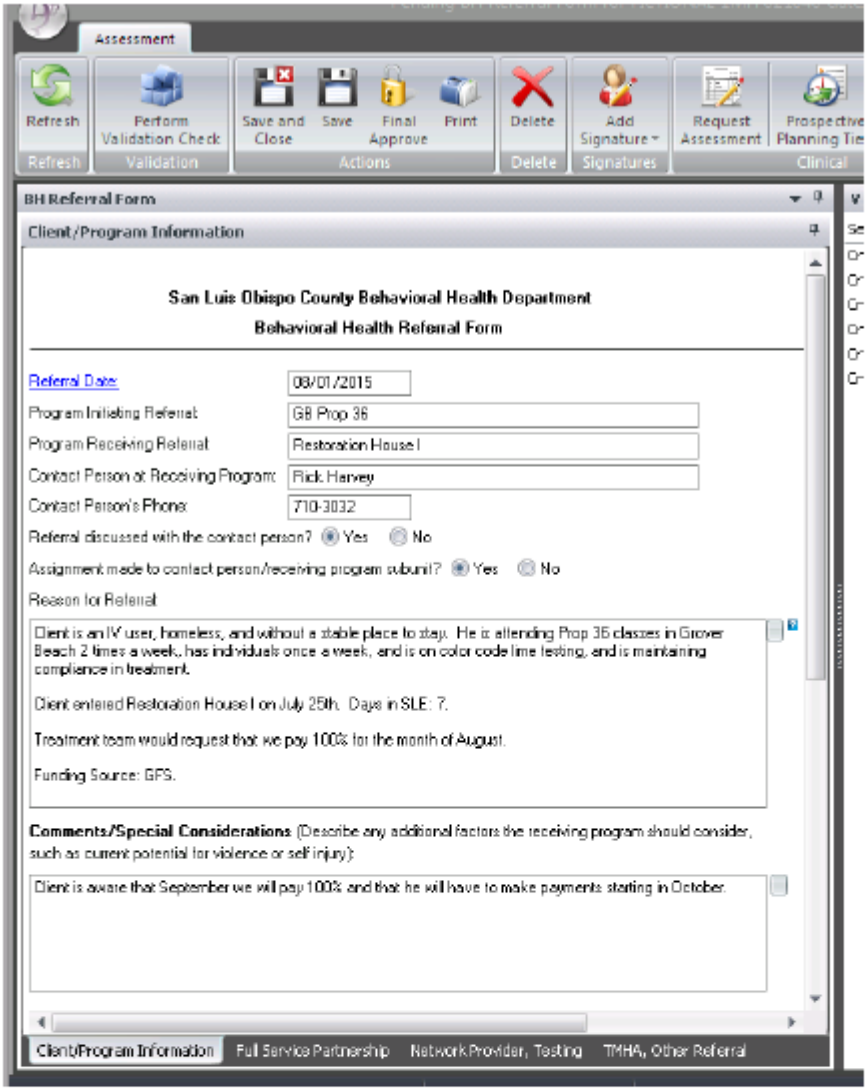
- For "Date" put in the date they are entering the SLE (not the current date).
- Then click "Save"
- Once you click "Save", this form will appear:



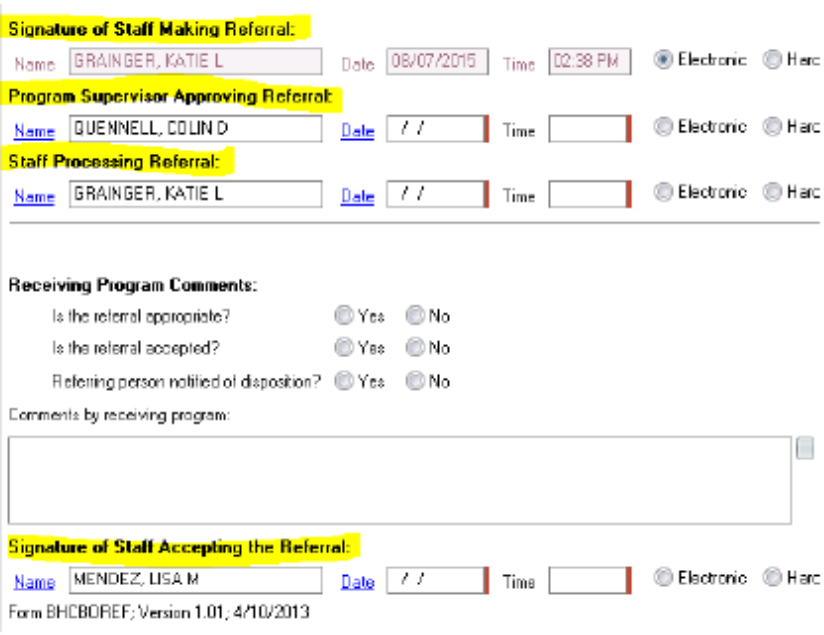
- List the following information needed for Supervisor & Accounting review on the Behavioral Health Referral Form:

  - **"Referral Date"** is the date the client entered the SLE if this is their intake BH Referral Form (for example, it could be June 25, 2016). OR if the client was already in SLE and you are creating another BH Referral Form for the following month, it would be the first day of the new month (for example, client entered SLE on June 25, 2016, and you already did that form for June – you would now complete July's BH Referral Form and enter 07/01/2016 for the referral date)
  - Under the **"Program Initiating Referral"** field, list DAS & assigned program (i.e. FTC, AB109, FRS, ATCC, Prop 36, etc).
  - **"Program Receiving Referral"** will be the appropriate SLE that the client is going to. If SLE has more than one house (for example, Gryphon, Restoration, Casa) PLEASE SPECIFY which home (i.e. Casa Solana II, Restoration I, Gryphon Women's SLO, etc.)
  - **"Contact Person at Receiving Program"** will be the name of the Executive Director listed on Sober Living Information Form (S://SLE's/Sober Living Information)

- **"Contact Person's Phone"** will be the contact phone number, also listed on Sober Living Information Form.
- **"Referral discussed with the contact person"** should be marked as "Yes" since you should have already contacted said SLE and made arrangements for client to move in.
- **"Assignment made to contact person/receiving program subunit"** should also be marked as "Yes." If you don't know how to open an SLE AZ subunit assignment, please refer to S://SLE's/Open and Closing SLE AZ Assignments.
- In the **"Reason for Referral"** field, list the following:
  - Date client entered into the SLE
    - If applicable, please also include date client has been at SLE including all stays.
  - Month you are requesting approval for, or a beginning and end date (i.e. Jan 1 – Jan 15, 2015 or January 2015 for the entire month).
  - Brief explanation stating client is following program requirements justifying continuation of payment and any other notes you feel will be helpful.
  - Any priority levels justifying why this client should be in an SLE (i.e. pregnant, IV user, Mental Health, homeless, CWS case kids 0-3 or 4-17, high risk, multiple relapses, etc.)
  - Funding source the payment should be coming from (AB109/PRTS funds; MIOCR grant; ADC/CDCI; BHTCC Grant; DSS (if client has open CWS case); or GFS (which would be applicable ONLY if client wouldn't fit under any other funding source).
  - Lastly, include how much you would like the County to pay (100%, 75%, 50%, 25%).
- Under **"Comments/Special Considerations"** you can put what future payment agreements you may have set up with the client (for example, we will pay 100% the first two months, you will have to pay 25% starting in October). This could also be the spot where you justify continued payment from the County after the 6 month guideline.
  - An example BH Referral Form through is shown below:

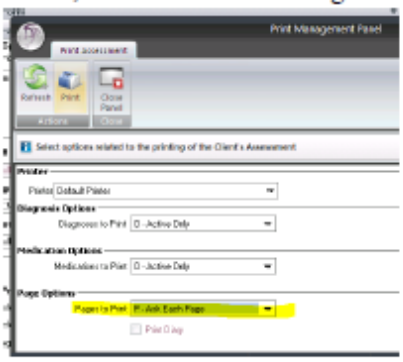


- **"Signature of Staff Making Referral"** – Referring Clinician. Would be the person creating the BH Referral Form (usually case manager or primary clinician). Enter in your AZ#, select "Electronic", enter in your password and click OK. You will see the area grey out with a date and timestamp.
- **"Program Supervisor Approving Referral"** is the Supervisor for the Program
  - **AB109** and **ADC/CDCI** SLE requests go to Clark Guest
  - **DSS** requests go to Colin Quennell
  - **BHTCC/ATCC/MIOCR** requests go to Teresa Pemberton
  - **GFS** (for detox only) go to Star Graber
  - **All other GFS** requests go to program/clinic supervisor (i.e. AT IOT would go to Clark Guest, GB IOT would go to Colin Quennell)
- **"Staff Processing Referral"** – SLE Contract Manager
- Then scroll down past "Receiving Program Comments" and you'll see **"Signature of Staff Accepting the Referral"** this will also be SLE Contract Manager.

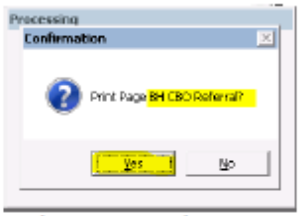


- Click "Save" (NOT Save and Close, still need to Print)

- Click "**Print**"
  - At "Page Options" – Pages to Print, select "P-Ask Each Page."



  - Confirmation pop-up will appear asking to "**Print Page BH CBO Referral?**"
    - Click "**Yes**"



  - For the other three confirmation pop-ups that appear, click "No."
  - You will get a print out with two pieces of paper, starting at the beginning of the Referral Form and ending at the last signature.

- Take the print out and immediately fax it to the SLE. SLE Fax numbers are located on S://SLE's/Sober Living Information
- Repeat process monthly if continued payment requested.
    - **IMPORTANT:** Get your BH Referral Forms in the first 10 days of the month and faxed over to the SLE. This is so that SLE's are aware of what the payment agreement is between said client and DAS, that way, if a client is partial self-payment, the SLE will be made aware in the beginning of the month to collect payment.
- When client is receiving the last month of County assistance, it is important to put in **"Comments/Special Considerations"** verbiage such as "as of August 31st, 2015, the client will have exhausted their six months of SLE assistance and will be self-pay going forward."
- If client leaves partway through month, update BH Referral Form to reflect. (For example, in the BH Referral Form above, if client left early, I would type in "Revised: client left SLE on August 18, 2015. Please only bill from August 1 – August 18, 2015. –KG") (always leave your initials under edits/revisions).
    - DAS Accountant II will not final approve until after last day of month so edits can be made accordingly.
    - If client leaves SLE early, and you go back to edit the BH Referral Form and notice that SLE Contract Manager has already signed it, please send her a quick email, and say something along the lines of "Client F.C., #600000 left SLE early, I have updated the BH Referral Form and closed out his SLE AZ subunit assignment."
- Once the client is no longer at their SLE, you will close out their SLE AZ subunit assignment.
    - For instructions on closing out SLE AZ assignments, reference S://SLE's/Open and Closing SLE AZ Assignments

If you have any other questions regarding SLE's, payment, referrals, etc., please contact SLE Contract Manager and they will be happy to help assist!

SLE FAQ's

Below are some FAQ's about SLE procedure. If you have any other questions you'd like answered, feel free to add below! ☺

1) **The word doc (Sober Living Information) that is stamped Confidential is NOT to be shared with clients.** Reason being, personal emails/cell numbers of executive directors. If clients would like SLE information, they can access that with our updated form here: S://Treatment Info/Treatment Resources & Referrals/SLO Co. Sober Living Environ, Residential TX Prov & Outpt Serv March 2014 (although it is current)

2) **Complaint Procedure:** If you have a complaint from a client (or yourself) about an SLE, the first step would be to try to resolve it yourself with the SLE, get to the bottom of it, etc. If you realize that this is an issue that I should be notified about, you would fill out a complaint form (S://SLE's/SLE Complaint Form). The form is a template, so it will open up a new doc, and you'll save to S://SLE's/(SLE Home Name)/Complaints. Save and email to me. I then resolve the issue and give SLE's input on improvement. I keep track of every complaint about an SLE in a tracking spreadsheet, then at the end of the FY when we are going to renew our contract with the SLE's, I review all the complaints from the previous FY with them and look at areas where we can modify their contract, etc.

3) **How to Complete a BH Referral Form:** I made a cheat sheet here S://SLE's/SLE Referral Form Procedure. Please, everyone who does BH Referral Forms, please read and follow next time you do a form!! :)
Important things to note: include things like Funding Source, how much we will pay (% or $ amount), know the correct signatures, and make sure each form is completed by calendar month.

4) **Also very important is to list the SPECIFIC facility (such as Gryphon Women's SLO, or Restoration III, etc.)** Reason being, we can charge different amounts at different facilities (if rent is more expensive in SLO, we can pay homes more to open up homes in the city of SLO, and not pay the same rate as Oceano/San Miguel, etc.) And, for example, Casa I and Casa II charge different amounts, making keeping accurate track of funding impossible if we don't know if the rent charged should be $900 or $400.

5) **Procedure with BH Referral Forms:** These should be completed the first week/ten days of the month and faxed over to the SLE's. If a client enters after the 10th day of the month, just complete the BH Referral Form and send over within a few days of client entering SLE. If a client was supposed to stay for the whole month and for whatever reason is exited or leaves early, what you will do is update your BH Referral Form, update the AZ SLE assignment, and send an email over to me stating something like "revised #600000's BH Referral Form for month of September." You will need to complete a form every calendar month.

6) **Self Pay Clients:** Self pay clients should still be open in AZ to their SLE during the duration of their stay there. Reason being, accurate reporting of how many clients we have in SLE's each month, and if there is a justification for needing more SLE beds or not. Also, if a client is self pay (or if a client was County pay but then transitioned to 100% self pay), you will want to STILL FILL OUT A BH REFERRAL FORM!!! :) I know it sounds crazy, but reason being is that these forms are also sources of documentation/communication for us. A common complaint from SLE's is that they were not made aware the client was supposed to be self pay, they submit an invoice to us at the end of the month, and then we don't pay it because we didn't have an approved Referral Form. I don't want the SLE's to lose out of money because we are not communicating with them at the beginning of the month that the client will be self pay. Easy way to resolve that complaint is that when a client is self pay, you simply submit a BH Referral Form to the SLE and state, "Client is now 100% Self Pay and will not be receiving any more County pay." (or verbiage like that). You would then leave said client open to AZ SLE assignment until they left the facility (or leave treatment).

7) **Helpful Tip:** Before submitting a BH Referral Form, look at your client's open AZ SLE assignment. Do they not have one open? Well, open one! Are they open to a home they have long since left, but it was never closed and changed to the new SLE... update the AZ SLE assignment! If you're going to revise a Form because someone was exited early, make sure to look at their assignments and close them out! Always helpful to consider the Assignments and BH Referral Form when completing the SLE process so everything is aligned.

8) **Lastly, some things that may help can be found on S://SLE's.** And I'm also here to help and answer any questions that may come up! I appreciate all everyone is doing and trying to make this more organized and efficient. Thanks so much! :)

Gradual Self Sufficiency Payment Plan for SLE's

There is a limit of six months of SLE payments per individual client with a graduated co-pay schedule wherein the client begins to make parts of their own SLE payments. Generally,

1 – 2 months	100% County responsibility
3 – 4 months	75% County responsibility
5 months	50% County responsibility
6 months	25% County responsibility

At the six month maximum limit, the following are considered:

- Client is moved to different funding source (e.g. perinatal, general fund)
- Client pays the SLE costs on their own (100% self pay)
- Client signs a payment agreement retroactive prior to receiving their SSI settlement
- Client is discharged from the SLE with a safe and sober housing plan
- Extension beyond the six months limit for extenuating circumstances may be granted with Management (Drug and Alcohol Services and/or other Department Division Manager) approval.

Transitioning to Self-Pay Letter

SAN LUIS OBISPO COUNTY HEALTH AGENCY

BEHAVIORAL HEALTH
2180 Johnson Avenue
San Luis Obispo, California 93401
805-781-4719 • FAX 805-781-1273

Jeff Hamm
Health Agency Director

Anne Robin
Behavioral Health Administrator

June 27, 2016

Dear Click here to enter text.:

Re: Transition to Self-Pay at SLE

You have been residing at Gryphon Sober Living Environment (SLE) since December 5, 2014. The total amount of time you have been in the SLE as of today is: 151 days, 5 month.

There is a limit of six months of SLE payments per individual client with a graduated co-pay schedule wherein the client begins to make SLE payments.

1 – 3 months	100% County responsibility
4 months	75% County responsibility
5 months	50% County responsibility
6 months	25% County responsibility

This letter is to inform you that payments from the County will be ending starting May 31, 2015.

For the month of May 2015 you will be 75% responsible for your stay and 100% responsible thereafter at this or any future SLE.

Here is a breakdown of the amount of rental assistance provided to you. This has been paid for by the San Luis Obispo County Behavioral Health Department.

Dec 2014: 100% coverage
Jan 2015: 100% coverage
Feb 2015: 75% coverage
March 2015: 50% coverage
April 2015: 100% coverage

Sincerely,

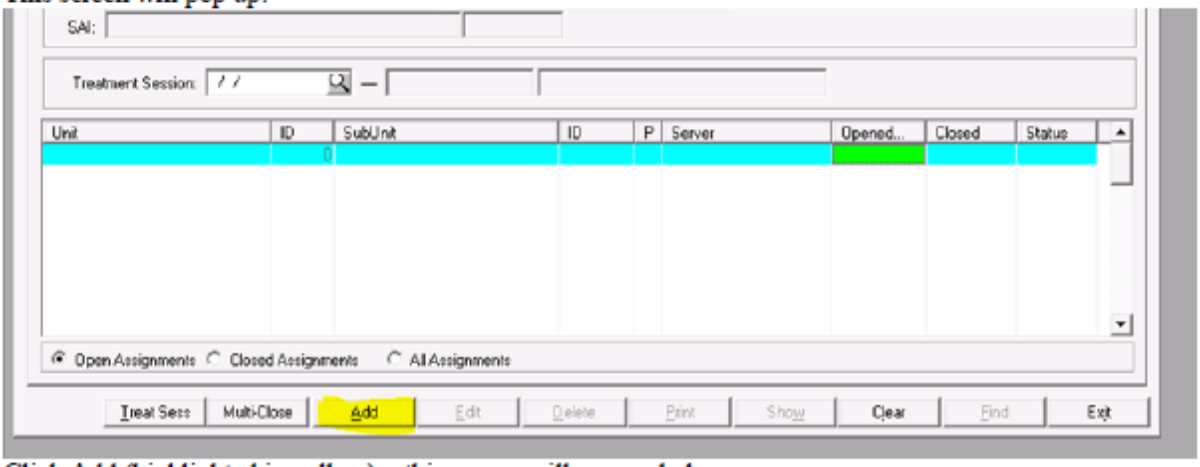
_____ _____

DAS Specialist Case Manager

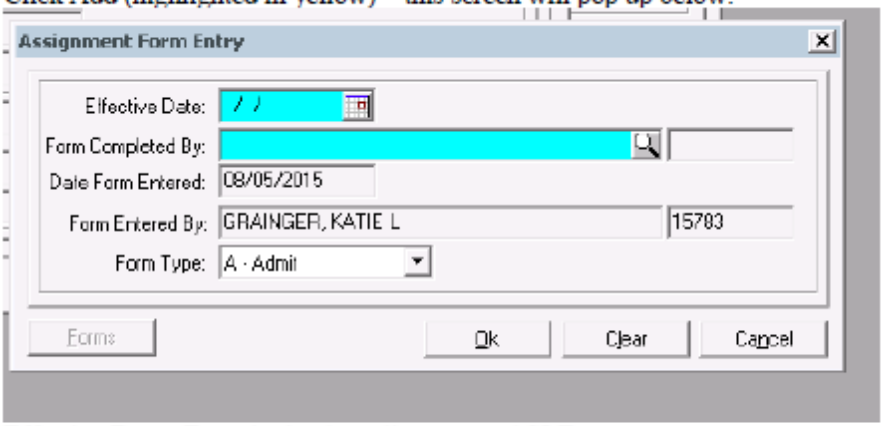
cc: SLE Home ( )
cc: Client file
cc: DPO

Open and Closing SLE AZ Assignments

To open up an SLE assignment in AZ
Pull up client information in Clinician's Homepage
Go To Client Assignments Maintenance
This screen will pop up:



Click Add (highlighted in yellow) – this screen will pop up below:



Effective Date: Enter in the date client entered SLE.

- Important Notes: Do not put client into SLE before treatment date (so for instance, if they were in Restoration House since 7/16, but didn't start AB109 treatment until 8/1, you would just enter in their effective date as of 8/1).
- Do NOT put in the current date (today's date). Enter in the date they actually entered into SLE.

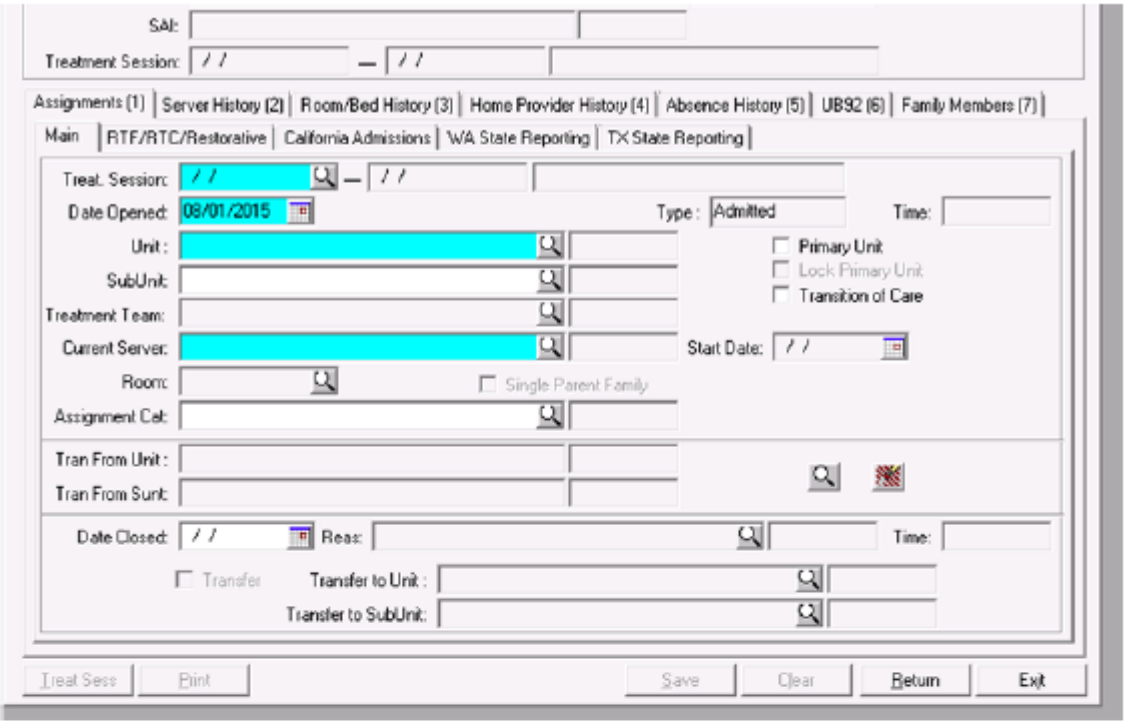
Form Completed By:

- Enter in your AZ number

Form Type:

- For opening clients into subunits, make sure it says "A-Admit"

Click Ok. New screen will pop up, shown below:



Note: Fill out all the fields highlighted in blue.

Treat. Session:

- Enter in the date they entered the SLE
- Open treatment session will pop up, click OK

Date Opened:

- Autopopulate with the date you entered as Admit

Unit:

- All SLE's Units is 7400. Type in 7400

Subunit:

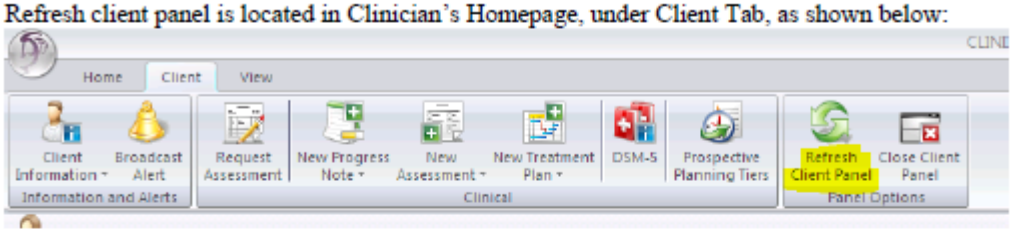
- 7402 = Out of County
- 7405 = Gryphon
- 7406 = Middlehouse
- 7407 = Captive Hearts
- 7408 = Casa Solana
- 7409 = Coastal Recovery (CRP) – not contracted with them anymore
- 7412 = Restoration House
- 7413 = Good Samaritan (Residential)
- 7414 = Victory Outreach (not contracted)
- 7415 = Seaview (not contracted)
- 7416 = House of Serenity
- 7417 = Bryan's House (women and kids)
- 7419 = Alano Club (not contracted)
- 7450 = Upham Apartments
- 7422 = JC House
- 7423 = Sowing Seeds Saving Souls Ministries

Current Server:

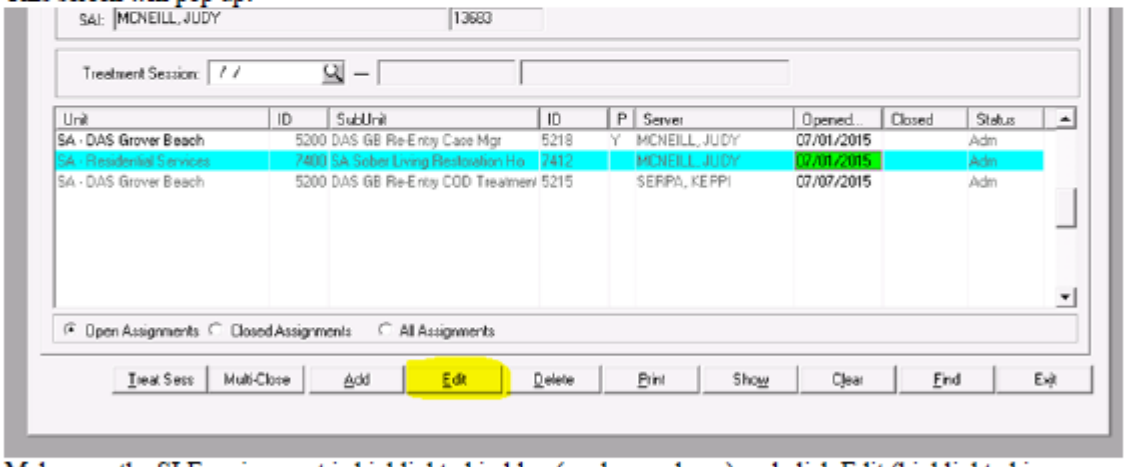
- Type in your AZ number (or case manager or whoever will be in charge of that client's BH Referral Forms)

Important: Do NOT lock as primary unit (that should be open treatment subunit… 5417, 5422, etc).
Click OK.

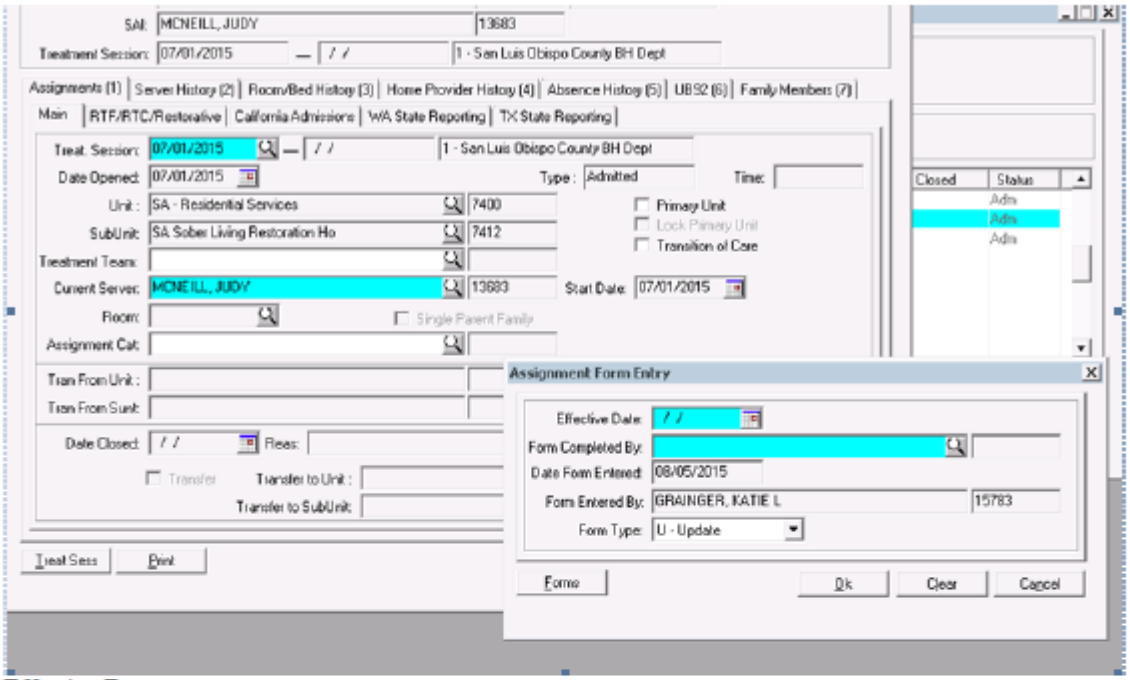
All done! To check and make sure it went in okay, refresh client panel, and you'll see the newly added in SLE AZ assignment.
Refresh client panel is located in Clinician's Homepage, under Client Tab, as shown below:



Closing AZ SLE Subunit Assignments:
Pull up client information in Clinician's Homepage
Go To Client Assignments Maintenance
This screen will pop up:



Make sure the SLE assignment is highlighted in blue (as shown above) and click Edit (highlighted in yellow).
Once you click Edit, this screen should pop up:



Effective Date:

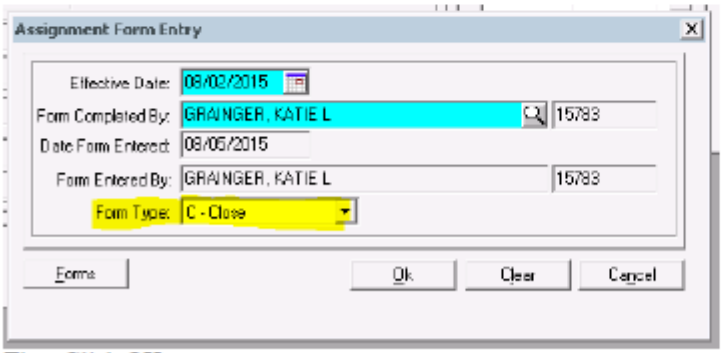
- Date the client left SLE

Form Completed By:

- Your AZ number

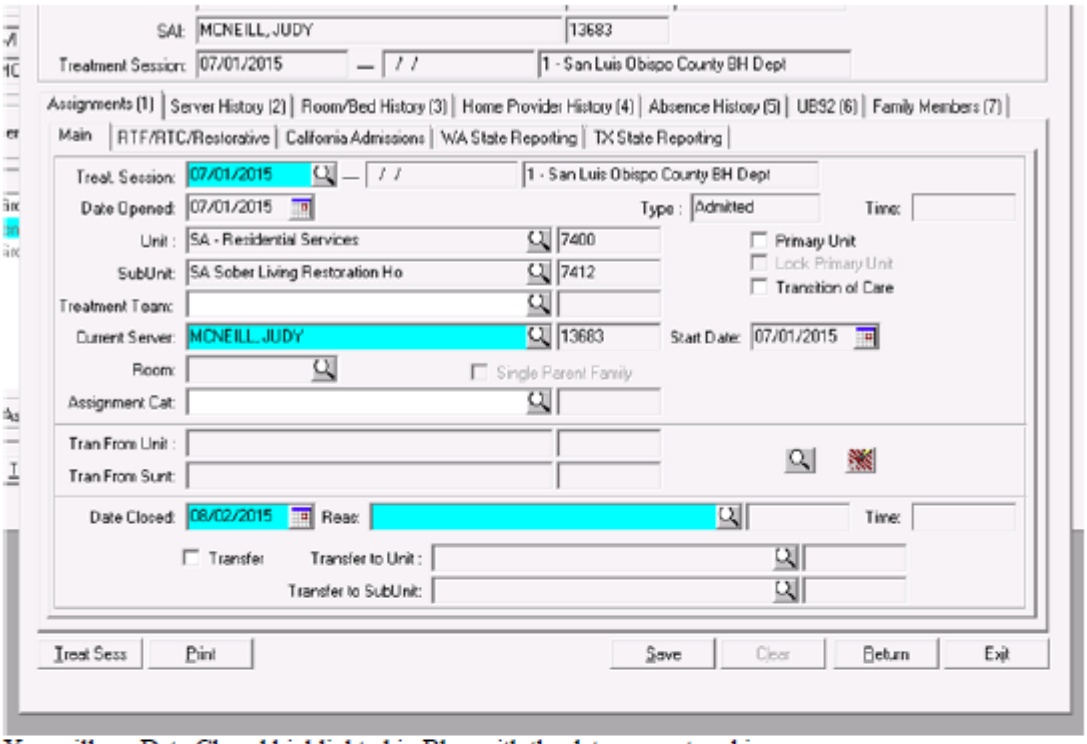
Form Type:

- Make Sure it Says "C-Close", as shown below:



Then Click OK

Once you click OK, this screen will pop up:



You will see Date Closed highlighted in Blue with the date you entered in.

Reas: You will need to give a reason the client left SLE

- 1 – SA Completed Tx Referred (this would be if someone completed their stay at an SLE, and was referred out to another one. For instance, someone completing Captive Hearts before moving out to Casa Solana II)
- 2 – SA Completed Tx Not Referred (this would be for someone completing an SLE stay, not referring out elsewhere. This could be someone staying at Gryphon for 6-9 months, doing well, and then transitioning out successfully into own permanent stable housing)
- 3 – SA Quit Sufficient Prog Ref (client no longer in SLE, but did well, and is now out, was given a referral elsewhere)
- 4 – SA Quit Sufficient Prog No Ref (this is if a client did well at SLE, left, no referral)
- 5 – SA Quit Inadequate Progress Ref (client left SLE, didn't do well, was referred to another one)
- 6 – SA Quit Inadequate Progress No Ref (client left SLE without progress, no referral. Example: client left on own accord, against staff advice, went on the run, is out to warrant).
- 7 – Deceased (client no longer in SLE because they died)
- 8 – Discharged/Transferred to Jail (Probation came to SLE to pick them up, or they went on run and taken into custody)
- 9 – Other (DON'T EVER USE THIS)

Once you select your Reason, click Save.

All done! To check and make sure it went in okay, refresh client panel, and you'll see the newly closed SLE AZ assignment

DL 937 Verification for Reduced Fee Identification Card

STATE OF CALIFORNIA
DMV
DEPARTMENT OF MOTOR VEHICLES
A Public Service Agency

VERIFICATION FOR REDUCED FEE IDENTIFICATION CARD

Instructions to the governmental or non-profit entity:

Please complete this form in its entirety and give to the applicant for further processing. *This form must be presented to the Department of Motor Vehicles (DMV) within 60 days of its completion by the governmental or non-profit entity.*

Applicant Information (Please Print):

LAST NAME	FIRST	MIDDLE	DATE OF BIRTH (MM/DD/YYYY)

ADDRESS	CITY	STATE	ZIP CODE	CA DRIVER LICENSE / IDENTIFICATION CARD NUMBER

The individual (applicant) named above meets the eligibility requirements for assistance programs under Chapter 2 or Chapter 3 of Part 3 of, or Part 5 of, or Article 9 of Chapter 10 of Part 6 of, or Chapter 10.1 or Chapter 10.3 of Part 6 of, Division 9 of the Welfare and Institutions Code and is qualified to obtain a California Identification card for a reduced fee as defined in Vehicle Code § 14902(c).

Government or Non-Profit Entity Information (Please Print):

PRINTED NAME OF REPRESENTATIVE FOR ENTITY

ENTITY NAME

ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NUMBER
				( )

I certify (or declare) under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

X _____ DATE

SIGNATURE OF REPRESENTATIVE FOR ENTITY

Instructions to the applicant:

Please bring this original, completed form (Verification for Reduced Fee Identification Card DL 937), to the DMV along with your payment and a completed Driver License or Identification Card Application (DL 44 form). Additional documentation may be required to complete your application. For more information, please refer to the California Driver Handbook or online at **www.dmv.ca.gov.** *This form must be presented to DMV within 60 days of its completion by the governmental or non-profit entity.*

Save time, make an appointment online at **www.dmv.ca.gov** or call 1-800-777-0133.

DL 937 (REV. 4/2003) IH

Clear Form Print

SLE Complaint Form

Sober Living Environment Problem Form

Reporting Staff Name:

Date:

Which Sober Living House(s):

Areas of Concern:

- ☐ Cleanliness
- ☐ Compliance Issues
- ☐ Consistency with all clients
- ☐ Disciplinary Actions
- ☐ Employment
- ☐ Exited w/out communication
- ☐ Food
- ☐ Health and Safety
- ☐ Heating
- ☐ Infrastructure
- ☐ Medications
- ☐ Number of residents
- ☐ Other residents using
- ☐ Transportation
- ☐ Other:

Description of Problem:

Attempts to resolve to this date:

Sober Living, Residential Treatment and Outpatient Services Information

SLO COUNTY SOBER LIVING ENVIRONMENTS, RESIDENTIAL TREATMENT and OUTPATIENT SERVICES

Providers with Contracts with San Luis Obispo County for Services

AEGIS Methadone Clinic 6500 Morro Road Atascadero, CA 93422 (805) 461-5212 http://aegistreatmentcenters.com/	AEGIS utilizes an evidence-based, multi-disciplinary and holistic treatment model to treat clients utilizing Methadone. Suboxone now available as well.
Bryan's House Director: Sandy Wortley 805-781-4753 Http://bryanshouse.wix.com/recovery	Women and Children Residential Family Treatment Court and CWS clients Intake through SLO County Drug and Alcohol Services Five beds for women with their children
Captive Hearts PO Box 1272 Grover Beach, CA 93483 805-481-4500 office closes at 3pm	Faith-based facility for females aged 18+. Ten beds Sober Living Environment 6 months to a year Daily rate: $40/day
Casa Solana I and II Grover Beach, CA 93433 805- 481-8555 office 9-2 M-F 805- 481-8556 805 710-0829	Facility for females aged 18-72. Casa I has 12 beds, 4 bath. Casa II has 8 beds, 3 bath. (12 step based program – some dual diagnosed probationers). Initial program is 90-days. Follow up can be six months in second transition house if space available. Random drug testing & full time manager. Casa I is $30/day. Casa II is $400/month, plus buy own food, toiletries, etc.
Drug and Alcohol Services 2180 Johnson Avenue San Luis Obispo, CA 93401 San Luis Obispo 805- 781-4275 Grover Beach 805- 473-7080 Atascadero 805- 461-6080 South Street 805-781-4861 Paso Robles 805-226-3200	Outpatient treatment programs : Adult, perinatal moms, parenting for dads ; youth and family ; Family Treatment Court ; Prop 36 ; Family counseling and support ; education groups ; UA testing ; licensed and/or certified staff. State certified outpatient, daycare, and outpatient detoxification treatment services. Screening and Assessment for all substance use disorder services covered by Medi-cal.
Gryphon Society P.O. Box 2217 Atascadero, CA 93423 Mens – Jimmy 805-550-7928 Womens – Becky Brown 805-748-6204	Men's Homes in Atascadero and Grover Beach Women's Homes in Atascadero and SLO ages 18-72 addicted to alcohol or drugs. Must stay 90 days. No serious mental disorders. Initial phone interview and then a face-to-face interview. $25/day- includes room & board. SSI Discounted.
House of Serenity 1320 Van Beurden Dr., Suite 103 (Mailing) Los Osos, CA 93402 Simone 805-801-3572	Women and Men ages 18+ 10 beds, 2 bath. 1 bed available for detoxification. Available at each home. $29/day
JC House PO Box 33 Oceano, CA 93475 Alvin Cable 805 234-2718	Men ages 18+ 13 beds, 3 bath, plus second chance room $25/day, cheaper for self pay clients ($440/month) Discounted rate if client pays for own food
Mental Health Services – SLO County 2178 Johnson Avenue San Luis Obispo, CA 93401 San Luis Obispo 805- 781-4700 Arroyo Grande 805- 473-7060 Atascadero 805- 461-6060	Community Mental Health Outpatient Treatment Services Screening and Assessment for all mental health treatment services covered by Medi-cal.
Middle House San Luis Obispo, CA 805- 544-8328 Ken Lumbattis House Manager	Men's Sober Living House – approx. $130/ week – needs to have a job. No serious mental disorders. Transitional home 14 beds, 6 bath.

Next Step Sober Living 1700 Creston Road Paso Robles Greg Lelli 805-712-1551	Men's Sober Living Home 9 beds, 2 bath $25/day
Restoration House PO Box 544 Oceano, CA 93475 Rick Harvey 805-710-3032	3 Homes in South County. Detoxification and med managed clients okay. $21/day
Sowing Seeds Saving Souls PO Box 4723 Paso Robles, CA 93447 ReRe Taylor 805-467-2420	Female Faith Based Sober Living Home 10 beds, 5 bedrooms $30/day

SLO COUNTY SOBER LIVING ENVIRONMENTS, RESIDENTIAL TREATMENT and OUTPATIENT SERVICES
Other Providers (no contracts)

(Disclaimer): This list is provided as a resource only. No endorsement or referral to any particular program should be assumed. Be a careful consumer and ask questions.

Alano Club 3075 Broad St San Luis Obispo, CA 93401 805-543-9817	Shon Hand, Manager 805-704-6483 Has sober living quarters above the Alano Club
Byond Dreams Stephanie Hunter cell 805-369-9529 P.O. Box 722, San Miguel, CA 93451 805-467-5300 byonddreamin@msn.com House Manager: Connie Deleonardis	Women's home 4 beds/1bath Daily rate: $33/day - $990 month
Cambria Connection 870 Main Street Cambria, CA 93428 805- 927-1654	Self help groups, early intervention, treatment, prevention, and referrals service (Drop In Prevention Center)
Central Coast Freedom Center 6005 Capistrano Ave Unit C Atascadero, CA 93422 (805) 242-9900 http://www.rehabsanluisobispo.com/	Drug and alcohol treatment program, with sober living for women (six beds available). The program has family therapy, group therapy, 12-step recovery, and holistic treatment available.
Coastal Recovery Project (CRP) PO Box 816 Guadalupe, CA 93434 Call Russ McCormick at (805) 234-3095	Men's Recovery Residence in San Luis Obispo, CA. 10 beds, 2 baths available. $25/day/bed. Will take clients on Suboxone.
Cottage Care Outpatient 1035 Peach Street #203 San Luis Obispo, CA 93401 805- 541-9113	Adults only/$4790 for program may take up to a year. Three phases of the program: 1. 4 meetings per week for 20 weeks 2. 2 meetings per week for 16 weeks 3. 1 year of follow up (no charge for longer) Must also attend 2 AA meetings per week & have an AA sponsor. Outpatient treatment.
Discipleship House 1359 21st Court Oceano, CA 93445 Contact LeAire Griffin at (805) 904-8230	Faith Based Men's Recovery Residence in Oceano 7 beds, 2 bath. House provides transportation, sober social Sundays, Health and Wellness, and employment opportunities. Cost is $30/day/bed
The Haven at Pismo 107 Nelson St, Suite 102 Arroyo Grande, CA 93420 (805) 202-3440 Dr. Ken Starr	Will be opening June 2016 The only in-patient detox and residential treatment center on the central coast of California. Mens and Womens residential with Residential, Medically Supervised Detox also available. Gender specific luxury homes, group and individualized counseling, evidence based treatment, medical care, family therapy, and more.
Lifestyles Recovery Center 715 24th Street Suite P Paso Robles, CA 93446 805- 238-2290 http://www.lifestylesrecoverycenter.org/	A 501c(3) non-profit corporation that provides group sessions and individual counseling to individuals dealing with drug and alcohol addiction, HIV prevention, and anger management. Drop in and prevention services for the underserved population Various classes and 12-Step and Recovery meetings/groups
North County Connection 8600 Atascadero Avenue Atascadero, CA 93442 805- 462-8600	Self help groups, early intervention and prevention referral service. Information clearinghouse.

Sunny Acres 10660 Los Osos Valley Road (office) San Luis Obispo, CA 93405 805-543-4918 office 805-543-5958 fax 805-234-5613 Dan Cell 805-550-0555 office cell www.sunnyacresca.com sunnyacresca2@gmail.com	$410 per month w/out meals; $550 a month w/ meals. Prepared meals: $1.00 breakfast, $1.50 lunch, $2.50 dinner. Shared rooms and vocational opportunities.
Sea View Morro Bay Chanel Channing (805)748-2088	Recovery residence for dual diagnosis clients
Victory Outreach Pastor Jason and Yolanda Wilson (805) 703-3753 vopasorobles@att.net PO Box 2295, PR 93447 Mens- Paso Robles, CA	Faith Based sober living with ties to residential facilities in other counties

IN PATIENT AND RESIDENTIAL PROGRAMS – OUT OF SLO COUNTY
(Not all are certified or licensed)

(Disclaimer): This list is provided as a resource only. No endorsement or referral to any particular program should be assumed. Be a careful consumer and ask questions.

Adult Rehabilitation Center (Salvation Army) 120 19th Street Bakersfield, CA 93301 661-325-8626 (see separate handout for more locations)	Men & Women 6 months
A Lujan Sober Living Homes 200 E San Martin Ave. #840, San Martin, CA 95046-9406 888-788-0883 Email: info@alujantx.com	The program offers a wide range of services allowing people to be involved in one or several levels of treatment. We also work with the drug court system and have extensive experience in the legal arena.
ASA- A Spiritual Abode 830 West Church Street Santa Maria, CA 93456 805-925-1352	Licensed/Certified Non-profit Facility Structured Sober Living Non-medical can bring Rx to take Males/Females 1yr. Residential
Beacon House 468 Pine Avenue Pacific Grove, CA 93950 831-372-2334 www.beaconhouse.org	Private Pay/Insurance $21,450 1st 30 days 30-90 day + program 18yrs and up Sober living aftercare Outpatient Services
Bethel House Santa Barbara Rescue Mission 535 East Yanonali Santa Barbara, CA 93105 805-966-1316	Clients must fill out app. Employee will call to set up initial appt. after app. has been received Females only
Betty Ford Center 39000 Bob Hope Drive Rancho Mirage, CA 92270 (760) 773-4100	30 day hospital based program ($24,000) Detox. Services available No Insurance Accepted
The Camp 3192 Glen Canyon Road P.O. Box 66569 Scotts Valley, CA 95067 800-924-2879/831-438-1868 camprecovery.com	30 Day in house detox. Treatment ($15,500 min.) Residential services for adults
Casa de las Amigas 160 North El Molino Avenue Pasadena, CA 91101 626-792-2770 626-792-5826 (fax) www.casadelasamigas.org	24-hour 12-step based alcohol and drug residential treatment center that offers five (5) levels of care for women. These include: Residential Treatment, Day Treatment, Outpatient Treatment, Sober Living, and Detoxification Services along with aftercare services.
Casa Latina 1430 Junewood Way Oxnard, CA 93030 805-988-1560	90 day to six month program for women and children 12 Step Based Sliding-scale fee
Casa Seca (SLE) 1613 North Broadway Santa Maria, CA 93458	Recovery home for men Min 6 month stay ($515 per month) 12 Step Based Client must call for initial interview
Casa Serena 1515 Bath Street Santa Barbara, CA 93101 805-966-1260	90 day program for women ($2,400 per month) 12 step sober living Scholarships available depending on income

Oliver House (Casa Serena Affiliate)	Client must call for brief phone interview and to schedule on-site interview. Clinical program manager is an LMFT, staffed by interns, trainees, and DAS staff. Prefer that Casa Serena program in done first Antidepressants are okay No pain, sleep, or muscle relaxer medications Women with children
Centerpoint 1601 Second Street Suite 104 San Rafael, CA 94901 415-456-6655	Men's residential Women's residential (allows children 5 and under) Outpatient services County funded
Cottage Care Hospital 320 West Pueblo Street P.O. Box 689 Santa Barbara, CA 93101 805-682-7111	In-patient setting 28 day program ($14600) Outpatient program also available
Delancy Street 600 The Embarcadero San Francisco, CA 94107 415-512-5104	Hardcore program for those strongly motivated to make lifestyle changes. 2 year program No fee 24/7 intake
MHS Family Recovery Center 1100 Sportfisher Drive Oceanside, CA 92054 760-439-6702	Residential, day treatment and next step programs with many services including drug testing, drug counseling and education, prenatal care Sliding scale
Eleventh Hour Residential Program 5639 East Park Circle Fresno, CA 93727 559-454-1819	Day Treatment: $325/day - Intensive Outpatient: $170 per session Transitional Living: $100/day Private pay/Insurance Scholarships may be available Male/Female
Good Samaritan Programs 401 West Morrison Avenue Santa Maria, CA 93458 805-347-3338	Overnight housing Meals for men, women, and children Women and Children preferred Maximum 30 day stay
Impact 1680 North Fair Oaks Pasadena, CA 91103 323-681-2575	Long Term Residential (4-6 months) Adult men and women Extensive group counseling component Individual counseling carried out in three phases Sliding scale fee
Jelani Inc. 1601 Quesada Avenue San Francisco, CA 94124 415-822-5977	6-9 month residential program for women who are pregnant or parenting Up to two children age 5 and up as well as babies
Newhall Manor 415-822-5977 Fax: 415-822-5943 Intake Coordinator: 415-822-5945 Program Supervisor: 415-970-9145	6-9month family program Serves one or two parent families with children, including single fathers.
Janus of Santa Cruz 516 Chestnut Santa Cruz, CA 95060 831-423-9015	Residential drug and alcohol treatment program for AA meetings, education, and counseling Serves Santa Cruz county Non-medical facility for women and children, and dual diagnosis. $6,000 per month
New House II 227 West Hayley Street Santa Barbara, CA 93101 805-962-8248	Men's Sober Living homes $24/day Client must call to schedule interview Treatment program, and Sober living environment only (Social model)
New House III 2434 Bath, Santa Barbara, CA 93101 805 563-6050	Men's Sober Living homes $30/day 3 meals included
New Life Community Services 707 Fair Avenue Santa Cruz, CA 95060 831-427-1007/831-458-1668	Residential, outpatient treatment for 6 months 12 Step social model recovery for men, women and children Sliding fee scale starting at $28 per day

Phoenix of Santa Barbara 107 East Micheltorena Street Santa Barbara, CA 93101 805-965-3434	Dual diagnosis program Psychiatric evaluations, drug and alcohol treatment, and support groups Non-profit Serves Santa Barbara county Accepts Medi-cal
Progress House, Inc. 838 Beach Court Coloma, CA 95613 530-626-9240 Ask For Sean	Men's Residential Program 1-3 months $4,500 per month for 30 days VA eligible
Progress House II 5607 Mount Murphy Garden Valley, CA 95633 530-626-9240 Ask For Sean	Women's Recovery Children's Recovery
Promises Treatment Center 3743 S. Barrington Avenue Los Angeles, CA 90066 310-390-2340 866-783-4287 http://www.promises.com	Men and women 30 day IP Detox available
Prototypes 2150 North Victoria Oxnard, CA 93036 805-382-6296	Residential treatment for pregnant women Women with children up to 10 yrs old Sliding fee scale
Puente House- Main Office 444 West Badillo Covina, CA 91723 626-967-1819 800-494-9844 www.puentehouse.org	Sober living environment Two men's facilities and one women's facility Fees include gym and Alano club membership 12 step philosophy Work Required Random testing
Recovery Point/Good Samaritan Shelter 731 South Lincoln Santa Maria, CA 93454 805-346-8185	Accepts pregnant women and has residential programs for women and their children Medi-Cal accepted Will not be turned away for inability to pay
River Community 23701 East Fork Road Azusa, CA 91702 626-910-1202	Adult dual diagnosis treatment program Insurance and SSI accepted
Santa Barbara Rescue Mission 535 E. Yanonoli Street Santa Barbara, CA 93103 805-966-1316	Men's Treatment Facility Affiliated with Bethel House One year program
Serenity Knolls P.O. Box 640 145 Tamal Road Forrest Knolls, CA 94933 415-488-0400 Website: Serenity Knolls.com	Twenty miles north of SF 28 day program $14,800 plus $100 deposit for meds Specializing in dual diagnosis Medically supervised detox 12 step social model with integrated clinical psychotherapy
Spencer House 6956 Matilija Avenue Van Nuys, CA 91405 818-785-6639 310-998-3680	12 step safe and sober living environment for men
Sun Street Centers 11 Peach Drive, Salinas, CA 93901 admin 831-753-5135 Community Recovery and Resource Center 128 E. Alisal Street, Salinas, CA 93901 831-753-5150 info@sunstreet.org www.sunstreetcenters.org	Men's residential program. Outpatient services. Pueblo del Mar Family Recovery Community. Prevention. Responsible Beverage Service Training. Driving Under the Influence Program. Alcohol and Drug Recovery Programs for Employees.
Teen Challenge: Men 650 Riverside Avenue Shafter, CA 93263 661-746-4917	Residential Christian life 1 year no charge No Psych meds and no sex offenders No 12step, No AOD classes

Teen Challenge: Women 301 East Roberts Lane Bakersfield, CA 90338 661-399-2273	Strictly Christian based program Intake every Tuesday Intake and enrollment on same day
Transitions Center 412 East Tunnel Santa Maria, CA 93454 805-925-0315/805-966-9668	Women and children Structured program with sliding fee scale School facilities during day Affiliated with Good Samaritan Shelter
Touchstones P.O. Box 849 525 North Parker Street, Orange, CA 92856 714-639-5542 www.socialmodel.com	Adolescent program Dual diagnosis Sliding fee scale 9th grade to 18yrs old Voluntary program with school on site
Turning Point 1315 25th Street San Diego, CA 92102 619-233-0067	Recovery home for women 3months to one year (or longer) $420 per month- room and board Primary focus: alcoholism
Vista del Mar 801 Seneca Street Ventura, CA 93001 805-653-6434	Medically supervised detox Clinical Psych evals. Dual diagnosis Specialty private insurance Not long term residential, but intense intake assessment
Walter Hoving Home 127 South El Molino avenue Pasadena, CA 91101 888-4hoving or collect 626-405-0950 Fax: 626-564-0952 www.walterhovinghome.com	Spiritually based non-profit drug and alcohol residential program for women ages 18 and over who have been involved in drug/alcohol/prostitution and other life controlling problems. Two programs offered 6-12 months Includes room and board for full program duration, classroom study in on campus learning center, individual/group counseling, structured work program and extra curricular activities. Funded through private donations Each student responsible for $500 sponsorship

Other possible resources:

Tarzana Treatment Center 800-996-1051 www.tarzanatc.org	Licensed residential and outpatient services for substance abuse and mental health concerns. Past experience with opiate addiction.
Hazelden Treatment Centers 800-257-7810 www.hazeldon.org	Licensed residential treatment programs in Oregon, Minnesota, Illinois and New York.

SLE Daily Bed Rates Chart

Provider (Location)	Target population	Rate	# of beds	Comment	Total $ per house per day	
Middle House (SLO)	Men (no children)	$ 22.00	14		$ 308.00	
Gryphon (AT)	Men (no children)	$ 25.00	13		$ 325.00	
Gryphon (GB)	Men (no children)	$ 25.00	13		$ 325.00	
House of Serenity (Los Osos)	Men (no children)	$ 29.00	8			
JC House (GB)	Men (no children)	$ 25.00	13		$ 325.00	
Next Step (Paso Robles)	Men (no children)	$ 25.00	9		$ 225.00	
Restoration House 1 (Oceano)	Men (no children)	$ 21.00	11		$ 231.00	
Restoration House 2 (Oceano)	Men (no children)	$ 21.00	10		$ 210.00	
Restoration House 3 (GB)	Men (no children)	$ 21.00	13		$ 273.00	
					$ -	
Captive Hearts (GB)	Women (no children)	$ 40.00	10		$ 400.00	
Gryphon (AT)	Women (no children)	$ 25.00	10		$ 250.00	
Gryphon (SLO)	Women (no children)	$ 25.00	9		$ 225.00	
Casa Solana I (GB)	Women (no children)	$ 30.00	12		$ 360.00	
Casa Solana II (GB)	Women (no children)	$ 14.00	8		$ 112.00	
House of Serenity (Los Osos)	Women (no children)	$ 29.00	9		$ 261.00	
Sowing Seeds Saving Souls (San Miguel)	Women (no children)	$ 30.00	10		$ 300.00	
Bryan's House (PR)	Women with Children		5	No bed day rate	$ -	
Upham Apts (SLO)	Families		2	County operated		Avg.
Total Capacity		$ 25.44	**179**		**$ 4,130.00**	**$ 26.82**

Revised April 2016

Treatment Information, Services, and Hours

San Luis Obispo County Drug and Alcohol has four different clinic locations. The main Health Agency building is located in San Luis Obispo, and other clinics are located along the County in Grover Beach, Atascadero, and Paso Robles. Programs are also held at youth schools and the County jail. There are also alumni and aftercare meetings held at the clinics for people to continue to get support after they have completed various programs.

Clients are assessed according to ASAM's Level of Care, and placed in an appropriate program. Various programs that the County offers are:

- Adult Level 0.5 (Early Intervention – Education)
- Adult Outpatient Level 1.0
- Adult Co-Occurring Disorders Level 1.0
- Detox/Medication Assisted Treatment Program
- AB109 Re-Entry Treatment Program
- Deferred Entry of Judgment (DEJ)
- Prop 36/1210
- Adult Drug Court
- Adult Treatment Court Collaborative for those with dual diagnosis, primary substance use
- Behavioral Health Treatment Court for those with dual diagnosis, primary mental health
- Perinatal Outpatient
- POEG
- Family Treatment Court
- Adult Intensive Outpatient Treatment
- Youth and Family Level 0.5
- Youth and Family Outpatient Treatment Level 1.0
- Juvenile Drug Court
- Youth Co-Occurring Disorders
- DUI (Driving Under the Influence) for first time and multiple offenders

Clinic hours range based on the program and some can start as early as DUI at 7am. Most morning track classes, however, start at 9am. Evening groups are also offered so that clients can partake in either morning or evening tracks in order to accommodate their personal and work schedule. Evening groups are usually completed by 7pm.

Revocation of Consent Form

Drug and Alcohol Services
San Luis Obispo County

REVOCATION OF CONSENT
FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Name of client:_____

On this date:_____ at this time _____ ☐ a.m. ☐ p.m. I revoke the right of Drug and Alcohol Services to release information to the following agencies or persons listed below.

Name of agency/person	Address

Revocability of Release

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 42 C.F.R. Part 2 you have the right to revoke any release of information that you have previously signed giving San Luis Obispo Drug and Alcohol Services permission to release information to another agency, business, person, or organization. However, both HIPAA and 42 C.F.R. Part 2 provide that if a program has already made a disclosure prior to the revocation, the program has acted in reliance on the consent and is not required to try to retrieve the information it has already disclosed. 45 C.F.R. § 164.508(b)(5); 42 C.F.R. § 2.31(a)(8).

Dated:_____ _____
Signature of Client

CLIENT NAME:_____ **CLIENT NUMBER:**_____

Consent for Release of Confidential Information Form (General)

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Name of client:_____
_____DOB:_____

I authorize San Luis Obispo County Drug and Alcohol Services to disclose to:
☒_____ ☐ County Mental Health
(Name of person or organization to which disclosure is to be made)

☐_____
(Name of person or organization to which disclosure is to be made)

the following information: Client identifying information, drug testing results, diagnosis, treatment plan, attendance, and progress in treatment._____
_____
(Nature and amount of information to be disclosed; as limited as possible)

The purpose of the disclosure authorized in this is to (be as specific as possible):
_____
_____

☐ Family members listed below for phone messages, payment information, and scheduling of appointments.

Name	Relationship to Client	Phone

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows (specification of the date, event or condition upon which this consent expires): One year from date signed.

I understand that generally San Luis Obispo County Drug and Alcohol Services may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Revocability of Release

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 42 C.F.R. Part 2 you have the right to revoke any release of information that you have previously signed giving San Luis Obispo Drug and Alcohol Services permission to release information to another agency, business, person, or organization. However, both HIPAA and 42 C.F.R. Part 2 provide that if a program has already made a disclosure prior to the revocation, the program has acted in reliance on the consent and is not required to try to retrieve the information it has already disclosed. 45 C.F.R. § 164.508(b)(5); 42 C.F.R. § 2.31(a)(8).

Dated:_____ _____
Signature of Client

_____
Signature of parent, guardian or authorized representative where required

CLIENT NAME:_____ **CLIENT NUMBER:**_____

Verification of Income Form

VERIFICATION OF INCOME

Applicant Name: _____

Instructions for Employer/Payment Source Representative: This is to certify the income received by the above named individual for purposes of program. This information will be used only to determine the eligibility status and level of benefit of the household. **Complete only the selected section below that includes an authorization to release information.**

Please return this form to:

Name & Title: ___ _____ Phone: _____
Address: _____ Fax: _____
Email: _____

☒ Employment Income

Applicant Release: I hereby authorize the release of the following employment information.
Applicant Signature: _____ Date: _____

Employer representative to complete this section:
The person named above is employed by _____since _____.
He/she is paid $_____ on a _____basis and is currently working an average of _____hours per _____.

Additional compensation please specify (if any):_____
Probability of continued employment:
_____

Authorized Employer Representative Signature: _____
Date:_____
Name, Title:
_____
Address and Phone:
_____

☐ Payments and/or Benefit Income (complete one form for each distinct source of income for person named above)

CIRCLE ONE: Social Security/SSI Pension/Retirement TANF
Public Assistance Unemployment Compensation Workers Compensation
Alimony Payments Foster Care Payments Child Support Payments
Armed Forces Income
Other (pls. specify): _____

Applicant Release: I hereby authorize the release of the following payment and/or benefit information.
Applicant Signature: _____ Date: _____

Payment source representative to complete this section:
Payments or benefits in the amount of $_____ are paid on a _____ basis.
The expected duration of the payments or benefits is _____.

Authorized Payment Source Representative Signature: _____
Date:_____
Name, Title:
_____
Address and Phone:
_____

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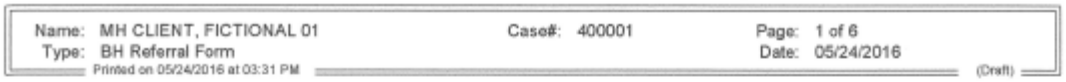
Attachment F. Recovery Residences

Behavioral Health Referral Form Template



Name: MH CLIENT, FICTIONAL 01 Case#: 400001 Page: 1 of 6
Type: BH Referral Form Date: 05/24/2016
Printed on 05/24/2016 at 03:31 PM (Draft)

San Luis Obispo County Behavioral Health Department

Behavioral Health Referral Form

Referral Date:

Program Initiating Referral:

Program Receiving Referral:

Contact Person at Receiving Program:

Contact Person's Phone:

Referral discussed with the contact person? O Yes O No

Assignment made to contact person/receiving program subunit? O Yes O No

Reason for Referral:

Comments/Special Considerations (Describe any additional factors the receiving program should consider, such as current potential for violence or self injury):

Signature of Staff Making Referral:

Name: Date: Time: Pending

Program Supervisor Approving Referral:

Name: Date: Time: Pending

Staff Processing Referral:

Name: Date: Time: Pending

Receiving Program Comments:

Is the referral appropriate? O Yes O No

Is the referral accepted? O Yes O No

Comments by receiving program:

Signature of Staff Accepting the Referral:

Name: Date: Time: Pending

Form BHCBOREF; Version 1.01; 4/10/2013

Name: MH CLIENT, FICTIONAL 01	Case#: 400001	Page: 3 of 6	
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San Luis Obispo County Behavioral Health Department

Full Service Partnership Referral

Youth FSP O Yes O No

- ☐ SED/SMI or 1st psychotic break or parent w/ SMI/drug abuse
- ☐ High user of MH or medical services due to MH symptoms
- ☐ Current/past multiple foster placements or aged/aging out
- ☐ At risk of/removed from home or moving to lower level care
- ☐ Homeless or at risk of homelessness
- ☐ Current/past justice system or law enforcement involvement
- ☐ New to MH; not served in past
- ☐ Co-occurring substance use/abuse issues
- ☐ Serious academic problems/failing grades/ERMHS eligible
- ☐ Exposed to violence; friends or family killed; family hx SMI
- ☐ Underserved/unserved, including uninsured/indigent
- ☐ Member of a minority or disadvantaged group

TAY FSP O Yes O No

- ☐ SED/SMI or 1st psychotic break or parent w/ SMI/drug abuse
- ☐ High user of MH or medical services due to MH symptoms
- ☐ Current/past multiple foster placements or aged/aging out
- ☐ D/C from RCL 10+/CTF/IMD/State Hospital, or Probation Camp
- ☐ Homeless or at risk of homelessness
- ☐ Current/past justice system or law enforcement involvement
- ☐ New to MH; not served in past
- ☐ Co-occurring substance use/abuse issues
- ☐ Serious academic problems/failing grades/ERMHS eligible
- ☐ Aging out of ERMHS/Youth MH/CWS/juvenile justice system
- ☐ Exposed to violence; friends or family killed; family hx SMI
- ☐ Underserved/unserved, including uninsured/indigent
- ☐ Member of a minority or disadvantaged group

Adult FSP O Yes O No

- ☐ SMI, needs intensive SMHS due to hx/current functioning
- ☐ High user of MH or medical services due to MH symptoms
- ☐ Discharged from IMD within past 12 months
- ☐ Homeless or at risk of homelessness
- ☐ Current/past justice system or law enforcement involvement
- ☐ New to MH; not served in past
- ☐ Co-occurring substance use/abuse issues
- ☐ Serious vocational problems; at risk of/recently fired
- ☐ Underserved/unserved, including uninsured/indigent
- ☐ Member of a minority or disadvantaged group

Name: MH CLIENT, FICTIONAL 01 Case#: 400001 Page: 4 of 6
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Older Adult FSP O Yes O No

- ☐ SMI, needs intensive SMHS due to hx/current functioning
- ☐ High user of MH or medical services due to MH symptoms
- ☐ Homeless or at risk of homelessness
- ☐ Home bound and unserved
- ☐ Current/past justice system or law enforcement involvement
- ☐ New to MH; not served in past
- ☐ Co-occurring substance use/abuse issues
- ☐ Underserved/unserved, including uninsured/indigent
- ☐ Member of a minority or disadvantaged group

Name: MH CLIENT, FICTIONAL 01 Case#: 400001 Page: 5 of 6
Type: BH Referral Form Date: 05/24/2016
Printed on 05/24/2016 at 03:31 PM (Draft)

San Luis Obispo County Behavioral Health Department

Network Provider Referral O Yes O No

Does client have full-scope Medi-Cal? O Yes O No

Is client likely to benefit from short-term therapy? O Yes O No

Does client have a history of consistent attendance? O Yes O No

Does client have specific measurable/attainable goals? O Yes O No

If yes to all above, describe treatment goals/recommended focus of treatment?

Receiving Program Comments

Assigned to a Network Provider? O Yes O No

Number of days until next available appointment 0

Psychological Testing Referral O Yes O No

Has the client previously been tested (send results if available)? O Yes O No

What questions do you want testing to help answer?

How will testing results improve treatment?

Name: MH CLIENT, FICTIONAL 01	Case#: 400001	Page: 6 of 6
Type: BH Referral Form		Date: 05/24/2016
Printed on 05/24/2016 at 03:31 PM		(Draft)

San Luis Obispo County Behavioral Health Department

Transitions Mental Health Association Referral O Yes O No

Is the client currently homeless? O Yes O No

Is client at risk of homelessness? O Yes O No

Does the client meet MHSA target population criteria? O Yes O No

Service Requested (specify):

☐ Housing ☐ Case Management ☐ Supported Employment
☐ Growing Grounds Farm

Wellness Center (specify):

☐ Life House (North County) ☐ Hope House (SLO) ☐ Safe Haven (South County)
☐ Other Specify

Other Referral: O Yes O No

Specify program:

Sample Recovery Residence Contract FY16-17
(Note) This is approved by County Counsel, but still pending some edits

CONTRACT FOR BEHAVIORAL HEALTH SERVICES
COUNTY OF SAN LUIS OBISPO BEHAVIORAL HEALTH SERVICES

THIS CONTRACT, entered into by and between the County of San Luis Obispo, a public entity in the State of California, (hereafter "County") and XXXXXX, a California corporation, also known as XXXXX, (hereafter "Contractor"):

WITNESSETH

WHEREAS, XXXXXXX;

WHEREAS, XXXXXXX;

WHEREAS, Contractor is specially trained, experienced, expert and competent to perform such special services; and

WHEREAS, Pursuant to Government Code, section 31000, the County may contract for special services on behalf of public entities including County Behavioral Health.

NOW, **THEREFORE**, in consideration of the covenants, conditions, agreements, and stipulations set forth herein, the parties agree as follows:

1. **Scope of Services**. County hereby engages Contractor to perform, and Contractor hereby agrees to perform for County the services set forth on Exhibit A, attached hereto and incorporated herein by reference, all pursuant to the terms and conditions hereinafter set forth.
2. **Compensation**. Contractor shall be compensated by County for performing said services in accordance with Exhibit B, attached hereto and incorporated herein by reference.
3. **Effective Date and Duration**. The effective date and duration of this Contract shall be as specified on Exhibit C, attached hereto and incorporated herein by reference.
4. **General Conditions**. Contractor and County shall comply with all provisions of County's General Conditions, a copy of which is attached hereto as Exhibit D and incorporated herein by reference.
5. **Special Conditions**. Contractor and County shall comply with the special conditions attached hereto as Exhibit E and incorporated herein by reference. In the event of conflicts between the provisions of the General Provisions and the Special Conditions, the provisions of the Special Conditions shall be controlling.
6. **Business Associate Agreement**. Contractor and County shall comply with the County's Business Associate Agreement in accordance with Exhibit F, a copy of which is attached hereto and incorporated herein by reference.
7. **Qualified Service Organization Agreement**. Contractor and County shall comply with all provisions of County's Qualified Service Organization Agreement attached hereto as Exhibit G and incorporated herein by reference.

IN WITNESS WHEREOF County and Contractor have executed this Contract on the day and year set forth below.

CONTRACTOR XXXXXXXXX XXXXXXXXXX	CONTRACTOR XXXXXXXXX XXXXXXXXX
By: _____ Name, Title	By: _____ Name, Title
Tax ID# Held in Confidential File	

Approved as to form and legal effect:

RITA L. NEAL
COUNTY COUNSEL

By: _____ Date: _____
Deputy County Counsel

COUNTY OF SAN LUIS OBISPO,
A Public Entity in the State of California

By: _____ Date: _____
Chair, Board of Supervisors

ATTEST

By: _____
County Clerk and Ex-Officio Clerk
of the Board of Supervisors

EXHIBIT A

CONTRACT FOR BEHAVIORAL HEALTH SERVICES
SCOPE OF SERVICES

1. **Recovery Residence and Sober Living Environment:** Services rendered pursuant to this agreement shall be provided at the following location (s):

   XXXXXXX

   XXXXXXX

   a. **Service Specifications:**

      1) Contractor will provide Recovery Residence Beds (RRBs) and Sober Living Environment and a sober living environment (SLE) services to individuals with substance use disorders (SUD) and have been referred by San Luis Obispo County Behavioral Health Department to the Contractor.
         i. Individuals referred have been identified by the Court, Probation, and Behavioral Health as having a SUD as established by a standardized instrument such as: ASAM's American Society of Addiction Medicine Screening and Assessment Tool for proper Level of Care
         ii. Individuals referred have been determined to require and benefit from a structured Recovery Residence in conjunction with other SUD treatment services and/or case management services.
      2) Contractor shall maintain Recovery Residence and Sober Living Environment housing in accordance with the California Consortium of Addiction Programs and Professionals (CCAPP) standards for registered sober living environments.
      3) Contractor acknowledges that it must obtain and maintain proper registration with the California Consortium of Addiction Programs and Professionals ("CCAPP") throughout the duration of this Contract. CCAPP registration can be obtained through https://www.ccapp.us/about/soberliving/.
      4) Contractor shall renew CCAPP registration annually, and a copy of the registration provided to the County.
      5) County will coordinate referrals and placement of clients in the Recovery Residence.
         i. The County will maintain the sole use of the RRBs purchased.
         ii. The County will determine discharge dates for each resident with the exception of harm or threats of harm to other residents, drug violations, or theft

(1) Contractor shall provide notification to County regarding any unscheduled client discharges immediately or on the next business day following the discharge. Contractor shall also provide such immediate communication to Probation and Department of Social Services when appropriate for the client.

(2) Contractor shall communicate immediately with Probation and the County regarding possible Probation violations and to inform Probation and the County as soon as possible if a resident under Probation supervision is to leave the Recovery Residence.

6) Recovery Residence and Sober Living Environment Facility Standards

i. Facility size is to be sufficient to accommodate at least three (3) adult individuals per location.

ii. Facility Living quarters and recovery areas shall be attractive, clean, safe and functional. Appropriate utility services must be provided.

iii. All pertinent licensing and safety requirements must be met, including, without limitation, local fire code, conditional use permits, and zoning requirements

iv. There shall be adequate indoor and outdoor space for residents and program needs.

v. The facility shall meet American with Disabilities Act (ADA) criteria.

vi. The facility must be a clean and sober home for adult individuals. Use of any alcohol or drugs should be strictly prohibited.

vii. The facility must also adhere to the Drug-Free Workplace Act of 1990 for all staff, paid or unpaid.

viii. Facility should be close to Behavioral Health Services and if not, transportation or public transportation needs to be provided to residents without the means.

7) Required Service Elements:

i. Contractor shall maintain a house completely free of alcohol or drug use. When Contractor or any of its employees, volunteers, or agents suspect a patient referred by County has used alcohol or illegal drugs, Contractor shall ensure that individual(s) suspected is/are promptly to be drug tested on site or referred to County for immediate testing.

ii. Contractor will establish a curfew. Visitors will not be allowed after curfew without prior permission from the house manager.

iii. Contractor will provide an on-site house manager, who can account for residents, performs drug and alcohol testing as deemed appropriate, and is responsible for the general living standards and cleanliness of the home. If a resident tests positive for a drug or alcohol while residing at the facility, Contractor shall ensure that its personnel communicate this to the appropriate County staff immediately or on the first business day following the positive test.

iv. Contractor shall maintain resident records and individual sign-in/out logs for each resident. At no cost to County, Contractor shall make such records e available for inspection upon request.

v. Contractor shall provide on-site cooking facilities or meals, lodging, bathing, laundry, area for exercise, recreation, and visiting capacity

vi. Contractor shall provide culturally competent recovery maintenance services including afternoon and overnight on-site supervision, seven days per week using paid or volunteer staffing..

vii. Contractor shall engage in collaboration with other treatment providers, including detoxification and medication services.

viii. Contractor shall collaborate with Probation officers, including in-home visitations, searches in conjunction with the client's terms and conditions, administration of any GPS monitoring devices, and conducting of drug and alcohol testing of residents.

ix. Drug testing devices and drug testing services will be included in the bed day cost.

x. Contractor shall engage in case planning meetings and communication with the County Treatment Team on a weekly basis.

xi. Contractor shall promptly provide any requested status updates regarding client progress in home.

xii. Contractor shall provide recovery based activities such as but not limited to: recovery meetings, in-home life skills training, educational classes, socialization activities, support for employment, etc.

(1) Contractor shall ensure that residents participate in a minimum of 3 weekly recovery groups either held at the home, or attend, as a group at a local meeting place.

xiii. Contractor shall provide exit and discharge planning in collaboration with County and Probation Department with linkage to acuity step down services.

xiv. Contractor shall authorize, comply with, and be available for site visits by County at least one time per year unless otherwise requested. Site visit time and location shall be at the discretion of the County.

b. Staffing

1) Contractor shall ensure staffing levels sufficient to provide afternoon and overnight on-site supervision, seven days per week.

2) Staffing is defined as paid or volunteer employment, student interns, temporary help, and subcontracted staff.

i. Contractor staff including volunteers who provide on-site supervision, must not currently have a Child Welfare Services open case or be a current client of San Luis Obispo County Behavioral Health Department.

(1) If contractor wishes for an exception to be made, contractor may apply to the San Luis Obispo County Behavioral Health Department, which may authorize an exception after a review of the individual's history and performance in services. All applications must be approved by the Behavioral Health Administrator prior to the individual's employment as a house manager.

ii. House managers shall not be on probation (including Post Release Case Services, Parole, or Mandatory Supervision)

(1) If contractor wishes for an exception to be made, contractor may apply to the Probation Department, which may authorize an exception after a review of the individual's criminal history and performance on probation or parole in the Probation Departments sole discretion. All applications must be approved, in writing by the Probation Department prior to the individual's employment as a house manager.

3) Contractor shall provide full house manager names and contact information upon request and immediately upon any personnel changes.

c. Transportation

1) Contractor shall provide transportation services and/or provide proximal, easy access to public transportation, specifically to client's outpatient treatment providers and appointments with law enforcement. Services may be required up to five days per week.

EXHIBIT B

CONTRACT FOR BEHAVIORAL HEALTH SERVICES

COMPENSATION

1. Compensation.

Prior to commencement of services, Contractor shall provide a valid, current taxpayer ID number to the San Luis Obispo County Auditor/Controller at: 1055 Monterey Street Room D220, San Luis Obispo, CA. 93408. County shall pay to Contractor as compensation in full for all services performed by Contractor pursuant to this Contract, the following sums in the following manner:

a. County's Maximum Cost of the Contract for Services.

1) County will pay the Contractor for actual services used by the County. Bed holds in advance of stay or admission are not compensable to Contractor under this Contract. In no event shall the County's obligation under this Contract exceed the maximum fixed amount set forth below. The maximum amount of the County's obligation under this and all other Recovery Residence providers' contracts is four hundred fifty nine thousand two hundred twenty eight dollars ($459,228~~XXXXXX~~). Contractor understands that it is one of many providers with whom County has contracts, and understands that the maximum amount set forth above is the maximum authorized for all providers, and not just for Contractor, and Contractor understands that without additional action by County, County is not authorized to pay more than the maximum amount specified in this paragraph to all providers.

2) Rate Per Service: County will pay Contractor for services provided.

3) Bed Day Rate for Adult Residential Services - $XXXX Per Day.

b. If applicable, should both parties exercise the right to renew this Contract as described in Exhibits C and D, the maximum fund amount for this Contract/these Contracts in total per renewal term is identical to the maximum fund amount in FY 2016-17 unless the Parties agree otherwise pursuant to Paragraph 30 of Exhibit D, Delegation of Authority.

2. Billing.

Contractor shall bill County for services provided under this Contract as follows: For all services in a calendar month, Contractor shall invoice County by the 30th day of the following calendar month. The invoice shall be itemized, client by client, showing each client's number of client days, the client day rate, and the offsetting revenues from that client (e.g., SSI payment). The invoice shall also contain the client's admission date and previous history of client days, previously applied offsetting revenues, and previous payments made by County. In short, it will be a running total for each client. Each client's account shall commence on a separate page of Contractor's letterhead so that no other client's information can be observed on the invoice.

3. Documentation.

If County deems applicable, as part of the monthly invoicing process, Contractor shall provide, with each monthly invoice, documentation pertaining to client services provided during

the invoiced month, as per any special requirements needed by third party payors or federal or state funding agencies. Contractor will provide documentation as per County guidelines, which can be found at

http://www.slocounty.ca.gov/health/Health_Agency_Support_Page_for_Contractors_and_Network_Providers.htm

4. Payments.

County shall, within thirty (30) days following receipt of a correct monthly invoice meeting all criteria in this Contract, pay the undisputed charges on the invoice. If there are any disputed charges on the invoice, County shall include the explanation of the nature of the dispute with the payment for the undisputed charges. The parties shall exchange any information needed to resolve the dispute within a reasonable time

5. Audit Risk.

In the case that Contractor provided services are billed by the County to Medi-Cal, Contractor agrees to accept risk for Medi-Cal exceptions related to deficiencies in documentation or any other areas of responsibility to County to the extent allowed by law. Contractor further agrees to be responsible for reimbursing County any revenues to be paid to the State or Federal government, including but not limited to exceptions resulting from Medi-Cal audit, or as identified through utilization review and medical review by insurance carriers or other auditors. Said reimbursements shall include all lost revenues, damages of any kind, costs and attorney fees incurred by the County, and other charges assessed against the County to the full extent allowed by law.

Furthermore, County shall provide Contractor a process for appealing or disputing Medi-Cal exceptions or deficiencies demonstrated specifically attributable to Contractor by the County. Reimbursement to the County by Contractor shall not be required until the completion of the appeal or dispute resolution process.

County may deduct any such funds from other payments to Contractor if County includes a description of the basis for the deduction with its payment.

6. Withholding Payment.

In addition to withholding payment due to disputed charges on an invoice, County shall have the right to withhold payment to Contractor under the following conditions:

a. Contractor has not documented or has not sufficiently documented Contractor's services according to client records standards of the industry and any special requirements needed by third party payors or federal or state funding agencies.
b. Contractor has failed or refused to furnish information or cooperate with any inspection, review or audit of Contractor's program or County's use of Contractor's program. This includes interviews or reviews of records in any form of information storage.
c. Contractor has failed to sufficiently itemize or document the itemized invoice.
d. Contractor's performance, in whole or in part, has not been sufficiently documented, County has the right to withhold payment to the Contractor, when, in the opinion of the County, and expressed in writing to the Contractor.

EXHIBIT C

CONTRACT FOR BEHAVIORAL HEALTH SERVICES

DURATION AND EFFECTIVE DATE

1. Effective Date.

This Contract shall be effective as of the date this Contract is signed by the Board of Supervisors for the County of San Luis Obispo, and that signature shall be the last to sign.

2. Service Date.

a. Services shall commence on or after July 1, 2016 and shall end upon the end of the duration date

b. The County Board of Supervisors specifically acknowledges that in anticipation of execution of this contract, services within the scope of this contract may have been provided in reliance on assurances that this contract would be executed by the parties on the effective date. The services may have been rendered from July 1, 2016 to the date the Parties are executing this contract and which were intended in the best interest of the public health and welfare. The Board of Supervisors expressly authorizes the retroactive effective date under this contract to July 1, 2016. The Board of Supervisors also expressly authorizes payment for those services accepted by the County at the same rates and under the same terms and conditions as stated in this contract, even though this contract is being signed after July 1, 2016.

c. If any services from July 1, 2016 until the effective date have been paid by a purchase order via the County Purchasing Agent, that amount shall be deducted from the maximum allowed expenditure under Paragraph 1.a of Exhibit B of this contract.

3. Duration Date.

This contract shall remain in effect from the effective date stated above until June 30, 2017, unless terminated sooner pursuant to Sections 6 or 7 of Exhibit D or renewed pursuant to Section 4 of this Exhibit.

4. Option to Renew for One Year

By mutual agreement of the County and Contractor, this Contract may be renewed for up to, but no more than, two (2) successive one-year renewal terms beginning immediately upon the expiration of the Contract's initial one-year term. Each such one-year renewal shall be made in writing. The Health Agency Director or his designee is hereby delegated the authority to determine whether to renew this Contract without additional approval by the Board of Supervisors, so long as the renewal is in writing, approved as to form and legality by County Counsel, and consistent with the limits described in Section 30 of Exhibit D, Delegation of Authority.

EXHIBIT D

CONTRACT FOR BEHAVIORAL HEALTH SERVICES

GENERAL CONDITIONS

1. Independent Contractor.

Contractor shall be deemed to be an independent contractor of County. Nothing in this contract shall be construed as creating an employer-employee relationship, partnership or a joint venture relationship. Nothing in this contract authorizes or permits the County to exercise discretion or control over the professional manner in which Contractor provides services. Contractor's services shall be provided in a manner consistent with all applicable standards and regulations governing such services.

2. No Eligibility for Fringe Benefits.

Contractor understands and agrees that Contractor and its personnel are not, and will not be, eligible for membership in or any benefits from any County group plan for hospital, surgical, or medical insurance, or for membership in any County retirement program, or for paid vacation, paid sick leave, or other leave, with or without pay, or for any other benefit which accrues to a County employee.

3. Warranty of Contractor for Provision of Services.

Contractor shall obtain and shall keep in full force and effect during the term of this Contract all permits, registrations and licenses necessary to accomplish the work specified in the Contract. Contractor shall furnish qualified professional personnel as prescribed by Title 9 of the California Code of Regulations, the Business and Professions Code, and all other applicable laws for the type of services rendered under this Contract. Contractor warrants that it, and each of the personnel employed or otherwise retained by Contractor, will at all times, to the extent required by law, be properly certified and licensed throughout the entire duration of this Contract under the local, state and federal laws and regulations applicable to the provision of services herein.

4. Warranty of Contractor re Compliance with all Laws.

Contractor shall keep informed of, observe, comply with, and cause all of its agents and personnel to observe and comply with all laws, rules, regulations, and administrative requirements adopted by federal, state, and local governments which in any way affect the conduct of work under this Contract. If any conflict arises between provisions of the scope of work or specifications in this Contract and any law, then the Contractor shall immediately notify the County in writing.

5. Power and Authority of Contractor.

If the Contractor is a corporation, Contractor represents and warrants that it is and will remain, throughout the term of this Contract, either a duly organized, validly existing California corporation in good standing under the laws of the State of California or a duly organized, validly existing foreign corporation in good standing in the state of incorporation and authorized to transact business in the State of California.

6. Termination for Cause.

If the County determines that there has been a material breach of this Contract by Independent Contractor that poses a threat to health and safety, the County may immediately terminate the Contract. In addition, if any of the following occur, County shall have the right to terminate this Contract effective immediately upon giving written notice to the Independent Contractor:

a. Contractor fails to perform his duties to the satisfaction of the County; or

b. Contractor fails to fulfill in a timely and professional manner his obligations under this Contract; or

c. Contractor fails to exercise good behavior either during or outside of working hours that is of such a nature as to bring discredit upon the County; or

d. Any requisite licenses or certifications held by Contractor are terminated, suspended, reduced, or restricted; or

e. Contractor has not, to the satisfaction of the County, documented or has not sufficiently documented services provided by Contractor, which includes without limitation, failure to meet industry standards or failure to satisfy any special requirements needed by third party payors or federal or state funding agencies; or.

f. Contractor has failed or refused to furnish information or cooperate with any inspection, review or audit of Contractor's program or County's use of Contractor's program. This includes interviews or reviews of records in any form of information storage; or

g. Contractor fails to comply with any provision of the Mental Health Compliance Plan, Cultural Competence Plan, and Code of Ethics.

All obligations to provide services shall automatically terminate on the effective date of termination.

For all other material breaches of this Contract, County must give Contractor written notice setting forth the nature of the breach. If Contractor fails to remedy said breach within ten (10) days from the date of the written notice, County may terminate the Contract. Contractor shall thereafter have no further rights, powers, or privileges against County under or arising out of this Contract.

In the event a breach does not result in termination, but does result in costs being incurred by County, said costs shall be charged to and paid by Independent Contractor, which costs may include, but are not limited to, costs incurred by County in investigating and communicating with Contractor regarding said breach, including staff time.

7. Termination for Convenience.

Either party may terminate this Contract at any time by giving the other party at least 30 calendar days' written notice of termination for convenience ("Notice of Termination for Convenience"). Termination for convenience shall be effective at 11:59 p.m., Pacific Standard Time, on the intended date for termination (the "Termination Date"). The terminating party shall deliver to the other party a notice specifying the date upon which such termination will become effective, which shall be at least 30 calendar days after the date of the notice.

Termination for convenience shall have no effect upon the rights and obligations of the parties arising out of any services, which were provided prior to the effective date of such termination. Contractor shall be paid for all work satisfactorily completed prior to the effective date of termination. After receiving a Notice of Termination for Convenience, Contractor shall, unless directed by County, place no further subcontracts for services or materials, terminate all subcontracts to the extent they relate to the work terminated, and settle all outstanding liabilities arising from the termination of subcontracts.

Neither this section nor Section 6 of this Exhibit apply to a decision by either party not to exercise an option to renew this contract.

8. Power to Terminate.

Termination of this Contract may be effectuated by the Health Agency Director without the need for action, approval, or ratification by the Board of Supervisors.

9. Non-Assignment of Contract.

Inasmuch as this Contract is intended to secure the specialized services of the Contractor, Contractor shall not delegate, assign, or otherwise transfer in whole or in part its rights or obligations under this contract without the prior written consent of County. Any such assignment, transfer, or delegation without the County's prior written consent shall be null and void.

10. Entire Agreement and Modifications.

This Contract supersedes all previous contracts between the parties hereto on the same subject matter and constitutes the entire understanding of the parties hereto on the subject matter of this Contract. Contractor shall be entitled to no other benefits than those specified herein. No changes, amendments or alterations shall be effective unless in writing and signed by both parties. Contractor specifically acknowledges that in entering into and executing this contract, Contractor relies solely upon the provisions contained in this Contract and no others.

11. Governing Law and Venue.

This Contract shall be governed by, and construed in accordance with, the laws of the State of California, without regard to its conflict of laws provisions. All of the parties' rights and obligations created hereunder shall be performed in the County of San Luis Obispo, State of California and such County shall be the venue for any action or proceeding that may be brought, or arise out of, this contract.

12. Waiver.

No delay or failure on the part of any party hereto in exercising any right, power or privilege under this Contract shall impair any such right power or privilege or be construed as a waiver of any default or any acquiescence therein. No single or partial exercise of any such right, power or privilege shall preclude the further exercise of such right power or privilege or the exercise of any other right, power or privilege. No waiver shall be valid unless made in writing and signed by the party against whom enforcement of such waiver is sought and then only to the extent expressly specified therein.

13. Severability.

The Contractor agrees that if any provision of this Contract is found to be invalid, illegal or unenforceable, such term or provision shall be deemed stricken and the remainder of the

Contract shall remain in full force and effect. Upon determination that any term or provision is invalid, illegal or unenforceable, the parties shall negotiate in good faith to modify this contract so as to affect the original intent of the parties as closely as possible.

14. Nondiscrimination.

Contractor agrees that it will abide by all Federal and State labor and employment laws and regulations pertaining to unlawful discrimination prohibiting discrimination against any employee or applicant for employment because of race, color, religion, sexual orientation, disability or national origin, and those conditions contained in Presidential Executive Order number 11246.

15. Notices.

All notices given or made pursuant hereto shall be in writing and shall be deemed to have been duly given if delivered personally, mailed by registered or certified mail (postage paid, return receipt requested) or sent by a nationally recognized overnight courier (providing proof of delivery) to the parties at the following addresses or sent by electronic transmission to the following facsimile numbers (or at such other address or facsimile number for a party as shall be specified by like notice):

Anne Robin, LMFT
Behavioral Health Services Administrator
2180 Johnson Avenue
San Luis Obispo, CA 93401-4535

And to Contractor at:

Any such notice shall be deemed to have been received if: (a) in the case of personal delivery or facsimile transmission with confirmation retained, on the date of such delivery or transmission; (b) in the case of nationally recognized overnight courier, on the next business day after the date sent; (3) in the case of mailing, on the third business day following posting.

16. Inspection Rights.

The Contractor shall allow the County and all other federal, state, and local governmental agencies to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract and to inspect, evaluate and audit any and all books, records, and facilities maintained by Contractor and subcontractors, pertaining to such service at any time during normal business hours. Books and records include, without limitation, all physical records originated or prepared pursuant to the performance under this Contract including work papers, reports, financial records and books of account. Upon request, at any time during the period of this Contract, and for a period of five years thereafter, the Contractor shall furnish any such record, or copy thereof, to County.

Contractor shall include a provision granting similar authorization in each of its contracts with any subcontractors.

17. Headings.

The headings contained in this Contract are for reference purposes only and shall not affect in any way the meaning or interpretation of this Contract.

18. Signatory Authority.

Contractor warrants that it has full power and authority to enter into and perform this Contract, and the person signing this Contract warrants that he/she has been properly authorized and empowered to enter into this Contract.

19. Indemnification.

To the fullest extent permitted by law, Contractor shall indemnify, defend, and hold harmless the County and its officers, agents, employees, and volunteers from and against all claims, demands, damages, liabilities, loss, costs, and expense (including attorney's fees and costs of litigation) of every nature arising out of or in connection with Contractor's performance or attempted performance of work hereunder or its failure to comply with any of its obligations contained in the agreement, except such loss or damage which was caused by sole negligence or willful misconduct of the County.

20. Insurance.

Contractor shall procure and maintain for the duration of the contract insurance against claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work hereunder by the Contractor, its agents, representatives, or employees.

MINIMUM SCOPE AND LIMIT OF INSURANCE.

Coverage should be at least as broad as:

a. **Commercial General Liability** (CGL): Insurance Services Office (ISO) Form CG 00 01 covering CGL on an "occurrence" basis for bodily injury and property damage, including products-completed operations, personal injury and advertising injury, with limits no less than **$1,000,000** per occurrence. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this project/location or the general aggregate limit shall be twice the required occurrence limit.

b. **Automobile Liability:** ISO Form Number CA 0001 covering, Code 1 (any auto), or if Contractor has no owned autos, Code 8 (hired) and 9 (non-owned), with limit no less than $1,000,000 per accident for bodily injury and property damage.

c. **Workers' Compensation** insurance as required by the State of California, with Statutory Limits, and Employer's Liability Insurance with limit of no less than $1,000,000 per accident for bodily injury or disease. If Contractor will provide leased employees, or, is an employee leasing or temporary staffing firm or a professional employer organization (PEO), coverage shall also include an Alternate Employer Endorsement (providing scope of coverage equivalent to ISO policy form WC 00 03 01 A) naming the County as the Alternate Employer, and the endorsement form shall be modified to provide that County will receive not less than thirty (30) days advance written notice of cancellation of this coverage provision. If applicable to Contractor's operations, coverage also shall be arranged to satisfy the requirements of any federal workers or workmen's compensation law or any federal occupational disease law.

(Not required if Contractor provides written verification it has no employees)

d. **Sexual Misconduct Liability, if applicable:** Insurance covering actual or alleged claims for sexual misconduct and/or molestation with limits of not less than $2 million per claim and $2 million aggregate, and claims for negligent employment, investigation, supervision, training or retention of, or failure to report to proper authorities, a person(s) who committed any act of abuse, molestation, harassment, mistreatment or maltreatment of a sexual nature.

e. **Professional Liability/Errors and Omissions:** Insurance covering Contractor's liability arising from or related to this Contract, with limits of not less than $1 million per claim and $2 million aggregate. Further, Contractor understands and agrees it shall maintain such coverage for a period of not less than three (3) years following this Agreement's expiration, termination or cancellation.

f. **Additional Insured Status:** The County, its officers, officials, employees, and volunteers are to be covered as insureds on the auto policy with respect to liability arising out of automobiles owned, leased, hired or borrowed by or on behalf of the Contractor; and on the CGL policy with respect to liability arising out of work or operations performed by or on behalf of the Contractor including materials, parts, or equipment furnished in connection with such work or operations. General liability coverage can be provided in the form of an endorsement to the Contractor's insurance (at least as broad as ISO Form CG 20 10, 11 85 or both CG 20 10 and CG 23 37 forms if later revisions used).

g. **Primary Coverage:** For any claims related to this contract, the Contractor's insurance coverage shall be primary insurance as respects the County, its officers, officials, employees, and volunteers. Any insurance or self-insurance maintained by the County, its officers, officials, employees, or volunteers shall be excess of the Contractor's insurance and shall not contribute with it.

h. **Notice of Cancellation:** Each insurance policy required above shall state that coverage shall not be canceled, except after thirty (30) days' prior written notice (10 days for non-payment) has been given to the County.

i. **Failure to Maintain Insurance**: Contractor's failure to maintain or to provide acceptable evidence that it maintains the required insurance shall constitute a material breach of the Contract, upon which the County immediately may withhold payments due to Contractor, and/or suspend or terminate this Contract. The County, at its sole discretion, may obtain damages from Contractor resulting from said breach.

j. **Waiver of Subrogation**: Contractor hereby grants to County a waiver of any right to subrogation which any insurer of said Contractor may acquire against the County by virtue of the payment of any loss under such insurance. Contractor agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not the County has received a waiver of subrogation endorsement from the insurer.

k. **Deductibles and Self-Insured Retentions**: Any deductibles or self-insured retentions must be declared to and approved by the County. The County may require the Contractor to provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention.

l. **Acceptability of Insurers**: Insurance is to be placed with insurers with a current A.M. Best's rating of no less than A:VII, unless otherwise acceptable to the County.

m. **Claims Made Policies**: If any of the required policies provide coverage on a claims-made basis:

1) The Retroactive Date must be shown and must be before the date of the contract or the beginning of contract work.

2) Insurance must be maintained and evidence of insurance must be provided for at least five (5) years after completion of the contract of work

3) If coverage is canceled or non-renewed, and not replaced with another claims-made policy form with a Retroactive Date prior to the contract effective date, the Contractor must purchase "extended reporting" coverage for a minimum of five (5) years after completion of contract work.

n. **Separation of Insureds**: All liability policies shall provide cross-liability coverage as would be afforded by the standard ISO (Insurance Services Office, Inc.) separation of insureds provision with no insured versus insured exclusions or limitations.

o. **Verification of Coverage**: Contractor shall furnish the County with original certificates and amendatory endorsements or copies of the applicable policy language effecting coverage required by this clause. All certificates and endorsements are to be received and approved by the County before work commences. However, failure to obtain the required documents prior to the work beginning shall not waive the Contractor's obligation to provide them. The County reserves the right to require complete, certified copies of all required insurance policies, including endorsements required by these specifications, at any time.

p. **Certificates and copies of any required endorsements shall be sent to**:

San Luis Obispo County Behavioral Health
Fiscal Department
2180 Johnson Avenue
San Luis Obispo, CA 93401

Attention: Name and Title of Department Contract

21. Nonappropriation of Funds.

During the term of this Contract, if the State or any federal government terminates or reduces it's funding to County for services that are to be provided under this Contract, then County may elect to terminate this Contract by giving written notice of termination to Contractor effectively immediately or on such other date as County specifies in the notice. In the event that the term of this Contract extends into fiscal year subsequent to that in which it was approved by the County, continuation of the Contract is contingent on the appropriation of funds by the San Luis Obispo County Board of Supervisors or, if applicable, provision of State or Federal funding source. If County notifies Contractor in writing that the funds for this Contract have not been appropriated or provided, this Contract will terminate. In such an event, the County shall have no further liability to pay any funds to the Contractor or to furnish any other consideration under this Contract, and the Contractor shall not be obligated to perform any provisions of this Contract or to provide services intended to be funded pursuant to this Contract. If partial funds are

appropriated or provided, the County shall have the option to either terminate this Contract with no liability to the County or offer a Contract amendment to the Contractor to reflect the reduced amount.

22. Force Majeure.

Neither the County nor the Contractor shall be deemed in default in the performance of the terms of this contract if either party is prevented from performing the terms of this Contract by causes beyond its control, including without limitation: acts of God; rulings or decisions by municipal, Federal, States or other governmental bodies; any laws or regulations of such municipal, Federal, States or other governmental bodies; or any catastrophe resulting from flood, fire, explosion, or other causes beyond the control of the defaulting party. Any party delayed by force majeure shall as soon as reasonably possible give the other party written notice of the delay. The party delayed shall use reasonable diligence to correct the cause of the delay, if correctable, and if the condition that caused the delay is corrected, the party delayed shall immediately give the other parties written notice thereof and shall resume performance under this Contract.

23. Fiscal Controls.

Contractor shall adhere to the accounting requirements, financial reporting, and internal control standards as described in the Auditor-Controller Contract Accounting and Administration Handbook, (Handbook) which contains the minimum required procedures and controls that must employed by Contractor's accounting and financial reporting system, and which is incorporated herein by reference. The handbook may be modified from time to time and contractor shall comply with modifications from and after the date modified. Contractor shall require subcontractors to adhere to the Handbook for any services funded through this contract, unless otherwise agreed upon in writing by County.

a. The Handbook is available at http://www.slocounty.ca.gov/AC/, under Policies and Procedures or at the Auditor-Controller's Office, 1055 Monterey Street Room D220, County Government Center, San Luis Obispo CA, 93408,

b. The Office of Management and Budget (OMB) circulars are available at http://www.whitehouse.gov/omb/circulars.

24. Inspection or Audit of Records by Local, State or Federal Agency.

Unless a longer period is required by law, pursuant to California Government Code section 8546.7, every County contract involving the expenditure of funds in excess of ten thousand dollars ($10,000) is subject to examination and audit of the State Auditor for a period of three years after final payment under the contract.

Additionally, the Contractor shall allow the County, State Department of Health Care Services (DHCS), United States Department of Health and Human Services (HHS), the Comptroller General of the United States (Government Accountability Office, GAO), and other authorized federal and state agencies, or their duly authorized representatives, to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract and to inspect, evaluate and audit any and all books, records, and facilities maintained by Contractor, pertaining to such service at any time during normal business hours. Books and records include, without limitation, all physical records originated or prepared pursuant to the performance under this Contract including work papers, reports, financial records, books of

account, beneficiary records, prescription files, and any other documentation pertaining to covered services and other related services for beneficiaries. Upon request, at any time during the period of this Contract, and for a period of five years thereafter, the Contractor shall furnish any such record, or copy thereof, to County, State DHCS, HHS, or GAO as requested.

25. Nondisclosure.

All reports, information, documents, or any other materials prepared by Contractor under this Contract are the property of the County unless otherwise provided herein. Such reports, information, documents and other materials shall not be disclosed by Contractor without County's prior written consent. Any requests for information shall be forwarded to County along with all copies of the information requested. County shall make sole decision whether and how to release information according to law.

26. Conflict of Interest.

Contractor acknowledges that Contractor is aware of and understands the provisions of Sections 1090 et seq. and 87100 et seq. of the Government Code, which relate to conflict of interest of public officers and employees. Contractor certifies that Contractor is unaware of any financial or economic interest of any public officer or employee of the County relating to this Contract. Contractor agrees to comply with applicable requirements of Government Code Section 87100 et seq. during the term of this Contract.

27. Immigration Reform and Control Act.

Contractor acknowledges that Contractor, and all subcontractors hired by Contractor to perform services under this Contract are aware of and understand the Immigration Reform and Control Act ("IRCA") of 1986, Public Law 99-603. Contractor certifies that Contractor is and shall remain in compliance with ICRA and shall ensure that any subcontractors hired by Contractor to perform services under this Contract are in compliance with IRCA.

28. Third Party Beneficiaries.

It is expressly understood that the enforcement of the terms and conditions and all rights of action related to enforcement, shall be strictly reserved to County and Contractor. Nothing contained in this contract shall give or allow and claim or right of action whatsoever by any other third person.

29. Tax Information Reporting.

Upon request, Contractor shall submit its tax identification number or social security number, whichever is applicable, in the form of a signed W-9 form, to facilitate appropriate fiscal management and reporting.

30. Delegation of Authority.

The component of services covered in this Contract and the related compensation rates are anticipated types and rates for services. Accordingly, the Board of Supervisors delegates to the Health Agency Director or designee the authority to amend this Contract to exchange, delete, or add to the types of services and/or to increase compensation to Contractor up to the change order limits specified in the County's Contracting for Services Policy.

Any amendment made pursuant to a delegation of authority will only be effective if, prior to the commencement of services or extension of said Contract, the amendment is memorialized in writing, is approved by County Counsel, and is signed by the Health Agency Director or

designee and does not exceed the change order limits. This delegation of authority is expressly limited as stated herein.

The Board of Supervisors expressly delegates to the Health Agency Director or designee the authority to decide whether to exercise the option to renew this agreement for two (2) one-year periods pursuant to Exhibit C. The Health Agency Director is permitted to agree to any rate change associated with a renewal of this contract so long as that rate change from the allowed expenditure under the initial term of this Contract falls within the change order limits of the County's Contracting for Services Policy.

EXHIBIT E

CONTRACT FOR BEHAVIORAL HEALTH SERVICES

SPECIAL CONDITIONS

1. Compliance with Health Care Laws.

Contractor agrees to abide by all applicable local, State and Federal laws, rules, regulations, guidelines, and directives for the provision of services hereunder, including without limitation, the applicable provisions of the Civil Code, Welfare and Institutions Code, the Health and Safety Code, the Family Code, the California Code of Regulations, the Code of Federal Regulations, and the Health Insurance Portability and Accountability Act. This obligation includes, without limitation, meeting delivery of service requirements, guaranteeing all client's rights provisions are satisfied, and maintaining the confidentiality of patient records.

2. No Discrimination In Level Of Services.

As a condition for reimbursement, Contractor shall provide to and ensure that clients served under this Contract receive the same level of services as provided to all other clients served regardless of status or source of funding.

3. Nondiscrimination.

Contractor shall comply with the provisions of Section 504 of the Rehabilitation Act of 1973, as amended pertaining to the prohibition of discrimination against qualified handicapped persons in all federally assisted programs or activities, as detailed in regulations signed by the Secretary of Health and Human services, effective June 2, 1977, and found in the Federal Register, Volume 42, No.86 dated May 4, 1977.

Contractor shall comply with the provisions of the Americans with Disabilities Act of 1990, the Fair Employment and Housing Act (Government Code section 12900 et seq.) and the applicable regulation promulgated thereunder (Title 2 Section 7285 et seq.) The Contractor shall give written notice of its obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

Contractor shall not engage in any unlawful discriminatory practices in the admission of beneficiaries, assignments of accommodations, access to programs or activities, treatment, evaluation, employment of personnel, or in any other respect on the basis of race, color, gender, religion, marital status, national origin, age, sexual preference or mental or physical handicap.

4. Quality Assurance.

Contractor agrees to conduct a program of quality assurance and program review that meets all requirements of the State Department of Health Care Services. Contractor agrees to cooperate fully with program monitoring or other programs that may be established by County to promote high standards of mental health care to clients at economical costs.

5. Compliance Certification.

Contractor will certify, on an annual basis that it has complied with the following elements of this of this Contract:

Exhibit D.26: Conflict of Interest

Exhibit E.6.; Screening for Inspector Generals' Excluded Provider List and Medi-Cal List of Excluded Providers

Exhibit E.7.; Compliance Plan

Exhibit E.8.; Cultural Competence Plan

Exhibit E.11.Disclosures - Conviction of Crimes / Ownership Interest of Greater than 5%

Contractor will sign the Contractor Certification form in conjunction with signing this Contract. The Contractor Certification form has been approved by the Health Agency Director and will be either provided with your contract or can be found at:

http://www.slocounty.ca.gov/health/Health_Agency_Support_Page_for_Contractors_and_Network_Providers.htm

6. Screening for Inspector Generals' Excluded Provider List and Medi-Cal List of Excluded Providers.

At the time of securing a new employee or service provider, Contractor shall conduct or cause to be conducted a screening and provide documentation to County certifying that its new employee or service provider is not listed on the Excluded Provider List of the Office of the Inspector General or the Medi-Cal List of Excluded Providers. On a monthly basis, Contractor shall conduct or cause to be conducted a screening of all employees, contractors or agents and shall sign a certification documenting that neither Contractor nor any of its employees, contractors or agents are listed on the Excluded Provider List of the Office of the Inspector General or the Medi-Cal List of Excluded Providers.

7. Compliance Plan.

Contractor shall at a minimum, adopt and comply with all provisions of the latest version of the Health Agency Compliance Plan and Code of Conduct–Contractor and Network Provider Version ("Compliance Plan"). Contractor may adopt and comply with an alternate Compliance Plan and Code of Conduct if granted written approval by the Health Agency Compliance Officer. Contractor shall adopt effective measures to enforce compliance with the Compliance Plan by its employees, subcontractors and agents.

Within 30 calendar days of hire, and annually thereafter, Contractor, its employees, contractors and agents shall read the latest edition of the Health Agency Compliance Plan and Code of Ethics and complete related training provided by Contractor or the Health Agency.

Contractor shall maintain records providing signatures (either actual or electronic) from each employee, contractor and agent stating that they read the Compliance Plan, completed the related training and agree to abide by its contents. (Relias Learning or equivalent E-learning records are sufficient to comply with this requirement)

The Compliance Plan and related training (YouTube video) may be found here:
http://www.slocounty.ca.gov/health/Health_Agency_Support_Page_for_Contractors_and_Network_Providers.htm

8. Compliance with County Cultural Competence Plan.

Consistent with the County Cultural Competence Plan, Contractor will provide services that meet the cultural, ethnic and linguistic backgrounds of their clients, including but not limited to, access to services in the appropriate language and/or reflecting the appropriate culture or ethnic group. Contractor will use professional skills, behaviors, and attitudes in its system that ensures that the system, or those being seen in the system, will work effectively in a cross cultural

environment. Contractor shall adopt effective measures to enforce compliance with the Cultural Competence Plan by its employees, subcontractors and agents.

Within 90 calendar days of hire, and annually thereafter, Contractor, its employees, contractors and agents shall read the latest edition of the Cultural Competence Employee Information Pamphlet and complete related training provided by the Health Agency.

Contractor shall maintain records providing signatures (either actual or electronic) from each employee, contractor and agent stating that they read the Cultural Competence Employee Information Pamphlet, completed the related training and agree to abide by its contents. (Relias Learning or equivalent E-learning records are sufficient to comply with this requirement)

The Cultural Competence Employee Information Pamphlet may be found here:
http://www.slocounty.ca.gov/health/Health_Agency_Support_Page_for_Contractors_and_Network_Providers.htm

The Cultural Competence Plan may be found here:
http://www.slocounty.ca.gov/health/Health_Agency_Support_Page_for_Contractors_and_Network_Providers.htm

9. Health Information Privacy and Security Policy and Training Program.

Contractor will provide health information privacy and security training to all employees as required by Title 22 of the California Code of Regulations, the Health Information Portability and Accountability Act of 1996, the California Medical Information Act, and as required by County.

Within 15 calendar days of hire, and annually thereafter, Contractor, its employees, contractors and agents shall read the latest edition of the Confidentiality Agreement and HIPAA primer for Contractor Use, and complete related training provided by the Health Agency. Contractor may adopt and comply with an alternate Confidentiality Agreement, HIPAA Policy, and related training if granted written approval by the Health Agency Compliance Officer.

Contractor shall maintain records providing signatures (either actual or electronic) from each employee, contractor and agent stating that they read the Health Information Privacy and Security Policy, completed the related training and agree to abide by its contents. (Relias Learning or equivalent E-learning records are sufficient to comply with this requirement)

The Health Information Privacy and Security Policy and Procedure may be found here:
http://www.slocounty.ca.gov/Assets/MHS/Contractor+Support+Documents/Health+Agency+Information+Privacy+and+Security+Policy+and+Procedure+-+For+Contractor+and+Network+Provider+Use.pdf

The Confidentiality Agreement and HIPAA Primer for Contractor Use may be found here:
http://www.slocounty.ca.gov/Assets/MHS/Contractor+Support+Documents/Confidentiality+Agreement+and+4-Page+HIPAA+Primer.pdf

10. Confidentiality.

Contractor shall abide by all applicable local, State and federal laws, rules, regulations, guidelines, and directives regarding the confidentiality and security of patient information, including without limitation, Sections14100.2 and 5328 et seq. of the Welfare and Institutions Code Sections 14100 and 5328 et seq., Section 431.300 et seq. of Title 42 of the Code of Federal Regulations, the Health Insurance Portability and Accountability Act (HIPAA) and its implementing regulations, including but not limited to Title 45 CFR Parts 142, 160, 162 and 164,

and the provisions of Exhibit F, and the Business Associate Agreement attached to this Contract and incorporated by this reference. Any conflict between the terms and conditions of this Contract and the Business Associate Agreement are to be read so that the more legally stringent terms and obligations of the Contractor shall control and be given effect. Contractor shall not disclose, except as otherwise specifically permitted by the Contract or authorized by the client/patient or the law, any such identifying information without prior written authorization in accordance with State and Federal laws.

11. Disclosures.

Pursuant to 42 CFR § 455.104 and 42 CFR § 455.106, Contractor will submit the disclosures described in this section regarding the Contractor's ownership and control and convictions of crimes. Contractor must submit new or updated disclosures to the Health Agency prior to entering into or renewing the Contract. Contractor shall submit an updated disclosure to the Health Agency within 35 calendar days of any change of ownership, conviction of crime by a Contractor employee, or upon request of the Department. Disclosures to be provided:

5% or More Ownership Interest:

a. The name and address of any person (individual or corporation) with an ownership or control interest in the contractor/network provider. The address for corporate entities shall include, as applicable, a primary business address, every business location, and a P.O. Box address;

b. Date of birth and Social Security Number (in the case of an individual);

c. Other tax identification number (in the case of a corporation with an ownership or control interest in the managed care entity or in any subcontractor in which the managed care entity has a 5 percent or more interest);

d. Whether the person (individual or corporation) with an ownership or control interest in the contractor/network provider is related to another person with ownership or control interest in the same or any other network provider of the Health Agency as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the managed care entity has a 5 percent or more interest is related to another person with ownership or control interest in the managed care entity as a spouse, parent, child, or sibling;

e. The name of any other disclosing entity in which the Contractor or subcontracting network provider has an ownership or control interest; and

f. The name, address, date of birth, and Social Security Number of any managing employee of the managed care entity.

Conviction of Crimes:

a. The identity of any person who is a managing employee of the Contractor who has been convicted of a crime related to federal health care programs. (42 C.F.R. § 455.106(a)(1), (2).)

b. The identity of any person who is an agent of the Contractor who has been convicted of a crime related to federal health care programs. (42 C.F.R. § 455.106(a)(1), (2).)

c. The Contractor shall supply the disclosures before entering into the contract and at any time upon the County's request.

d. Network providers should submit the same disclosures to the County regarding the network providers' criminal convictions. Network providers shall supply the disclosures before entering into the contract and at any time upon the Department's request.

The Health Agency Disclosure of Ownership Interest and Conviction of Crimes form can be found at:
http://www.slocounty.ca.gov/health/Health_Agency_Support_Page_for_Contractors_and_Network_Providers.htm

12. Record keeping and reporting of services.

Contractor shall:

a. Keep complete and accurate records for each client treated pursuant to this Contract, which shall include, but not be limited to, diagnostic and evaluation studies, treatment plans, medication log, progress notes, program compliance, outcome measurement and records of services provided in sufficient detail to permit an evaluation of services without prior notice. Such records shall comply with all applicable Federal, State, and County record maintenance requirements

b. Submit informational reports as required by County on forms provided by or acceptable to County with respect to Contractor's program, major incidents, and fiscal activities of the program.

c. Collect and provide County with all data and information County deems necessary for County to satisfy State reporting requirements, which shall include, without limitation, Medi-Cal Cost reports in accordance with Welfare and Institutions Code 5651(a)(4), 5664(a) and (b), 5705(b)(3), 5718(c) and guidelines established by DHCS. Said information shall be due no later than 90 days after close of fiscal year of each year, unless a written extension is approved by the County. Contractor shall provide such information in accordance with the requirements of the Short-Doyle/Medi-Cal Cost Reporting System Manual, applicable state manuals and/or training materials, and other written guidelines that may be provided by County to Contractor.

13. State Audits.

Pursuant to California Code of Regulations, title 9, section 1810.380, Contractor shall be subject to State oversight, including site visits and monitoring of data reports and claims processing; and reviews of program and fiscal operations to verify that medically necessary services are provide in compliance with said code and the contract between the State and County. If the Contractor is determined to be out of compliance with State or Federal laws and regulations, the State may require actions of the County to rectify any out of compliance issue, which may include financial implications. Contractor agrees to be held responsible for their portion of any action the State may impose on the County.

14. Equipment.

Contractor shall furnish all personnel, supplies, equipment, telephone, furniture, utilities, and quarters necessary for the performance of services pursuant to this Contract with the exception of:

a. All required Behavioral Health forms;

b. County may at its option and at County's sole discretion, elect to provide certain equipment which shall remain County property and be returned to the County upon earlier demand by or in no event later than the termination of the Contract. Contractor may at its option use County provided equipment for non-County clients as long as the equipment in any given instance is not for the sole use of non-County clients.

15. Other Employment.

Contractor shall retain the right to provide services at another facility or to operate a separate private practice; subject, however, to the conditions that:

a. No such private practice shall be conducted or solicited on County premises or from County-referred clients.

b. Such other employment shall not conflict with the duties, or the time periods within which to perform those duties, described in this Contract.

c. The insurance coverage provided by the County or by the Contractor for the benefit of the County herein is in no way applicable to or diminished by any other employment or services not expressly set forth in this Contract.

16. State Department of Health Care Services Contract.

Contractor agrees that this Contract shall be governed by and construed in accordance with the laws, regulations and contractual obligations of County under its agreement with the State Department of Health Care Services to provide specialty mental health services to Medi-Cal beneficiaries of San Luis Obispo County. (Medi-Cal Specialty Mental Health Services, Welfare and Institutions Code section 5775).

17. Use of Information Provided by the Social Security Administration

Contractor shall comply with all conditions required under the Social Security Administration agreement with the California Department of Health Care Services available at http://www.slocounty.ca.gov/Assets/MHS/Contractor+Support+Documents/Contract+Exhibit+G+-+SSA+Information+Security+Requirements.pdf

18. Placement Authority.

County will have sole and exclusive right to screen and approve or disapprove clients prior to placement in Contractor's facility. Approval must be obtained in writing by client's case manager or designee prior to placement under this Contract.

19. License Information.

Contractor agrees that all facilities and staff including, but not limited to, all professional and paraprofessional staff used to provide services will maintain throughout the term of this Contract, such qualifications, licenses and/or permits as are required by state or local law. Contractor shall provide County a list of all licensed persons who may be providing services under this Contract. The list shall include the name, title, professional degree, license number, and NPI number.

20. Professional Licensing Waiver Requirements.

Contractor is required to comply with DMH Letter No 02-09 regarding waivers for professional licensing of all psychologists, clinical social workers, or marriage and family therapists employed by, or under contract to, County.

21. Gifts.

Gifts may not be charged to this Contract, whether to Contractor staff or anyone else. However, incentive items for youth clients used in a clinical behavioral modification program are allowed with clinical documentation and compliance with established County procedures.

22. Reports of Death, Injury, Damage or Abuse.

If the County discovers any practice, procedure, or policy of the Contractor which deviates from the requirements of this Contract, violates federal or state law, threatens the success of the program conducted pursuant to this Contract, jeopardizes the fiscal integrity of such program, or compromises the health or safety of recipients of service, County may require corrective action, withhold payment in whole or in part, or terminate this Contract immediately. If County notifies Contractor that corrective action is required, Contractor shall promptly initiate and correct any and all discrepancies, violations or deficiencies to the satisfaction of the County within thirty (30) days, unless County notifies Contractor that it is necessary to make corrections at an earlier date in order to protect the health and safety of recipients of service.

Contractor agrees to notify the County immediately should Contractor be investigated, charged, or convicted of a health care related offense. During the pendency of any such proceedings, Contractor shall keep the County fully informed about the status of such proceedings and to consult with the County prior to taking any action which will directly impact the County. This Contract may be terminated immediately by County upon the actual exclusion, debarment, loss of licensure, or conviction of Contractor of a health care offense. Contractor will indemnify, defend, and hold harmless the County for any loss or damage resulting from the conviction, debarment, or exclusion of Contract or subcontractors.

If Contractor is an in-patient facility, Contractor shall submit its patient admissions and length of stay requests for utilization review through existing hospital systems or professional standards review organizations.

REPORTS OF DEATH, INJURY, DAMAGE, OR ABUSE

a. Reports of Death, Injury, or Damage. If death, serious personal injury, or substantial property damage occur in connection with the performance of this Contract and involving County's clients, Contractor shall immediately notify the County's Behavioral Health Administrator by telephone. In addition, Contractor shall promptly submit to County a written report including: (1) the name and address of the injured /deceased person; (2) the time and location of the incident; (3) the names and addresses of Contractor s employees or agents who were involved with the incident; (4) the names of County employees, if any, involved with the incident; and (5) a detailed description of the incident.

b. Child Abuse Reporting. Contractor shall ensure that all known or suspected instances of child abuse or neglect are promptly reported to proper authorities as required by the Child Abuse and Neglect Reporting Act, Penal Code § 11164, et eq. Contractor shall require that all of its employees, consultants, and agents performing services under this Contract who are mandated reporters under the Act sign statements indicating that they know of and will comply with the Act's reporting requirements

c. Elder Abuse Reporting. Contractor shall ensure that all known or suspected instances of abuse or neglect of elderly people 65 years of age or older and dependent adults age 18 or

older are promptly reported to proper authorities as required by the Elder Abuse and Dependent Adult Protection Act (Welfare and Institutions Code § 15600 Code, et seq.). Contractor shall require that all of its employees, consultants, and agents performing services under this Contract who are mandated reporters under the Act sign statements indicating that they know of and will comply with the Act's reporting requirements

23. Trafficking Victims Protection Act of 2000

Contractor shall comply with Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000 as amended (22 U.S.C. 7104(g)) as amended by section 1702. For full text:

http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title22-section7104d&num=0&edition=prelim

24. Disclosure of Unusual Incidents.

Contractor shall notify the County's Behavioral Health Administrator, by telephone, of the violation of any provision of this Contract within 24 hours of obtaining reasonable cause to believe such a violation occurred. Notice of such violation shall be confirmed by deliver to the County's Behavioral Health Administrator, within 72 hours of obtaining a reasonable cause to believe that such violation occurred, of a written notice which shall describe the violation in detail. Contractor shall comply with state law and the County's policies and requirements concerning the reporting of unusual occurrences and incidents.

25. Standard for Security Configurations, if applicable.

a. Contractors accessing County's electronic health records system shall abide by and implement the standard Security Configurations below. The Contractor shall configure its computers with the applicable United States Government Configuration Baseline (USGCB) and ensure that its computers have and maintain the latest operating system patch level and anti-virus software level.

b. The Contractor shall apply approved security configurations to information technology (IT) that is used to process information on behalf of County. The following security configuration requirements apply: USGCB

c. The Contractor shall ensure IT applications operated on behalf of the County are fully functional and operate correctly on systems configured in accordance with the above configuration requirements. The Contractor shall test applicable product versions with all relevant and current updates and patches installed. The Contractor shall ensure currently supported versions of information technology products met the latest USGCB major version and subsequent major versions.

d. The Contractor shall ensure IT applications designed for end users run in the standard user context without requiring elevated administrative privileges.

e. The Contractor shall ensure hardware and software installation, operation, maintenance, update, and patching will not alter the configuration settings or requirements specified above.

f. The Contractor shall ensure that its subcontractors (at all tiers) which perform work under this contract comply with the requirements contained in this clause.

g. The Contractor shall ensure that computers which store PHI and/or PII locally have hard drive encryption installed and enabled.

For those Contractors accessing County's electronic health records system, County shall not provide the Contractor with computer hardware support in connection with the performance of this Contract. The County shall provide the Contractor with necessary electronic health records software support in connection with the performance of this Contract. The County and Contractor shall be aware of and exclusively responsible for all legal implications of the County providing the Contractor with any Computer support in connection with the performance of this contract.

26. Charitable Choice.

Contractor shall not use any money provided under this Contract for any inherently religious activities such as worship, sectarian instruction, and proselytization. In regard to rendering assistance, Contractor shall not discriminate against an individual on the basis of religion, a religious belief, or refusal to actively participate in a religious practice. If an individual objects to the religious character of a program, Contractor shall provide a secular alternative at no unreasonable inconvenience or expense to the individual or the County.

Contractor shall comply by 42 Code of Federal Regulations, Part 54.

a. Contractor shall submit documentation annually showing the total number of referrals necessitated by religious objection to other alternative substance abuse activities. This information must be submitted to the County by September 1st of each year, including the September 1st after the termination of this Contract. The annual submission shall contain all substantive information required by the County and be formatted in a manner prescribed by Department of Healthcare Services.

EXHIBIT F

CONTRACT FOR BEHAVIORAL HEALTH SERVICES

BUSINESS ASSOCIATE AGREEMENT

1. General Provisions and Recitals.

A. All terms used, but not otherwise defined below herein, have the same meaning as in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act ("HITECH"), and their implementing regulations at 45 CFR Parts 160 through 165 ("HIPAA regulations") (collectively along with state law privacy rules as "HIPAA laws") as they may exist now or be hereafter amended.

B. A business associate relationship under the HIPAA laws between Contractor and County arises to the extent that Contractor performs, or delegates to subcontractors to perform, functions or activities on behalf of County under the Agreement.

C. County wishes to disclose to Contractor certain information pursuant to the terms of the Agreement, some of which may constitute Protected Health Information ("PHI"), as defined by the HIPAA laws, to be used or disclosed in the course of providing services and activities pursuant to, and as set forth, in the Agreement.

D. The parties intend to protect the privacy and provide for the security of PHI that may be created, received, maintained, transmitted, used, or disclosed pursuant to the Agreement in compliance with the applicable standards, implementation specifications, and requirements of the HIPAA laws.

E. The HIPAA Privacy and Security rules apply to Contractor in the same manner as they apply to County. Contractor agrees therefore to be in compliance at all times with the terms of this Business Associate Agreement and the applicable standards, implementation specifications, and requirements of the Privacy and the Security rules with respect to PHI and electronic PHI created, received, maintained, transmitted, used, or disclosed pursuant to the Agreement.

2. Definitions.

A. "Administrative Safeguards" are administrative actions, and policies and procedures, to manage the selection, development, implementation, and maintenance of security measures to protect electronic PHI and to manage the conduct of Contractor's workforce in relation to the protection of that information.

B. "Agent" shall have the meaning as determined in accordance with the federal common law of agency.

C. "Breach" means the acquisition, access, use, or disclosure of PHI in a manner not permitted under the HIPAA laws which compromise the security or privacy of the PHI.

(1) Breach excludes:

(a) Any unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of Contractor or County, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under the Privacy Rule.

(b) Any County PHI that has been inadvertently disclosed shall not be further used or disclosed except in compliance with law.

(c) A disclosure of PHI where Contractor or County has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

(2) Except as provided in paragraph (a) of this definition, an acquisition, access, use, or disclosure of PHI in a manner not permitted under the HIPAA Privacy Rule is presumed to be a breach unless Contractor demonstrates that there is a low probability that the PHI has been compromised based on a risk assessment of at least the following factors:

(a) The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;

(b) The unauthorized person who used the PHI or to whom the disclosure was made;

(c) Whether the PHI was actually acquired or viewed; and

(d) The extent to which the risk to the PHI has been mitigated.

D. "County PHI" means either: (1) PHI disclosed by County to Contractor; or (2) PHI created, received, maintained, or transmitted by Contractor pursuant to executing its obligations under the Contract.

E. "Individual" shall have the meaning given to such term under the HIPAA Privacy Rule in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

F. "Minimum Necessary" shall mean the Privacy Rule Standards in 45 CFR §164.502(b) and §164.514(d)(1).

G. "Physical Safeguards" are physical measures, policies, and procedures to protect Contractor's electronic information systems and related buildings and equipment, from natural and environmental hazards, and unauthorized intrusion required by the HIPAA laws.

H. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his or her designee.

3. Obligations and Activities of Contractor as a Business Associate.

A. Contractor agrees not to use or further disclose County PHI other than as permitted or required by this Business Associate Agreement or as required by law.

B. Contractor agrees to use appropriate safeguards and other legally-required

safeguards to prevent use or disclosure of County PHI other than as provided for by this Business Associate Agreement.

C. Contractor agrees to comply with the HIPAA Security Rule at Subpart C of 45 CFR Part 164 with respect to electronic County PHI.

D. Contractor agrees to mitigate, to the extent practicable, any harmful effect that is known to Contractor of a Use or Disclosure of County PHI by Contractor in violation of the requirements of this Business Associate Agreement or HIPAA laws.

E. Contractor shall ensure that any Subcontractors that create, receive, maintain, or transmit PHI on behalf of Contractor agree to the same restrictions and conditions that apply through this Business Associate Agreement to Contractor with respect to such information.

F. Contractor agrees to provide access, within ten (10) calendar days of receipt of a written request by County, to PHI in a Designated Record Set, to County or, as directed by County, to an Individual in order to meet the requirements under 45 CFR § 164.524 or any other provision of the HIPAA laws.

G. Contractor agrees to make any amendment(s) to PHI in a Designated Record Set that County directs or agrees to pursuant to 45 CFR § 164.526 at the request of County or an Individual, within fifteen (15) calendar days of receipt of said request by County. Contractor agrees to notify County in writing no later than ten (10) calendar days after said amendment is completed.

H. Contractor agrees to make internal practices, books, and records, including policies and procedures, relating to the use and disclosure of PHI received from, or created or received by Contractor on behalf of, County available to County and the Secretary in a time and manner as determined by County or as designated by the Secretary for purposes of the Secretary determining County's compliance with the HIPAA laws.

I. Contractor agrees to document any Disclosures of County PHI that Contractor creates, receives, maintains, or transmits on behalf of County, and to make information related to such Disclosures available as would be required for County to respond to a request by an Individual for an accounting of Disclosures of PHI in accordance with 45 CFR § 164.528.

J. Contractor agrees to provide County or an Individual, as directed by County, in a time and manner to be determined by County, any information collected in accordance with the Agreement, in order to permit County to respond to a request by an Individual for an accounting of Disclosures of PHI in accordance with the HIPAA laws.

K. Contractor agrees that to the extent Contractor carries out County's obligation under the HIPAA laws Contractor will comply with the requirements of the HIPAA laws that apply to County in the performance of such obligation.

L. Contractor shall honor all restrictions consistent with 45 C.F.R. §164.522 that the County or the Individual makes the Contractor aware of, including the Individual's right to restrict certain disclosures of PHI to a health plan where the individual pays out of pocket in full for the healthcare item or service, in accordance with HITECH Act

Section 13405(a).

M. Contractor shall train and use reasonable measures to ensure compliance with the requirements of this Business Associate Agreement by employees who assist in the performance of functions or activities on behalf of County under this Contract and use or disclose protected information; and discipline employees who intentionally violate any provisions.

N. Contractor agrees to report to County immediately any Use or Disclosure of PHI not provided for by this Business Associate Agreement of which Contractor becomes aware. Contractor must report to County Breaches of County PHI in accordance with the HIPAA laws.

O. Contractor shall notify County within twenty-four (24) hours of discovering any Security Incident, including all data Breaches or compromises of County PHI, however, both parties agree to a delay in the notification if so advised by a law enforcement official pursuant to 45 CFR § 164.412.

(1) A Breach shall be treated as discovered by Contractor as of the first day on which such Breach is known to Contractor or, by exercising reasonable diligence, would have been known to Contractor.

(2) Contractor shall be deemed to have knowledge of a Breach, if the Breach is known, or by exercising reasonable diligence would have known, to any person who is an employee, officer, or other Agent of Contractor, as determined by federal or state common law of agency.

(3) Contractor's initial notification shall be oral and followed by written notification within 24 hours of the oral notification.

(4) Oral notification shall be made to the HIPAA Privacy Officer by calling 805-781-4788 and to the HIPAA Security Officer by calling 805-781-4100. Written notification shall be sent to the following address:

HIPAA Privacy Officer
San Luis Obispo County Health Agency
2180 Johnson Avenue
San Luis Obispo, CA 93401

Or by Email at: Privacy@co.slo.ca.us

(5) Contractor's notification shall include, to the extent possible:

(a) The identification of each Individual whose County PHI has been, or is reasonably believed by Contractor to have been, accessed, acquired, used, or disclosed during the Breach;

(b) Any other information that County is required to include in the notification to Individual under 45 CFR §164.404 (c) at the time Contractor is required to notify County or promptly thereafter as this information becomes available, even after the regulatory sixty (60) day

period set forth in 45 CFR § 164.410 (b) has elapsed, including:

(i) A brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known;

(ii) A description of the types of County PHI that were involved in the Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);

(iii) Any steps Individuals should take to protect themselves from potential harm resulting from the Breach;

(iv) A brief description of what Contractor is doing to investigate the Breach, to mitigate harm to Individuals, and to protect against any future Breaches; and

(v) Contact procedures for Individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, web site, or postal address.

P. County may require Contractor to provide notice to the Individual as required in 45 CFR § 164.404, if it is reasonable to do so under the circumstances, at the sole discretion of the County.

Q. In the event that Contractor is responsible for a Breach of County PHI in violation of the HIPAA Privacy Rule, Contractor shall have the burden of demonstrating that Contractor made all notifications to County consistent with Paragraph O and as required by the Breach notification regulations, or, in the alternative, that the acquisition, access, use, or disclosure of PHI did not constitute a Breach.

R. Contractor shall maintain documentation of all required notifications to County of a Breach or its risk assessment under 45 CFR § 164.402 to demonstrate that a Breach did not occur.

S. Contractor shall provide County all specific and pertinent information about the Breach, including the information listed above, if not yet provided, to permit County to meet its notification obligations under Subpart D of 45 CFR Part 164 as soon as practicable, but in no event later than ten (10) calendar days after Contractor's initial notice of the Breach to County.

T. Contractor shall continue to provide all additional pertinent information about the Breach to County as it may become available, in reporting increments of five (5) business days after the last report to County. Contractor shall also respond in good faith to any reasonable requests for further information, or follow-up information after report to County, when such request is made by County.

U. Contractor shall bear all expense or other costs associated with the Breach and shall reimburse County for all expenses County incurs in addressing the Breach and consequences thereof, including costs of investigation, notification, remediation, documentation or other costs associated with addressing the Breach.

V. Contractor shall train and use effective measures to ensure compliance with the requirements of this Exhibit by employees who assist in the performance of functions or activities on behalf of County under this Contract and use or disclose protected information; and discipline employees who intentionally or repeatedly violate any provisions.

6. Permitted Use and Disclosure by Contractor.

A. Contractor may use or further disclose County PHI as necessary to perform functions, activities, or services for, or on behalf of, County as specified in the Agreement, provided that such use or Disclosure would not violate the HIPAA Privacy Rule if done by County except for the specific Uses and Disclosures set forth below.

(1) Contractor may use County PHI, if necessary, for the proper management and administration of Contractor or to carry out legal responsibilities of Contractor.

(2) Contractor may disclose County PHI for the proper management and administration of Contractor or to carry out the legal responsibilities of Contractor, if:

(a) The Disclosure is required by law; or

(b) Contractor obtains reasonable assurances from the person to whom the PHI is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person and the person immediately notifies Contractor of any instance of which it is aware in which the confidentiality of the information has been breached.

(3) Contractor may use or further disclose County PHI to provide Data Aggregation services relating to the Health Care Operations of Contractor.

B. Contractor shall make Uses, Disclosures, and requests for County PHI consistent with the Minimum Necessary principle as defined herein.

C. Contractor may use or disclose County PHI as required by law.

7. Obligations of County.

A. County shall notify Contractor of any limitation(s) in County's notice of privacy practices in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Contractor's Use or Disclosure of PHI.

B. County shall notify Contractor of any changes in, or revocation of, the permission by an Individual to use or disclose his or her PHI, to the extent that such changes may affect Contractor's Use or Disclosure of PHI.

C. County shall notify Contractor of any restriction to the Use or Disclosure of PHI that County has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Contractor's Use or Disclosure of PHI.

D. County shall not request Contractor to use or disclose PHI in any manner that

would not be permissible under the HIPAA Privacy Rule if done by County.

8. Business Associate Termination.

A. Upon County's knowledge of a material breach or violation by Contractor of the requirements of this Business Associate Agreement, County shall:

(1) Provide an opportunity for Contractor to cure the material breach or end the violation within thirty (30) business days; or

(2) Have the discretion to unilaterally and immediately terminate the Agreement, if Contractor is unwilling or unable to cure the material breach or end the violation within (30) calendar days.

B. Upon termination of the Agreement, Contractor shall either destroy or return to County all PHI Contractor received from County or Contractor created, maintained, or received on behalf of County in conformity with the HIPAA Privacy Rule.

(1) This provision shall apply to all PHI that is in the possession of Subcontractors or Agents of Contractor.

(2) Contractor shall retain no copies of the PHI.

(3) In the event that Contractor determines that returning or destroying the PHI is not feasible, Contractor shall provide to County notification of the conditions that make return or destruction infeasible. Upon determination by County that return or destruction of PHI is infeasible, Contractor shall extend the protections of this Business Associate Agreement to such PHI and limit further Uses and Disclosures of such PHI to those purposes that make the return or destruction infeasible, for as long as Contractor maintains such PHI.

C. The obligations of this Business Associate Agreement shall survive the termination of the Contract.

EXHIBIT G

CONTRACT FOR BEHAVIORAL HEALTH SERVICES

QUALIFIED SERVICE ORGANIZATION AGREEMENT

1. Contractor agrees that it is a Qualified Service Organization to the County within the meaning of 42 Code of Federal Regulations sections 2.11 and 2.12.
2. Contractor acknowledges that in receiving, storing, processing or otherwise dealing with any patient records from County or through performing its obligations per this contract the programs, Contractor is fully bound by 42 Code of Federal Regulations Part 2 and analogous state laws.
3. Contractor further agrees that if necessary, it will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by 42 Code of Regulations Part 2.

EXHIBIT H

SIGN IN/OUT LOG

Resident Sign-In/Out Sheet	
Resident:	
Facility:	
House:	

Date	Initials	Location	Time In	Time Out	Notes

EXHIBIT I

SAMPLE INVOICE and CLIENT LOG

Facility Letterhead

Invoice for Sober Living Environment (SLE) Bed days

Billing Period Invoice Information	
Invoice Date:	
Billing Month & Year :	
Additional Information:	Please see log below for listing & billing details.
Total Invoice Amount:	$

Resident Name	Acct #	Billing Start Date	Billing End Date	Total Bed Days	Bed Day Rate	Total Cost	Less Client Billed	Invoice Amount
1.					$	$	$	$
2.					$	$	$	$
3.					$	$	$	$
4.								
5.								
6.								
7.								
8.								
9.								

EXHIBIT J

Facility Letterhead

MONTHLY CHARITABLE CHOICE LOG OF CLIENTS IN SOBER LIVING ENVIRONMENTS (SLES)

Wishing for Alternative to Religious Services

Resident Name	Acct #	Date of Incident	Client Objection	SLE Resolution

Gradual Self Sufficiency Payment Plan

Gradual Self Sufficiency Payment Plan for Recovery Residences:

There is a limit of six months of SLE payments per individual client with a graduated co-pay schedule wherein the client begins to make parts of their own SLE payments. Generally,

1 – 2 months	100% County responsibility
3 – 4 months	75% County responsibility
5 months	50% County responsibility
6 months	25% County responsibility

At the six month maximum limit, the following are considered:

- Client pays the SLE costs on their own (100% self-pay)
- Client signs a payment agreement retroactive prior to receiving their SSI settlement
- Client is discharged from the SLE with a safe and sober housing plan
- Extension beyond the six months limit for extenuating circumstances may be granted with Management (Drug and Alcohol Services and/or other Department Division Manager) approval.

Funding Sources FY16-17:

ADC: $8,000	(0.75 referrals each month)
AB109: $299,828	(29 referrals each month)
BHTCC: $51,400	(5 referrals each month)
GFS: $109,000	(10.5 referrals each month)
DSS: $135,000	(13 referrals each month, keep in mind this funding source has also covered Upham and Bryan's House)
MIOCR: $20,600	(2 referrals each month)

Attachment G. Holman Group and Network Providers

Network Provider Referral

San Luis Obispo County Behavioral Health Department Mental Health Services	Effective Date: 11/17/2015 Page 1 of 6

10.03 Network Provider Referral

I. PURPOSE

To ensure San Luis Obispo County Medi-Cal beneficiaries who qualify for Specialty Mental Health Services are provided initial access to services in a timely manner based on the urgency of the consumer's need for services. *Refer to Policy 3.00, Access to Services, for information regarding time standards established by the MHP's standard.*

II. POICY

San Luis Obispo County Mental Health:

- Offers a range of Specialty Mental Health Services that is adequate for the anticipated number of clients served by the Mental Health Plan (MHP).
- Maintains a panel of Network Providers (NWP) that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of clients served by the MHP.

III. Reference

CCR, Title 9, Chapter 11, Section 1810.310(a)(5)(A)(B)

IV. PROCEDURE

A. Prospective NWP clients must have a comprehensive mental health assessment conducted at a local Mental Health Clinic. Referrals for a NWP are sent to Managed Care by clinic-based clinicians or by a Site Authorization Team (SAT).

B. Treatment Modality: A Brief Therapy model is used for NWP services. Up to 18 individual, family or collateral sessions may be authorized per year. Occasionally, additional sessions may be authorized on a case by case basis. Brief Therapy may be a stand alone service or may be part of a recovery program that includes other services at a Mental Health Clinic, including medication support and Recovery Groups

C. Client Prerequisites for Network Provider Services: (Must all be "yes"?)

1. Does client have full-scope Medi-Cal?
2. Is client motivated for treatment and likely to benefit from short-term therapy?
3. Does client have a history of attending scheduled appointments, with few FTS?
4. Have the therapist and client been able to identify issues that need to be addressed in therapy (related to current impairment and diagnosis)?

D. NWP Referral Process

Responsibilities of the referring clinical staff

1. Ensures that the client is eligible for NWP services (i.e. answer is "Yes" to all above questions).

2. Fully completes a Network Provider Authorization Worksheet (Attachment A) and obtains Program Supervisor signature. This is a billable, Case Management service.
   a. The Network Provider Authorization Worksheet must document target symptoms causing current functional impairment.
   b. Treatment objectives must be observable/measurable and likely to be accomplished within the allotted sessions.
   c. Additional information or concerns are very helpful to Network Providers.

3. Ensures that any request for psychological testing includes a completed Network Provider Authorization Worksheet **and** a Referral for Psychological Testing form (Attachment B).

Responsibilities of clinic MRT/Front Office staff

1. Processes referral to Managed Care:
   a. Obtains all required signatures for opening before sending to Managed Care.
   b. Closes clinic units and subunits as applicable.
   c. Opens to Managed Care Program Supervisor, Subunit 1003 for Adults 1004 for Youth.

2. Copies and sends the following via interoffice mail to Managed Care MRT:
   a. Original Network Provider Authorization Worksheet and a MEDS Screen
   b. If all clinic subunits are closing, send the original chart.
   c. If clinic subunits remain open, send copies of the following:
      - Copy of Medi-Cal card
      - Cost Agreement and Signature Page
      - Any current exchanges/disclosure
      - Current Care Plan
      - Master Service Plan
      - Service Plan(s) if applicable
      - Initial Assessment (Goldenrod)
      - Current progress notes for 1 month
      - Psychiatric Assessment
      - Most recent MD progress note (if applicable)
      - Court orders (if minor is a 300 WIC dependent of the court)
      - Psychological Evaluation (if applicable)

- The entire original Managed Care section of the chart, if the client received NWP treatment in the past. (Including all Client Care Plans, authorizations and billing information).

Note: When *any* item listed is available in Anasazi, it no longer needs to be copied and sent to Managed Care.

Responsibilities of the Managed Care staff

1. Reviews the referral and clarifies the reason for the referral or treatment objective, if needed.
2. Contacts potential Network Providers to discuss the referral and confirms availability to treat client.
3. Documents the provider's next available appointment for a new client, which must be within 14 days of accepting the referral, on the Network Provider tab of the BH Referral form.
4. Contacts the client by phone and by letter after a Network Provider agrees to accept the referral. The call and letter both instruct the client how to contact the NWP to begin treatment.
5. Completes the Network Provider worksheet and submits it to the Managed Care HIT to enter the assignment in Anasazi.
6. Writes a case management progress note to document the successful referral.

Conclusion of Therapy with Network Provider

1. Network Providers will use the authorized sessions to conclude the therapy episode with the client.
2. If the client is open at a local clinic for other services or requires ongoing treatment, Managed Care will transfer the case to the local clinic. The clinic SAT will determine the types of services needed for ongoing care.
3. The Managed Care Program Supervisor will complete a Discharge Summary for the case to be closed by the Managed Care HIT upon receiving the Closing Summary from the Network Provider if the client is not open to a clinic and requires no ongoing care.

Subsequent Referrals for NWP Therapy

1. Each client may have only one Network Provider therapy episode per year. A client may request a new referral for therapy one year after the previous therapy episode start date.

2. If the client's case was closed, the client may access services as described in Policy titled *Access to Services*. If medical necessity criteria are met for specialty mental health services and a referral to a NWP is appropriate, clinic staff will complete a new Network Provider Authorization Worksheet to refer the client to NWP services.

3. If the case remained open for clinic-based services, the Single Accountable Individual (SAI) completes a new Network Provider Authorization Worksheet as described above.

V. DOCUMENT HISTORY

Revision Date:	Section Revised:	Details of Revision:
4/2015		
11/12/2015	Procedure	Miscellaneous process revisions
Prior Approval dates:		
10/2012		

Signature on File	11/17/2015
Approved by: Anne Robin, LMFT Behavioral Health Administrator	Date

REQUEST FOR NETWORK PROVIDER

TO BE COMPLETED BY REFERRING CLINICIAN: Referral Date: _____

Client Name: _____ MH Client Number: _____

_____ Language: _____

_____ Language Other: _____

DOB: _____ SSN: _____ Phone _____

PERSON AUTHORIZED TO SIGN FOR TREATMENT OF MINOR: Legal Status: ☐ N/A ☐ Detained ☐ 300 Dependent

Parent: _____ Guardian: _____ Other: _____ (Specify Name)

Care Provider: _____ Ph.: _____ ☐ shelter ☐ foster ☐ Adoptive ☐ Relative ☐ Parent

Reason For Referral:

_____

_____

_____

Focus of Treatment:

_____

_____

_____

Suggested Modality:

_____

_____

_____

Comments:

_____

_____

_____

Referring MH Clinician: _____ (Signature) Phone: _____

DSS: ☐ AD ☐ NNR ☐ CW ☐ CWS

CWS Worker _____ Ph. _____ CalWorks Worker _____ Ph. _____

Adoptions Worker _____ Ph. _____ DSS Staff Notified (when applicable): _____ Date

TO BE COMPLETED BY MANAGED CARE CLINICIAN:

NETWORK PROVIDER: _____ PHONE: _____

DATE AUTHORIZED: _____

CPT Code	Proc. Code	Minutes	Description	Number of Initial Authorized Sessions
90801	331	90	Initial Diagnostic Interview	
90806	341	50	Individual Psychotherapy	
90847	321	60	Family Therapy	
90853	351	60	Group Psychotherapy	
90805	361	30	Med. Mgt. & Psychotherapy	
96100	252	Max 7 Hours	Psychological Testing	
99482	301	10	Case Management	

Managed Care Clinician _____ (Signature) Date: _____

NETWORK PROVIDER AUTHORIZATION WORKSHEET

Attachment B

San Luis Obispo County Mental Health Services
Phone #(800) 838-1381
2178 Johnson Avenue
Fax # (805) 781-4176
San Luis Obispo CA 93401

10.03 Network Provider Referral Page 6 of 6

REFERRED BY :_____ Sample. Do not copy this page _____

ASSESSMENT QUESTION :_____

HOW COULD RESULTS OF TESTING AFFECT YOUR TREATMENT PLAN ?_____

PRIOR PSYCHOLOGICAL TESTING/RESULTS:_____

PHYSICAL CONDITIONS WHICH MIGHT INTERFERE WITH TEST PERFORMANCE? (e.g. vision, hearing, epilepsy, hyperactivity, medication, etc). _____

COMMENTS:_____

CLINICIAN SIGNATURE & DISCIPLINE_____DATE_____
PSYCHIATRIST SIGNATURE:_____DATE_____

AUTHORIZATION DATE: _____ ☐ No authorization at this time

TEST TO BE GIVEN BY: _____

AUTHORIZATION SIGNATURE & DISCIPLINE: _____DATE: _____

CLIENTNAME_____MEDICAL RECORD NUMBER_____
Last, First- Please Print

PSYCHOLOGICAL TESTING REQUEST

Monitoring and Authorizing Network Provider Services

San Luis Obispo County Behavioral Health Department Mental Health Services	Effective Date: 10/30/2015 Page 1 of 3

10.14 Monitoring and Authorizing Network Provider Services

I. PURPOSE

To ensure Client Care Plans and Progress Notes documenting services requested and provided by Network Providers are reviewed in a consistent, timely manner and are monitored for medical necessity and to confirm documentation standards are met.

II. POLICY

The Mental Health Managed Care Site Authorization Team (SAT) performs quality review and authorization functions for beneficiaries whose specialty mental health services are provided by Network Provider panel members. The Managed Care SAT is composed of licensed clinicians (LMFT, LCSW, LPCC or Psychologist) and waivered/registered interns. The Behavioral Health Medical Director is available for consultation as needed.

Licensed Managed Care staff:

1. Ensure that beneficiaries served by Network Providers meet medical necessity criteria for specialty mental health services.
2. Review payment authorization requests from Network Providers and make timely authorization decisions.
3. Review Client Care Plans and Progress Notes to ensure that Network Providers maintain client records in a manner that meets state, federal, and the MHP's Quality Management Program standards.

III. REFERENCES

- California Code of Regulations, Title 9, §1810.435(b)(4,5), §1830.205, §1830.210 and §1830.215
- Contract with Department of Health Care Services (DHCS), Exhibit B, Sections 1, 2, 4, 7, 11 through 14, 16

- Policy 3.20, *Authorization/Approval of Services* for information about medical necessity and the MHP's SAT process.
- Policy 10.03, *Network Provider Referral* for a description of the referral process, initial determination of medical necessity, and the Network Provider brief therapy model.
- Policy 10.10, *Network Provider Credentialing* for a description of Network Provider credentialing and contracting requirements.

IV. PROCEDURE

A. Initial Authorization

After locating a Network Provider with a current opening and the ability to meet the beneficiary's treatment, language and cultural needs, Managed Care staff preauthorize one assessment and two therapy sessions.

B. Client Care Plan Review

Prior to the fourth therapy session, the Network Provider and beneficiary develop a Client Care Plan, which documents the beneficiary's strengths, current symptoms, impairments, goals and objectives.

The Client Care Plan must:

- Contain specific observable and/or quantifiable goals and objectives
- Identify the number and type of therapy sessions requested
- Identify the proposed interventions, which must:
  - ✓ Address the identified functional impairments which are a result of the mental disorder
  - ✓ Be consistent with the client plan goal and with the qualifying diagnoses
- Be signed by the Network Provider, the client (age 12 and older), and, (if applicable), by the Parent/Legally Responsible Person.

If the plan documents medical necessity for ongoing services and contains all the necessary elements, Managed Care staff preauthorize the services requested by the Network Provider. The authorization is valid for six (6) months or until the sessions are utilized, whichever comes first. If the Client Care Plan does not meet documentation standards, it is returned to the Network Provider for revision. If the Network Provider's request for services is modified or denied, an appropriate NOA is sent to the provider and beneficiary. See Policy 3.30, *Notices of Action* for detail.

The Network Provider completes a new Client Care Plan prior to the end of an authorization to request additional sessions. Managed Care staff review the request and make an authorization decision based on the documentation of medical necessity, the appropriateness of the interventions, the availability of other resources, and other relevant factors. If the Network Provider's request for services is modified or denied, an appropriate NOA is sent to the provider and beneficiary. See Policy 3.30, *Notices of Action* for detail.

C. Quarterly Progress Note Audits

Network Providers submit progress notes to match billing for services rendered in January, April, July and October each year. Managed Care staff audit a random sample of at least 10% of the progress notes using the MHP's Progress Note Audit Tool (Attachment A). Minor errors (missing license or signature of provider, inconsistent dates, etc.) are returned to the Network Provider for correction. If a note does not meet the MHP's documentation standards, the service is voided and a letter is sent to the Network Provider to correct the deficiency.

Results of the audit are reported to the Quality Support Team (QST) Committee on a quarterly basis. The results are also distributed to the Network Providers and are used to help direct training efforts.

D. Network Provider Documentation Training

- A Client Care Plan documentation manual is distributed to each Network Provider.

The documentation manual is periodically updated and redistributed.

- A quarterly newsletter provides updates on documentation, feedback from progress note audits, and other relevant information.
- Periodic Network Provider trainings review documentation issues.
- Network Providers participate in MHP trainings.

Attachment A: Progress Note Audit Tool

Progress Notes			
YES	**NO**	**N/A**	**Note date:** **Procedure Code**:
			1. Is the billing time reasonable for this service?
			2. Is there documentation of client encounters including clinical decisions and interventions?
			3. Is the focus of the intervention to address the impairment caused by the covered diagnosis (and not solely academic, vocational, recreational, socialization, transport, clerical, payee-related)?
			4. Is the documentation legible?
			5. Was the service billed appropriately for the setting?
			6. Is there a signature of the staff providing the service with their professional degree, license, or job title?
			7. If this is a group note, are the interventions individualized?
			8. Is the note written according to the MHP Standard Progress Note format?

V. DOCUMENT HISTORY

Revision Date:	Section Revised:	Details of Revision:
10/28/2015		Added purpose, reformatted
Prior Approval dates:		
12/21/2012		

Signature on File	10/30/2015
Approved by: Anne Robin, LMFT Behavioral Health Administrator	Date

Behavioral Health Referral to Holman Group

San Luis Obispo County Behavioral Health Department
Referral to CenCal Health/Holman Group

Referral Date:

Date Authorization to Use and/or Disclose PHI was obtained:

Client's Name:
Last Name: MH CLIENT First Name: FICTIONAL 01

DOB 01/01/1988

Client's Address: 11 FICTION WAY Apt #

City/State/ZIP SAN LUIS OBISPO CA 93401

Client's Phone Number: 555-5551

Primary Language of Client Spanish

Parent/Guardian Name

Parent/Guardian Phone Relationship to Client

Language, Parent/Guardian Spanish

Primary Care Physician Name:

Type:

O ABA
O Non-specialty M.H. Services
San Luis Obispo County Behavioral Health is referring this patient to you for non-specialty mental health services. He/She has been stable for at least 6 months or is a new client with mild to moderate levels of functional impairment.

Does ABA referral have MD/ PhD letter included?

O Yes O No

Additional information:

Current Medications:

Comments/Special Considerations (describe any additional factors):

Managed Care Comments/Follow-up

Form MHCCHHG; Version 1.03; 09/04/2015

Risk Factor and Functional Impairment Ratings Scales

Risk Asssment:
Review the Help Text descriptions (from the Adult Needs and Strengths Assessment (ANSA), copyright by Praed Foundation) and select the items that most closely match the client's current level of risk. Describe 'Severe' items in the comment box below and specify safety plan.

Referral Decision Support:
Severe/Significant/Acute: Refer to SLO Mental Health for routine, crisis, or acute specialty mental health services.
Moderate: Evaluate in context of levels of impairment. **May** qualify for specialty mental health services (SMHS).
Mild: Risk factor does not indicate a need for SMHS.
None: Risk factor does not indicate a need for SMHS.

Rate Overall Level of Danger to Self
O None O Mild O Moderate O Severe/Significant/Acute

Rate Overall Level of Danger to Others
O None O Mild O Moderate O Severe/Significant/Acute

Rate Overall Level of Self Injurious Behavior
O None O Mild O Moderate O Severe/Significant/Acute

Risk Factors Comments/Safety Plan:

Functional Impairment/Life Domain Functioning: Review Help Text descriptions; select the items that most closely match the client's current impairments. Describe the client's impairments in the comment box below (required for ratings of severe and moderate, optional for mild or none).

Referral Decision Support (if impairment is due to mental illness):
Severe/Significant: Refer to SLO County Mental Health.
Moderate: Refer for non-specialty mental health services unless there is a reasonable probability of significant deterioration or failure to progress developmentally in this area of functioning (Describe reasonable probability below).
Mild: Impairment does not indicate a need for SMHS. Consider referral for non-specialty mental health services.
None: Impairment does not indicate a need for SMHS. Consider referral for non-specialty services.

Rate Overall Level of Self Care/ADL Impairment
O None O Mild O Moderate O Severe/Significant/Acute
If Impaired, Select Primary Reason:

Rate Overall Level of Employment Impairment
O None O Mild O Moderate O Severe/Significant
If Impaired, Select Primary Reason:

Rate Overall Level of Family Impairment
O None O Mild O Moderate O Severe/Significant
If Impaired, Select Primary Reason:

Rate Overall Level of Residential Impairment

O None O Mild O Moderate O Severe/Significant

If Impaired, Select Primary Reason:

Rate Overall Level of Social Impairment

O None O Mild O Moderate O Severe/Significant

If Impaired, Select Primary Reason:

Rate Overall Level of School Behavior Impairment

O None or N/A O Mild O Moderate O Severe/Significant

If Impaired, Select Primary Reason:

Funtional Impairment Comments:

Referred for non-specialty mental health services? O Yes O No

Signatures

(Text Printing Suppressed)

Signature	OBC	E	Signature Line Heading	Name	Date	Time
Pending	☐	S	Staff Processing			
Pending	☐	S	Clinician			
Pending	☐	S	MC PS/Designee			

Procedure for Referrals to the Holman Group

Category:	Subject: Referrals to the Holman Group
Clinical Documentation	Scope: SLO Behavioral Health Department – Mental Health Services
	Effective Date: 12/15/2014 Page 1 of 2

Purpose:
To clarify the referral process to the Holman Group when a Medi-Cal beneficiary does not meet medical necessity for Specialty Mental Health Services (SMHS)

Procedure:
Confidentiality Issues
An Authorization to Use/Disclose PHI is not required to facilitate a referral for appropriate services (W&I Code 5328 (a)). However, clinicians are strongly encouraged to describe the Holman Group and its services during the intake or other face-to-face service if it appears that treatment by the Holman Group will be the recommended level of care. An Authorization to Use/Disclose PHI may then be obtained.

Referral Process

- When SAT determines that a Medi-Cal beneficiary does not meet medical necessity for SMHS and that the client will be referred to the Holman Group, the Program Supervisor will assign a clinician to inform the client of this determination and complete the referral procedure. If the client was receiving SMHS but is ready to step down to the Holman Group, the assigned clinician will usually be the SAI.

- The assigned clinician discusses the referral with the client by phone or in person.

- The assigned clinician completes both tabs of the "MH Referral to CenCal Health/Holman Group" assessment in Anasazi. It is important to complete the referral fully to clearly communicate the findings of the SAT and to facilitate the acceptance of the referral. Some information will pull forward into the referral, but it must be reviewed and edited as needed.
  - Tab 1 contains demographic and general information about the referral
  - Tab 2 imports risk factor ratings (adults only) and impairment ratings from the Assessment

- Disclosure of PHI in the course of providing a referral must be logged (W&I Code 5328.6). The assigned clinician will:
  - Launch the BH Record of Disclosure in Anasazi
  - Enter "Holman Group" in the "Disclosed To" section
  - Enter "Holman Referral dated xx/xx/14" in the "Description of Information Disclosed" section
  - Enter "Referral to Holman Group" in the "Purpose of Disclosure" section
  - Sign the BH Record of Disclosure as the Clinician
  - Route the BH Record of Disclosure to the HIT (enter the HIT's name in the Staff Disclosing Information signature line).

- The HIT will:
  - Finish and Final Approve the BH Record of Disclosure
  - Route the MH Referral to CenCal Health/Holman Group to the Managed Care Program Supervisor
  - Fax the referral and a current MEDS screen to the Holman Group

- The Managed Care Program Supervisor will contact the Holman Group to confirm that they have accepted responsibility for providing services (W&I Code 5008 (d)). Once confirmation has been received, the Managed Care Program Supervisor will final approve the MH Referral to CenCal Health/Holman Group and inform the referring clinic's HIT that the case may be closed.

- After the Holman Group accepts the referral, the record will be closed an NOA A will be mailed to the client by the HIT per existing procedure. **Note:** An NOA A is only needed if SMHS are being denied after the initial comprehensive assessment, not for referrals of stable clients who are stepping down.

- If the client was receiving SMHS and is stepping down to Holman Group, the assigned clinician will complete a MH Outpatient Discharge Summary in Anasazi.
- If the Managed Care Program Supervisor is unable to confirm that the Holman Group has accepted the referral within 30 days of the referral, or if the Holman Group does not accept the case, the Managed Care Program Supervisor will contact the referring clinician and/or the Program Supervisor to discuss the needs of the client. Staff will re-evaluate whether SMHS will be offered/continued, if other referrals are needed, or if the Problem Resolution process will be utilized on behalf of the client.
- The Managed Care Program Supervisor will initiate the Problem Resolution process jointly developed by Behavioral Health, CenCal Health and the Holman Group if needed, and will coordinate with the clinic site Program Supervisor.
- The client's case will remain open at the clinic site during the time needed to verify that the referral was accepted and during the Problem Resolution process (if utilized).

Revision History

Date:	Section Revised:	Details of Revision:
10/10/14	Original procedure	
12/15/14	Referral process	Additional direction for ensuring the referral is accepted by the Holman Group is provided.

Attachment H. Patient's Rights Advocate

Patients' Rights Advocate

4.00 Patients' Rights Advocate

I. PURPOSE

To clarify the duties and responsibilities of the Patient's Rights Advocate (PRA).

II. POLICY

San Luis Obispo County Behavioral Health (SLOBH) will implement a problem resolution process that enables each beneficiary to resolve problems or concerns about any issue related to SLOBH's performance of its duties. The PRA will ensure that beneficiary rights are promoted and protected and that the problem resolution process works effectively for SLOBH beneficiaries.

III. REFERENCE

Welfare & Institutions Code, §§ 5520 – 5523

IV. DUTIES

The PRA will:

- Ensure beneficiaries are informed of their rights
- Advocate for beneficiaries
- Receive and investigate complaints
- Monitor mental health facilities, services and programs for compliance with patient's rights provisions
- Provide training and education for providers and beneficiaries
- Exchange information with the State Patient's Rights Program

V. PROCEDURE

A. Beneficiary Informing

1. The PRA will ensure that beneficiaries are informed of their rights and have access to the problem resolution processes. Informing materials will be provided to clients at the beginning of services and upon request thereafter. Informing materials will be available in English, Spanish and alternative formats.
2. The PRA will ensure that the Beneficiary Handbook, *Guide to Mental Health Services*, which contains detailed information about the problem resolution and rights, will be available at all certified sites and through the 24/7 Central Access line at: 800-838-1381.
3. The PRA will ensure that SLOBH's Client Information Centers contain notices explaining grievance, appeal, and expedited appeal processes

and patient's rights so that the information will be readily available to both beneficiaries and staff.

4. The PRA will ensure that Consumer Request Forms and postage paid, self-addressed envelopes will be available in each Client Information Center. Clients will be able to obtain, complete and return a Consumer Request Forms without having to make a verbal or written request to anyone.
5. The PRA will ensure that contact information for the PRA and the State Office of Patients' Rights will be posted in all Mental Health facilities.

B. Problem Resolution

1. The PRA will receive, investigate and resolve complaints received from providers or beneficiaries about violations of patient's rights. Refer to Policy 4.07 *Grievances, Appeals and Expedited Appeals* for detail.
2. The PRA will track, log and respond to advocates to beneficiaries and/or representatives regarding requests for Second Opinions, Change of Provider, Grievances, Appeals and Expedited Appeals.
3. The PRA will, at the beneficiary's request, assist the beneficiary with problem resolution processes. Assistance will include, but not be limited to, help writing the grievance/appeal/expedited appeal on a Consumer Request Form.
4. The PRA will coordinate prompt resolution of grievances and appeals and will notify beneficiaries of the disposition of the problem.

C. Monitoring for compliance

1. The PRA will monitor mental health facilities, services and programs for compliance with statutory and regulatory patients' rights provisions.
2. The PRA will review instances when a specific right has been denied to a patient at the SLOBH Psychiatric Health Facility.

D. Training and Education

1. The PRA will provide training and education about mental health law and patients' rights to mental health providers.
2. The PRA will provide training and education about mental health law and patients' rights to family and community members.

E. Coordination with State Agencies

1. The PRA will provide de-identified data to the Department of Health Care Services (DHCS) on an annual basis. The information from the Grievance/Appeal Log is used by DHCS to monitor SLOBH's performance.

2. The PRA will coordinate with the State Office of Patients' Rights.

F. Quality Improvement and System Change

1. The PRA will present problem resolution issues to the Quality Support Team (QST) Committee a quarterly basis (more frequently if needed) for quality improvement purposes.

2. The PRA will participate on key QST committees and subcommittees to ensure that beneficiaries concerns have a voice in SLOBH decision making.

3. The QST Committee and the PRA will forward concerns to the Behavioral Health Administrator as needed to effect system changes.

G. Organizational Structure

1. The PRA will directly report to the Behavioral Health Administrator.

2. The PRA will receive additional support from the QST Division Manager.

VI. DOCUMENT HISTORY

Revision Date:	Section Revised:	Details of Revision:
11/18/2015	All	Added purpose, reformatted, added F
Prior Approval dates: 5/30/2009, 6/5/2010, 10/12/2012		

Signature on File	11/19/2015

Approved by: Anne Robin, LMFT Date
Behavioral Health Administrator

Change of Provider Request

San Luis Obispo County Behavioral Health Mental Health Services	Effective Date: 11/18/2015 Page 1 of 2

4.03 Change of Provider Request

I. PURPOSE

To clarify the Change of Provider Request process

II. POLICY

San Luis Obispo County Behavioral Health (SLOBH) will, whenever feasible, provide beneficiaries an opportunity to change persons providing outpatient Specialty Mental Health Services. SLOBH will limit the choice to another provider employed by or contracting with SLOBH.

III. REFERENCES

- California Code of Regulations, Title 9, §1830.225
- Code of Federal Regulations, Title 42, §438.10, §438.406
- MHP Contract, Exhibit A, Attachment I, Section 7

Policy 4.07 *Grievances, Appeals and Expedited Appeals*

IV. PROCEDURE

A. Beneficiary Informing

1. Beneficiaries will be informed of the right to request a change of provider at the beginning of services and upon request thereafter.
2. The Beneficiary Handbook, *Guide to Mental Health Services*, contains detailed information about the process and will be available at all certified sites and through the 24/7 Central Access line at: 800-838-1381.
3. SLOBH will post Client Information Centers at each certified site. Consumer Request Forms and postage paid, self-addressed envelopes will be available in each Client Information Center. Clients are able to obtain, complete and return a Consumer Request Forms without having to make a verbal or written request to anyone.

B. A change of provider request that is the result of beneficiary dissatisfaction with any aspect of care will be considered a grievance and will be processed according to Policy 4.07 *Grievances, Appeals and Expedited Appeals*.

C. A beneficiary may request a change of provider at any time, either orally or on a written Consumer Request Form.

D. SLOBH staff, including the Patient's Rights Advocate (PRA), will be available to assist the beneficiary with completing the Consumer Request Form.

E. The Consumer Request Form will be sent to the PRA, who will review the form and take following action:

1. Log the change of provider request and send the consumer a confirmation letter to the beneficiary within one working day.
2. If the request has been resolved at the clinic or program level, the PRA will confirm the disposition of the request with the beneficiary in writing.
3. If the request has not been resolved, the PRA will then send a copy of the Consumer Request Form to the appropriate Program Supervisor or Medical Director for review and disposition.
4. The Program Supervisor or Medical Director will notify the PRA of the resolution of the request within 60 calendar days of the request.

F. The PRA will present change of provider request data to the Quality Support Team (QST) Committee a quarterly basis (more frequently if needed) for quality improvement purposes. The QST Committee will forward concerns to the Behavioral Health Administrator as needed to effect system changes.

Revision Date:	Section Revised:	Details of Revision:
11/18/2015	All	Reformatted
Prior Approval dates: 5/30/2009, 6/5/2010		

Signature on File	11/18/2015

Approved by: Anne Robin, LMFT Date
Behavioral Health Administrator

Second Opinions

San Luis Obispo County Behavioral Health Department	Page 1 of 3
Mental Health Services	Effective Date: 11/18/2015

4.04 Second Opinions

I. PURPOSE

- To clarify when Medi-Cal beneficiaries are entitled to a second opinion
- To clarify other instances when second opinion may be provided to a client

II. POLICY

At the request of a beneficiary, San Luis Obispo County Behavioral Health Department (SLOBH) will provide for a second opinion by a licensed mental health professional when the SLOBH determines that the medical necessity criteria have not been met and that the beneficiary is, therefore, not entitled to any specialty mental health services.

SLOBH will honor all other requests for second opinions to the extent resources are available and the request is clinically indicated.

III. REFERENCES

- California Code of Regulations, Title 9, §§ 1810.405(e), 1830.205, 1830.210
- Code of Federal Regulations, Title 42, §438.206(b)(3)
- MHP Contract, Exhibit A, Attachment I, Section 1(d)

Policy 4.07, *Grievances, Appeals and Expedited Appeals*
Policy 3.30, *Notices of Action*

IV. PROCEDURE

A. Beneficiary Informing

1. Information regarding second opinions will be provided to clients at the beginning of services and upon request thereafter.
2. The Beneficiary Handbook, *Guide to Mental Health Services*, contains detailed information about the process and will be available at all certified sites and through the 24/7 Central Access line at: 800-838-1381.
3. SLOBH will post Client Information Centers at each certified site, which will contain notices explaining second opinions to ensure that the information is readily available to both beneficiaries and staff.
4. Consumer Request Forms and postage paid, self-addressed envelopes will be available in each Client Information Center. Clients are able to obtain, complete and return a Consumer Request Forms without having to make a verbal or written request to anyone.
5. SLOBH will provide the beneficiary with a Notice of Action (NOA) A when SLOBH determines that the client does not meet the medical necessity criteria and, therefore, is not entitled to any specialty mental health

services. The NOA will provide the beneficiary with information about how to file an appeal or expedited appeal.

B. A request for second opinion following an NOA A will be considered an appeal or an expedited appeal and will be processed according to Policy 4.07 *Grievances, Appeals and Expedited Appeals*. Refer to policy 4.07 for details regarding:

- Filing the appeal/second opinion request
- Assistance from SLOBH staff including the Patient's Rights Advocate (PRA)
- Logging/confirming receipt by the PRA
- Timeline for resolution (45 days from receipt of appeal)
- Review process, including the beneficiary's access to the record and ability to present evidence
- Notification of Disposition
- Payment for services, including "aid paid pending"

C. SLOBH will utilize licensed mental health professionals (other than a licensed psychiatric technician or a licensed vocational nurse) who were not involved in the initial assessment to review evidence and make decisions on second opinion appeals/expedited appeals.

D. SLOBH will determine whether the second opinion requires a face-to-face encounter with the beneficiary.

E. SLOBH will train staff in documentation trainings that second opinions are offered at no cost to clients.

F. Clients who seek a second opinion will not be subject to discrimination or any other penalty.

G. Appealing the Second Opinion Decision

If the second opinion/appeal is not resolved wholly in favor of the beneficiary, the PRA will inform the beneficiary of the right to a fair hearing and the procedure for filing for a fair hearing after the appeal process has been exhausted.

H. Other Second Opinion Requests

1. When clinical decision is disputed or a client requests a second opinion at a time other than described in B above, SLOBH will honor the request to the extent resources are available and if the request is clinically indicated.

2. SLOBH's Medical Director and PRA will be consulted as needed to determine if a second opinion is warranted.

I. The PRA will present second opinion request data to the Quality Support Team (QST) Committee on a quarterly basis (more frequently if needed) for quality improvement purposes. The QST Committee will forward concerns to the Behavioral Health Administrator as needed to effect system changes.

VI. DOCUMENT HISTORY

Revision Date:	Section Revised:	Details of Revision:
11/18/2015	All	Added Purpose, reformatted
Prior Approval dates: 5/30/2009, 6/5/2010, 10/12/2015		

Signature on File	11/18/2015

Approved by: Anne Robin, LMFT Date
Behavioral Health Administrator

Beneficiary Grievances, Appeals and Expedited Appeals

4.07 Beneficiary Grievances, Appeals & Expedited Appeals

I. PURPOSE

To ensure that all Medi-Cal beneficiaries are informed of and have access to effective problem resolution processes

II. POLICY

San Luis Obispo County Behavioral Health (SLOBH) will implement a problem resolution process that enables each beneficiary to resolve problems or concerns about any issue related to SLOBH's performance of its duties.

The Appeals and Expedited Appeals processes will ensure that beneficiaries have consistent and timely means to respond to any action taken by SLOBH. The Grievance process will ensure that beneficiaries have a consistent and timely means to resolve all other concerns about the care they receive at SLOBH.

SLOBH will ensure that all Medi-Cal beneficiaries are well informed about the appeals process.

SLOBH will process Grievances, Appeals and Expedited Appeals within the time frames established by law.

III. REFERENCES

- California Code of Regulations, Title 9, §§ 1810.200, 1810.375, 1810.203.5, 1810.216.2, 1812.218.1, 1850.205 – 1850.208
- Code of Federal Regulations, Title 42, §§ 438.400 – 438.424
- MHP Contract, Exhibit A, Attachment I, Sections 7 and 15
- DMH Letter 05-03

IV. DEFINITIONS

"Action" means:

A. A determination that medical necessity criteria have not been met and the beneficiary is not entitled to any Specialty Mental Health Service (SMHS)
B. A denial, modification or reduction of a provider's request for authorization prior to the delivery of the service
C. A denial, modification, reduction or termination of a provider's request for payment authorization after the service after the service was provided
D. A failure to act within the timeframes for resolution of grievances, appeals, or expedited appeals
E. A failure to provide a specialty mental health service within the timeframe established by the MHP

"Appeal" means:

A. A request by a beneficiary or representative for review of an Action
B. A request by a beneficiary or representative for review of SLOBH's determination to deny or modify a beneficiary's request for a covered SMHS
C. A request by a beneficiary or representative for review of the timeliness of the delivery of SMHS
D. A request by a contractor provider for review of client record review findings that resulted in the disallowance of paid claims

"Expedited Appeal":

The accelerated resolution of an appeal when SLOBH determines or the beneficiary and/or the beneficiary's provider certifies that following the timeframe for an appeal would seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.

"Grievance" means:

A beneficiary's verbal or written expression of dissatisfaction about any matter other than a matter covered by an appeal

V. PROCEDURE

A. Beneficiary Informing

1. Information regarding the problem resolution processes will be provided to clients at the beginning of services and upon request thereafter.
2. The Beneficiary Handbook, *Guide to Mental Health Services*, contains detailed information about the processes and will be available at all certified sites and through the 24/7 Central Access line at: 800-838-1381.
3. SLOBH will post Client Information Centers at each certified site, which will contain notices explaining grievance, appeal, and expedited appeal processes to ensure that the information is readily available to both beneficiaries and staff.
4. Consumer Request Forms and postage paid, self-addressed envelopes will be available in each Client Information Center. Clients are able to obtain, complete and return a Consumer Request Forms without having to make a verbal or written request to anyone.

B. General Provisions

1. A beneficiary may authorize another person to act on the beneficiary's behalf, including the Mental Health care provider in an appeal or expedited appeal. The beneficiary's legal representative may use the grievance/appeal/expedited appeal processes on the beneficiary's behalf.

2. All grievances/appeals/expedited appeals will be directed to the Patients' Rights Advocate (PRA) for logging and assistance.

3. A beneficiary or a provider will not be subject to discrimination or any other penalty or punitive action for filing a grievance/appeal/expedited appeal

4. All grievances/appeals/expedited appeals will be resolved in a confidential manner that respects the rights and dignity of the beneficiary.

5. The PRA will present problem resolution issues to the Quality Support Team (QST) Committee a quarterly basis (more frequently if needed) for quality improvement purposes. The QST Committee will forward concerns to the Behavioral Health Administrator as needed to effect system changes.

C. Filing a Grievance/Appeal/Expedited Appeal

1. Appeals and expedited appeals must be filed within 90 days of the action that is being appealed.

2. Grievances will be filed orally or in writing.

3. Appeals will be initially filed orally or in writing. An oral appeal will be followed up in writing by the beneficiary.

4. Expedited appeals will be filed orally without requiring that the request be followed by a written appeal.

5. The Consumer Request Form will be available for written submission of grievances/appeals/expedited appeals.

6. The PRA will, at the beneficiary's request, assist with these filing processes. Assistance will include, but not be limited to, help writing the grievance/appeal/expedited appeal on a Consumer Request Form.

7. The date of the initial oral or written submission starts the disposition timeline.

8. If SLOBH denies a beneficiary's request for expedited appeal resolution, the PRA will:

   - Resolve the issue as a standard appeal
   - Make reasonable efforts to promptly notify the beneficiary and/or representative of the denial of the request for an expedited appeal

- Provide written notice within two calendar days of the date of the denial

D. Grievance/Appeal Log and Confirmation of Receipt

1. The PRA will record each grievance/appeal/expedited appeal in a Grievance/Appeal Log within one working day of receipt. The log will contain all of the following:

   - Name of the beneficiary
   - Date of receipt of the grievance/appeal/expedited appeal
   - Nature of the problem
   - Persons responsible for resolution
   - Final dispositions (or reason for lack of disposition)
   - Date the written decision is sent to the beneficiary

2. The PRA will report de-identified data to DHCS from the log on an annual basis.

3. The PRA will retain the log for seven years.

4. The PRA will send written confirmation to the beneficiary within one working day of the receipt of the grievance/appeal/expedited appeal.

E. Timelines for Resolution

	Disposition and Notification Timeline*
Grievance	60 calendar days
Appeal	45 calendar days
Expedited Appeal	3 working days

1. If the grievance/appeal/expedited appeal is not resolved in the allotted timeframe, the PRA will notify the beneficiary and issue a NOA-D.

2. Timeframes may be extended by up to 14 calendar days if the beneficiary requests an extension or if SLOBH determines that there is a need for additional information and that the delay is in the beneficiary's interest.

3. If SLOBH extends the timeframes, the PRA shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension and the reasons for the extension in writing.

F. Review process

1. SLOBH will allow the beneficiary and/or representative to examine the beneficiary's medical records and any other documents or records considered before and during the appeal process.

2. In an appeal or expedited appeal, SLOBH will provide the beneficiary with a reasonable opportunity to present evidence in person or in writing.

3. SLOBH will utilize staff who were not involved in any previous review or decision-making on the issue to review evidence and make decisions on grievances/appeals/expedited appeals.

4. If an appeal or expedited appeal is about a clinical issue, SLO BH will utilize staff with appropriate clinical expertise to review and make decisions on the appeal.

G. Notification of Disposition

1. The PRA will notify providers involved in the grievance/appeal/expedited appeal of the final disposition of the process.

2. The PRA will notify the beneficiary and/or his or her representative of the resolution of the grievance or appeal in writing. The notice will contain:

   - The results of the appeal resolution process
   - The date that the appeal decision was made
   - If an appeal is not resolved wholly in favor of the beneficiary, the notice shall also contain information regarding the beneficiary's right to a fair hearing and the procedure for filing for a fair hearing after the appeal process has been exhausted

3. In addition to written notification following an expedited appeal, the PRA will make reasonable efforts to provide oral notice to the beneficiary and/or his or her representative.

H. SLOBH will promptly provide or arrange and pay for the disputed services if the decision of the appeal resolution process reverses a decision to deny, limit or delay services.

I. Aid Paid Pending

1. SLOBH will provide "aid paid pending" (APP) services during the resolution of an appeal or expedited appeal to beneficiaries who have filed a timely appeal (10 days from the date the Notice Of Action (NOA) was mailed or 10 days from the date the NOA was personally given to the beneficiary).

2. The beneficiary must either have an existing service authorization which has not lapsed and the service is being terminated, reduced, or denied for renewal by the MHP.

3. This action will permit a beneficiary to continue to receive their existing services until the period covered by the existing authorization expires, the date an appeal is resolved or a hearing decision is rendered, or the date on which the appeal is otherwise withdrawn or closed, whichever is earliest.

4. AAP services will be provided at no cost to the beneficiary.

VI. DOCUMENT HISTORY

Revision Date:	Section Revised:	Details of Revision:
11/18/2015	Purpose All	Added Purpose Combined Policies 4.02, 4.07, 4.08, 4.10
Prior Approval dates: 5/30/2009, 6/5/2010, 10/12/2015		

Signature on File	11/18/2015
Approved by: Anne Robin, LMFT Behavioral Health Administrator	Date

Fair Hearing Process

4.09 Fair Hearing Process

I. PURPOSE

To ensure that all Medi-Cal beneficiaries are informed of and have access to effective problem resolution processes

To clarify that a fair hearing is the last stage in the problem resolution process and is available when a beneficiary has exhausted the SLOBH's problem resolution process

II. POLICY

San Luis Obispo County Behavioral Health (SLOBH) department will implement a problem resolution process that enables each beneficiary to resolve problems or concerns about any issue related to SLOBH's performance of its duties.

SLOBH will inform beneficiaries of the availability of the fair hearing process and how to file for a Fair hearing. SLOBH will assist beneficiaries with filling upon request.

III. REFERENCES

- California Code of Regulations, Title 9, §§1810.216.4, 1810.216.6 1850.205, 1850.207, 1850.210 –1850.215,
- California Code of Regulations, Title 22, §§51014.1 – 51014.2, 50951 – 50955
- Welfare & Institutions Code §§10950 – 10965
- Code of Federal Regulations, Title 42, §§438.400 – 438.424
- MHP Contract, Exhibit A, Attachment I, Sections 7 and 15
- DMH Letter No. 05-03

Policy 4.07 *Grievances, Appeals and Expedited Appeals*
Policy 3.30 *Notices of Action*

IV. DEFINITIONS

"Fair Hearing" means the State hearing provided to beneficiaries. A Fair Hearing is an independent review of requests for Specialty Mental Health Services (SMHS) conducted by the California Department of Social Services to ensure beneficiaries receive the services to which they are entitled under the Medi-Cal program. A request for fair hearing is the final level of review for an appeal.

"Expedited Fair Hearing" means a fair hearing that can be used when the mental health plan determines or the beneficiary and/or the beneficiary's provider certifies that that following the timeframe for a fair hearing would seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.

V. PROCEDURE

A. Beneficiary Informing

1. Information regarding the problem resolution processes will be provided to clients at the beginning of services and upon request thereafter.
2. The Beneficiary Handbook, *Guide to Mental Health Services*, contains detailed information about the appeal and fair hearing processes and will be available at all certified sites and through the 24/7 Central Access line at: 800-838-1381.
3. SLOBH will post Client Information Centers at each certified site, which will contain notices explaining appeal and expedited appeal processes to ensure that the information is readily available to both beneficiaries and staff.
4. The second page of the Notice of Action (NOA) explains how to file for a fair hearing. An NOA will be sent to each beneficiary when SLOBH takes any action that could result in an appeal. Refer to Policy 3.30 *Notices of Action* for detail. However, requests for fair hearing may be filed even if no Notice of Action was received.
5. The SLOBH Patients' Rights Advocate (PRA) will notify the beneficiary and/or his or her representative of the resolution of the grievance or appeal in writing. If an appeal is not resolved wholly in favor of the beneficiary, the notice shall also contain information regarding the beneficiary's right to a fair hearing and the procedure for filing for a fair hearing. Refer to Policy 4.07 *Grievances, Appeals and Expedited Appeals* for detail.

B. General Provisions

1. A beneficiary may authorize another person to act on the beneficiary's behalf.
2. All fair hearing requests will be directed to the PRA for logging and assistance. The PRA will, at the beneficiary's request, assist with the filing process. Assistance will include, but not be limited to, help writing the fair hearing request.
3. A beneficiary or a provider will not be subject to discrimination or any other penalty or punitive action for filing a fair hearing request.
4. All fair hearing requests will be resolved in a confidential manner that respects the rights and dignity of the beneficiary.
5. The PRA will present problem resolution issues to the Quality Support Team (QST) Committee a quarterly basis (more frequently if needed) for quality improvement purposes. The QST Committee will forward

concerns to the Behavioral Health Administrator as needed to effect system changes.

C. Fair Hearing

1. The Managed Care Program Supervisor will represent SLOBH as the Fair Hearing Officer in the fair hearing, and will present evidence for the action taken by SLOBH.

2. SLOBH will promptly implement the terms of the fair hearing if the decision of the Administrative Law Judge or other hearing officer reverses the previous action taken by SLOBH.

D. Aid Paid Pending

1. SLOBH will provide "aid paid pending" (APP) services during the resolution of a fair hearing to beneficiaries who have filed a timely fair hearing request (10 days from the date the NOA was mailed or 10 days from the date the NOA was personally given to the beneficiary).

2. The beneficiary must have an existing service authorization which has not lapsed and the service is being terminated, reduced, or denied for renewal by SLOBH.

3. This action will permit a beneficiary to continue to receive their existing services until the period covered by the existing authorization expires, a hearing decision is rendered, or the appeal is withdrawn or closed, whichever is earliest.

4. AAP services will be provided at no cost to the beneficiary.

Revision Date:	Section Revised:	Details of Revision:
11/16/2015	All	Reformatted, simplified procedure
Prior Approval dates: 5/30/2009, 6/5/2012, 10/12/2012		

Signature on File	11/19/2015
Approved by: Anne Robin, LMFT Behavioral Health Administrator	Date

Attachment I. Behavioral Health Referral Form

Sample Behavioral Health Referral Form

Name: MH CLIENT, FICTIONAL 01 Case#: 400001 Page: 1 of 6
Type: BH Referral Form Date: 05/24/2016
Printed on 05/24/2016 at 03:31 PM (Draft)

San Luis Obispo County Behavioral Health Department
Behavioral Health Referral Form

Referral Date:
Program Initiating Referral:
Program Receiving Referral:
Contact Person at Receiving Program:
Contact Person's Phone:
Referral discussed with the contact person? O Yes O No
Assignment made to contact person/receiving program subunit? O Yes O No
Reason for Referral:

Comments/Special Considerations (Describe any additional factors the receiving program should consider, such as current potential for violence or self injury):

Signature of Staff Making Referral:

Name: Date: Time: Pending

Program Supervisor Approving Referral:

Name: Date: Time: Pending

Staff Processing Referral:

Name: Date: Time: Pending

Receiving Program Comments:

Is the referral appropriate? O Yes O No
Is the referral accepted? O Yes O No

Comments by receiving program:

Signature of Staff Accepting the Referral:

Name: Date: Time: Pending

Form BHCBOREF; Version 1.01; 4/10/2013

San Luis Obispo County Behavioral Health Department

Full Service Partnership Referral

Youth FSP O Yes O No

- ☐ SED/SMI or 1st psychotic break or parent w/ SMI/drug abuse
- ☐ High user of MH or medical services due to MH symptoms
- ☐ Current/past multiple foster placements or aged/aging out
- ☐ At risk of/removed from home or moving to lower level care
- ☐ Homeless or at risk of homelessness
- ☐ Current/past justice system or law enforcement involvement
- ☐ New to MH; not served in past
- ☐ Co-occurring substance use/abuse issues
- ☐ Serious academic problems/failing grades/ERMHS eligible
- ☐ Exposed to violence; friends or family killed; family hx SMI
- ☐ Underserved/unserved, including uninsured/indigent
- ☐ Member of a minority or disadvantaged group

TAY FSP O Yes O No

- ☐ SED/SMI or 1st psychotic break or parent w/ SMI/drug abuse
- ☐ High user of MH or medical services due to MH symptoms
- ☐ Current/past multiple foster placements or aged/aging out
- ☐ D/C from RCL 10+/CTF/IMD/State Hospital, or Probation Camp
- ☐ Homeless or at risk of homelessness
- ☐ Current/past justice system or law enforcement involvement
- ☐ New to MH; not served in past
- ☐ Co-occurring substance use/abuse issues
- ☐ Serious academic problems/failing grades/ERMHS eligible
- ☐ Aging out of ERMHS/Youth MH/CWS/juvenile justice system
- ☐ Exposed to violence; friends or family killed; family hx SMI
- ☐ Underserved/unserved, including uninsured/indigent
- ☐ Member of a minority or disadvantaged group

Adult FSP O Yes O No

- ☐ SMI, needs intensive SMHS due to hx/current functioning
- ☐ High user of MH or medical services due to MH symptoms
- ☐ Discharged from IMD within past 12 months
- ☐ Homeless or at risk of homelessness
- ☐ Current/past justice system or law enforcement involvement
- ☐ New to MH; not served in past
- ☐ Co-occurring substance use/abuse issues
- ☐ Serious vocational problems; at risk of/recently fired
- ☐ Underserved/unserved, including uninsured/indigent
- ☐ Member of a minority or disadvantaged group

Name: MH CLIENT, FICTIONAL 01 Case#: 400001 Page: 4 of 6
Type: BH Referral Form Date: 05/24/2016
Printed on 05/24/2016 at 03:31 PM (Draft)

Older Adult FSP O Yes O No

- ☐ SMI, needs intensive SMHS due to hx/current functioning
- ☐ High user of MH or medical services due to MH symptoms
- ☐ Homeless or at risk of homelessness
- ☐ Home bound and unserved
- ☐ Current/past justice system or law enforcement involvement
- ☐ New to MH; not served in past
- ☐ Co-occurring substance use/abuse issues
- ☐ Underserved/unserved, including uninsured/indigent
- ☐ Member of a minority or disadvantaged group

Name: MH CLIENT, FICTIONAL 01 Case#: 400001 Page: 5 of 6
Type: BH Referral Form Date: 05/24/2016
Printed on 05/24/2016 at 03:31 PM (Draft)

San Luis Obispo County Behavioral Health Department

Network Provider Referral O Yes O No

Does client have full-scope Medi-Cal? O Yes O No

Is client likely to benefit from short-term therapy? O Yes O No

Does client have a history of consistent attendance? O Yes O No

Does client have specific measurable/attainable goals? O Yes O No

If yes to all above, describe treatment goals/recommended focus of treatment?

Receiving Program Comments

Assigned to a Network Provider? O Yes O No

Number of days until next available appointment 0

Psychological Testing Referral O Yes O No

Has the client previously been tested (send results if available)? O Yes O No

What questions do you want testing to help answer?

How will testing results improve treatment?

Name: MH CLIENT, FICTIONAL 01	Case#: 400001	Page: 6 of 6
Type: BH Referral Form		Date: 05/24/2016
Printed on 05/24/2016 at 03:31 PM		(Draft)

San Luis Obispo County Behavioral Health Department

Transitions Mental Health Association Referral O Yes O No

Is the client currently homeless? O Yes O No

Is client at risk of homelessness? O Yes O No

Does the client meet MHSA target population criteria? O Yes O No

Service Requested (specify):

☐ Housing ☐ Case Management ☐ Supported Employment

☐ Growing Grounds Farm

Wellness Center (specify):

☐ Life House (North County) ☐ Hope House (SLO) ☐ Safe Haven (South County)

☐ Other Specify

Other Referral: O Yes O No

Specify program:

Attachment J. List of Providers

Table of Providers

Attachment J. Providers			
Provider Name	Title	FTE	Location
Graber, Starlene	Division Manager	1.00	San Luis Obispo
Hortillosa, Elaine	Administrative Services Officer II	1.00	San Luis Obispo
Berg, Steve	DAS Program Supervisor	1.00	San Luis Obispo
Vacant Position	DAS Program Supervisor	1.00	San Luis Obispo
Pemberton, Teresa	MH Program Supervisor	1.00	San Luis Obispo
Grainger, Katie	Administrative Services Officer I	1.00	San Luis Obispo
Perez, Irma	Administrative Services Officer I	1.00	San Luis Obispo
Lopez, Ricardo	DAS Specialist II	1.00	San Luis Obispo
Calloway, Chandra	MH Therapist III	1.00	San Luis Obispo
Dolezal, Kathryn “Katie”	MH Nurse Practitioner	0.75	San Luis Obispo
Vacant Position	MH Nurse Practitioner	0.50	San Luis Obispo
Vacant Position	DAS Specialist II	1.00	San Luis Obispo
Gibson, Gary	DAS Specialist I	1.00	San Luis Obispo
Caldeira, Cynthia	DAS Specialist III	1.00	San Luis Obispo
Nelson, Cynthia	DAS Specialist IV	1.00	San Luis Obispo
Woodward, Jennifer	DAS Specialist II	1.00	San Luis Obispo
Hoffman, Paul “Corey”	DAS Specialist II	1.00	San Luis Obispo
Otten, Robert	DAS Specialist II	1.00	San Luis Obispo
Cazier, Cheryl	DAS Specialist III	1.00	San Luis Obispo
Matthews, Vicki	DAS Specialist III	1.00	San Luis Obispo
Lopez-Weichinger, Brenda	DAS Specialist II	1.00	San Luis Obispo
Peters, Roger	MH Therapist III	1.00	San Luis Obispo
Hodges, Justin	DAS Specialist I	1.00	San Luis Obispo
Vacant Position	DAS Case Manager	1.00	San Luis Obispo
Vacant Position	DAS Worker	1.00	San Luis Obispo
Mora, Yesenia	MH Therapist IV	1.00	San Luis Obispo
Maddox, Emily	DAS Program Supervisor	1.00	Paso Robles
Dozier, Alisha	DAS Specialist I	1.00	Paso Robles
Alba, Vanessa	DAS Specialist I	1.00	Paso Robles
Vacant Position	DAS Worker I	1.00	Paso Robles
Madden, April	DAS Specialist I	1.00	Paso Robles
Adler, Jamie	DAS Specialist III	1.00	Paso Robles
Michetti, Annika	DAS Specialist II	0.50	Paso Robles
Axelrod, Michael	DAS Specialist II	1.00	Paso Robles
Vacant Position	MH Therapist IV	1.00	Paso Robles
Vacant Position	MH Therapist III	1.00	Paso Robles
Vacant Position	DAS Case Manager	1.00	Paso Robles
Vacant Position	DAS Worker	0.50	Paso Robles
Vacant Position	DAS Worker	0.50	Paso Robles
Vacant Position	MH Therapist III	1.00	Paso Robles

Provider Name	Title	FTE	Location
Goodman, Kevin	DAS Specialist III	1.00	Jail
Curry, Else Mai	DAS Specialist I	1.00	Jail
Dutton, Sally	DAS Specialist III	1.00	Jail
Guest, Clark	DAS Program Supervisor	1.00	Atascadero
Leigan, Elisa	DAS Specialist IV	1.00	Atascadero
Schwab, Kimberly	DAS Specialist III	1.00	Atascadero
Vacant Position	DAS Specialist III	1.00	Atascadero
Reynolds, Paterese	DAS Specialist II	1.00	Atascadero
Aquino, Maria	DAS Specialist II	1.00	Atascadero
Miramontes, Dave	DAS Specialist I	1.00	Atascadero
Gustavson-DuFour, Jennifer	DAS Specialist III	1.00	Atascadero
Terrio, Kelsey	DAS Specialist IV	1.00	Atascadero
McAllister, Alicia	DAS Specialist II	1.00	Atascadero
Reynolds, Nathaniel	DAS Specialist II	1.00	Atascadero
Vacant Position	DAS Case Manager	1.00	Atascadero
Vacant Position	Psych Tech	1.00	Atascadero
Quennell, Colin	DAS Program Supervisor	1.00	Grover Beach
Schmidt, Julianne	DAS Specialist III	1.00	Grover Beach
Vasquez, Elba	DAS Worker I	1.00	Grover Beach
Jenkins, Megan	DAS Specialist IV	1.00	Grover Beach
Brock, Leonard	DAS Specialist I	1.00	Grover Beach
Sorensen, Heather	DAS Specialist II	1.00	Grover Beach
Estrada, Elexia	DAS Specialist III	1.00	Grover Beach
Gurrola, Robert	DAS Specialist I	1.00	Grover Beach
Rafferty, Cathleen	DAS Specialist I	1.00	Grover Beach
McGuinness, Candance	DAS Specialist II	1.00	Grover Beach
Cantu, Humberto	DAS Specialist I	1.00	Grover Beach
Franklin, Deanna	DAS Specialist III	1.00	Grover Beach
Vacant Position	DAS Case Manager	1.00	Grover Beach
Vacant Position	Psych Tech	1.00	Grover Beach
Sheeler, Stu	MH Therapist III	1.00	Jail
Myers, Sean	MH Therapist III	1.00	Forensics
Gillespie, Betty	DAS Specialist III	1.00	Forensics
Vacant Position	MH Therapist IV	1.00	Jail
Larson, Vanessa	MH Therapist III	1.00	Forensics
Vacant Position	MH Therapist III	1.00	Jail
Loya, Kenneth “Ken”	DAS Specialist III	1.00	Forensics
Helwig, David	MH Therapist IV	1.00	Jail
Woodbury, Joshua	MH Therapist III	1.00	Forensics
Corcoran, Amanda	MH Therapist III	1.00	Forensics
Mendoza, Gricel	MH Therapist III	1.00	Forensics
Armendariz, Rosie	DAS Specialist I	1.00	Forensics
Roberts, Erin	MH Therapist II	0.50	Forensics
Serpa, Keppi	MH Therapist IV	1.00	Forensics
Vacant Position	MH Worker	1.00	Forensics
Bryan’s House	Women and Children Residential Facility	n/a	Contracted Provider
AEGIS	Methadone and Narcotic Replacement Therapy Clinic	n/a	Contracted Provider
Peters, Joshua	MH Program Supervisor	1.00	Youth Treatment

Provider Name	Title	FTE	Location
Cozzetto-Duong, Jessica	DAS Specialist II	0.50	Youth Treatment
Paramore, Kristina	DAS Specialist III	1.00	Youth Treatment
Hook, Andrew	DAS Specialist II	1.00	Youth Treatment
Christensen, Jaime	DAS Specialist II	1.00	Youth Treatment
Bany, Jessica	MH Therapist IV	0.50	Youth Treatment
Vacant Position	MH Therapist III	1.00	Youth Treatment
Vacant Position	MH Therapist III	1.00	Youth Treatment
Lawrence, Holl-Lee	DAS Specialist III	1.00	Youth Treatment
Vacant Position	DAS Specialist II	1.00	Youth Treatment

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