

DRAFT

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL

Implementation Plan For
Drug Medi-Cal Organized Delivery System Waiver

August 10, 2015

COUNTY OF LOS ANGELES IMPLEMENTATION PLAN FOR
THE DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM WAIVER

PART I. PLAN QUESTIONS

1. Stakeholders Participation

The following County agencies and other entities were involved in developing the County Plan:

2. Community Input

Community input was initially gathered by:

3. Ongoing Coordination of Services and Activities

During plan implementation, the County will use the following process to continue ongoing coordination of services and activities:

4. Prior Care Coordination and Integration Activities

The County’s substance use disorder (Department of Public Health, Substance Abuse Prevention and Control Program), mental health (Department of Mental Health), and physical health (Department of Health Services) agencies have a long history of collaboration to address the multiple co-occurring behavioral health and health conditions of their shared patients.

5. Services Available Under the DMC-ODS County Plan

Attachments 1A and 1B, and Part II section below entitled, Expansion of Services, describe the substance use disorder (SUD) benefit packages for adults and adolescents under the DMC-ODS County Plan. These services will be provided primarily through contracts with community-based organizations comprising the County SUD provider network. The County also directly operates the Antelope Valley Rehabilitation Centers that provide residential treatment services at a facility in Acton and an outpatient program in Lancaster for adult men and women.

6. Toll-Free Access Number

See Part II section below entitled Beneficiary Access Line that describes the toll-free number for prospective clients to call to access DMC-ODS services.

7. County Participation in DMC-ODS Evaluation

The County agrees to participate in providing data and information to the University of California, Los Angeles Integrated Substance Abuse Programs for the DMC-ODS evaluation. The County already has an established relationship with this entity for conducting evaluation of its overall adult SUD treatment program and for various grant projects.

47 PART II. PLAN DESCRIPTION: NARRATIVE DESCRIPTION OF THE COUNTY'S PLAN

48

49 **1. Collaborative Process**

50

51 See preceding Part I section entitled Stakeholders Participation that describes the County collaborative
52 process to plan DMC-ODS services.

53

54 **2. Client Flow**

55

56 See attached chart describing client flow through the DMC organized systems of care (Attachment 2).

57

58 Los Angeles County, through the Department of Public Health – Substance Abuse Prevention and
59 Control Program (DPH-DPH-SAPC) operates two Systems of Care for substance use disorder (SUD)
60 treatment services, one for adults and one for adolescents (under 18 years of age). Services are
61 delivered through contracts with community-based State-certified and/or –licensed SUD treatment
62 programs and the County-operated Antelope Valley Rehabilitation Centers (AVRC), a residential
63 treatment facility and an outpatient program for adult men and women.

64

65 There is no “wrong door” to enter SUD services. Referrals are accepted from all sources, including
66 County Medi-Cal managed care health plans, other County departments, criminal justice and juvenile
67 justice agencies, child dependency system, community-based human service agencies, families, and self.

68

69 All individuals seeking admission to SUD services can access services by contacting the Access Line using
70 a dedicated toll-free telephone line at any time (see Beneficiary Access Line description below) or by
71 contacting any contracted-SUD network provider and requesting admission. At that time, the individual
72 will participate in a screening interview to determine Medi-Cal eligibility status and an initial SUD
73 screening based on the American Society of Addiction Medicine (ASAM) Criteria, resulting in a
74 provisional level of care (LOC) placement and assistance in admission to a County-contracted SUD
75 treatment program at the indicated provisional level of placement.

76

77 Should the provisional placement screening determine that placement in a residential treatment
78 program is indicated, the network provider of residential services will submit an authorization request to
79 the County DPH-SAPC’s Division’s Office of the Medical Director, who will conduct an authorization
80 review and approve or deny the request within 24 hours of receiving the authorization request from the
81 network provider. There is no pre-authorization needed for admission of the individual to be placed in a
82 non-residential level of care. The Access Line or network provider staff will assist the individual with
83 placement and admission at the appropriate LOC indicated. Services available to each individual will
84 include the entire range of services contained in the attached benefit packages for adults and
85 adolescents, including medication services (see Attachments 1A and 1B).

86

87 The SUD treatment program will conduct a more intensive psychosocial clinical assessment, based on
88 the ASAM Placement Criteria, to establish and/or confirm the appropriate LOC placement. The initial
89 medical necessity determination will be conducted through a face-to-face or telehealth review by a
90 Medical Director, licensed physician, or Licensed Practitioner of the Healing Arts. Once the LOC and
91 medical necessity has been established, the individual will be enrolled in a SUD treatment program.

92

93 Where indicated, the SUD treatment provider will either place the beneficiary in an appropriate LOC
94 within its own facility or coordinate a referral with another network provider capable of providing the
95 appropriate LOC. When referring to another provider, the assessing agency will follow up with the
96 beneficiary to ensure a successful referral.

97
98 Should it be determined that the individual requires a change in level of care during the course of
99 treatment, the current treatment provider will assist the individual in transferring to the appropriate
100 level of care within the provider organization, by making a referral to another treatment program, or by
101 requesting assistance from the Access Line. If authorization is needed for admission into residential
102 treatment services, the residential treatment provider accepting the individual will request County
103 authorization prior to admitting the individual.

104
105 As the individual progresses in treatment, the treatment plan for adults will be updated at least every 90
106 days for outpatient services and 30 days for residential services unless there is a change in treatment
107 level of care or a significant event that requires a new treatment plan. For adolescents, the treatment
108 plan will be updated at least every 30 days for outpatient services and weekly for residential services
109 unless there is a change in treatment level of care or a significant event requires a new treatment plan.
110 As a beneficiary progresses through treatment, the corresponding treatment plan will be reviewed and
111 adjusted accordingly. If a beneficiary's condition does not show improvement at a given LOC or with a
112 particular intervention, then a progress review, abbreviated assessment, and treatment plan
113 modification will be made in order to improve therapeutic outcomes

114
115 Discharge planning is an integral component of the treatment process and begins at time of admission.
116 Processes to prepare the individual for return or reentry into the community include linkages to
117 essential supportive services such as education, employment and training, housing, benefit enrollment,
118 and other human services as indicated at assessment and during the treatment process.

119
120 Beneficiaries who no longer meet medical necessity criteria for SUD treatment services, or prematurely
121 exit the SUD system of care, will receive recovery monitoring services for a minimum of 6 months by the
122 last treatment provider of care, who will reengage the individual in treatment if needed.

123
124 **3. Beneficiary Access Line**

125
126 The County will operate a toll-free access line (Access Line) dedicated solely for this purpose and
127 available to individuals 24 hours, 7 days a week. The line will be staffed on weekdays from 8 a.m. to 6
128 p.m. with a message service at night, weekends, and holidays. Calls received after hours or on
129 weekends and holidays will be returned on the first following working day according to instructions left
130 by the caller.

131
132 Access Line staff will conduct screening interviews with callers using a separate adolescent or adult
133 screening protocol based on the ASAM Placement Criteria , make a provisional determination of level of
134 care, and schedule an admission appointment with a network provider. The Access Line will use an
135 automated system to schedule admission appointments. A reminder and follow-up process will be
136 established with the individual for the admission appointment. All Access Line procedures will be
137 conducted with the individual as a full participant in the decision-making process.

138

139 The following system information will be collected for continuous quality improvement purposes:

- 140 • Number of calls received;
- 141 • Number of screenings conducted (difference between number of calls and number of screenings
142 denotes call abandonment);
- 143 • Demographic characteristics of callers (age, gender, ethnicity/race, primary language if non-
144 English speaking, zip code of residence);
- 145 • Number of referrals to treatment by service type/level of care;
- 146 • Number of days to admission appointment;
- 147 • Number of individuals linked with ; and
- 148 • Analysis of wait time to treatment enrollment.

149
150 All beneficiaries will have services available to assist with admission into SUD services, with transitioning
151 from one level of service to another, and transitioning across mental health, physical health and social
152 service systems. Treatment provider staff will monitor and track beneficiary progress, coordinate care,
153 and provide linkages with community support services, as well as coordinate referrals to appropriate
154 SUD services. They will also participate in case conferences with network providers as beneficiaries
155 move between levels of care and into post-discharge recovery services activities to support successful
156 transition.

157

158 **4. Treatment Services and**

159 **5. Expansion of Services**

160

161 The County will implement an initial benefit package of SUD services within the initial twelve months of
162 approval of its DMC-ODS implementation plan. At a minimum, the following services will comprise the
163 initial benefit package:

164

165 Initial Benefit Package for Adults

166 Outpatient Services (ASAM Level 1)

167 Intensive Outpatient Treatment (ASAM Level 2.1)

168 Residential Treatment

169 Clinically Managed Low-Intensity (ASAM Level 3.1)

170 Clinically Managed Population-Specific High-Intensity (ASAM Level 3.3)

171 Clinically Managed High-Intensity (ASAM Level 3.5)

172 Withdrawal Management

173 Ambulatory Withdrawal Management without Extended On-site (ASAM Level 1-WM)

174 Clinically Managed Residential Withdrawal Management (ASAM Level 3.2-WM)

175 Medication-Assisted Treatment

176 Narcotic Treatment Program/Opioid Treatment Program (ASAM Level OTP)

177 Addiction Medications with Concurrent Outpatient or Residential Treatment

178 Recovery Support (Post-Discharge)

179

180 Initial Benefit Package for Adolescents

181 Outpatient Services (ASAM Level 1)

182 Intensive Outpatient Treatment (ASAM Level 2.1)

183 Residential Treatment

184 Clinically Managed Low-Intensity (ASAM Level 3.1)

185 Clinically Managed Population-Specific High-Intensity (ASAM Level 3.3)

186 Clinically Managed High-Intensity (ASAM Level 3.5)

187 Recovery Support (Post-Discharge)

188

189 By the end of the three year demonstration period, Los Angeles County will implement the full range of
190 ASAM levels of care comprised of the following services:

191

192 Services for Adults

193 Outpatient Services (ASAM Level 1)

194 Intensive Outpatient Treatment (ASAM Level 2.1)

195 Residential Treatment

196 Clinically Managed Low-Intensity (ASAM Level 3.1)

197 Clinically Managed Population-Specific High-Intensity (ASAM Level 3.3)

198 Clinically Managed High-Intensity (ASAM Level 3.5)

199 Withdrawal Management

200 Ambulatory Withdrawal Management without Extended On-site (ASAM Level 1-WM)

201 Ambulatory Withdrawal Management with Extended On-site (ASAM Level 2-WM)

202 Clinically Managed Residential Withdrawal Management (ASAM Level 3.2-WM)

203 Medication-Assisted Treatment

204 Narcotic Treatment Programs (ASAM Level OTP)

205 Addiction Medications with Concurrent Outpatient or Residential Treatment

206 Recovery Support (Post-Discharge)

207

208 Services for Adolescents

209 Outpatient Services (ASAM Level 1)

210 Intensive Outpatient Treatment (ASAM Level 2.1)

211 Residential Treatment

212 Clinically Managed Low-Intensity (ASAM Level 3.1)

213 Clinically Managed Population-Specific High-Intensity (ASAM Level 3.3)

214 Clinically Managed High-Intensity (ASAM Level 3.5)

215 Recovery Support (Post-Discharge)

216

217 Note: The benefit package for adolescents is established as a developmentally-appropriate set of
218 services. Not all levels of care or types of services available to adults are included in the benefit package
219 for adolescents, such as Withdrawal Management and Medication-Assisted Treatment, because these
220 services are generally not approved or appropriate for this population. However, on a case-by-case
221 basis as determined as medically necessary with prior authorization by THE COUNTY, such services will
222 be available to adolescents.

223

224 Services not included in the initial benefit packages will be phased into the benefit package with the
225 following timelines:

226

227 Services for Adults

228 • July 1, 2016 – Implement the initial benefit packages for adults.

229 • June 30, 2017 – Complete inclusion of all addiction medications. Continue adding network
230 providers to fill gaps in access to SUD treatment services.

- 231 • June 30, 2018 – Complete inclusion of Withdrawal Management Level 2-WM. Expand provider
232 network to ensure full access to all areas of the County for full implementation of the ASAM
233 continuum of care.

234

235 Services for Adolescents

- 236 • July 1, 2016 – Implement the initial benefit packages for adolescents.
237 • June 30, 2017 - Continue adding network providers to fill gaps in access to SUD treatment
238 services.
239 • June 30, 2018 – Complete expanding provider network to ensure full access to all areas of the
240 County for full implementation of developmentally-appropriate ASAM continuum of care.

241

242 **6. Coordination with Mental Health**

243

244 A current Memorandum of Understanding (MOU) between DPH-SAPC and the Department of Mental
245 Health (DMH) defines the coordination of mental health and SUD services for Medi-Cal beneficiaries.
246 DMH is responsible for serving beneficiaries with diagnosed serious mental illness and co-occurring SUD.
247 DPH-SAPC is responsible for serving beneficiaries with SUD alone or with co-occurring mild to moderate
248 mental health conditions. DPH-SAPC and DMH work closely together to ensure that services are being
249 provided adequately and appropriately for beneficiaries with co-occurring disorders. Increasingly, DMH
250 has added DPH-SAPC network providers to its contracted specialty mental health provider network to
251 support an integrated approach to services.

252

253 The two County Medi-Cal managed care health plans (Health Net and LA Care) are responsible for
254 addressing the mental health services needs of its members with mild to moderate mental health
255 conditions. DPH-SAPC coordinates care with the two County health plans for those with co-occurring
256 SUD and mild to moderate mental health conditions. This relationship is established and defined
257 through MOUs with the two County health plans. DPH-SAPC and the two County health plans are
258 actively assisting the County-contracted SUD network providers to become credentialed by the health
259 plans to provide services for mild to moderate mental health conditions as a means to implement
260 integrated care for this population.

261

262 **7. Coordination with Physical Health**

263

264 In compliance with the DMC ODS Standard Terms and Conditions, DPH-SAPC established MOUs with the
265 two County Medi-Cal managed care health plans (Health Net and LA Care) that defines the coordination
266 of physical health and SUD services for Medi-Cal beneficiaries (see Attachments 3 and 4).

267

268 DPH-SAPC has already established MOUs with the two County health plans, the Department of Health
269 Services, the Department of Mental Health, and the Department of Public Social Services for the
270 County's participation in the Cal MediConnect demonstration project for dual Medicare and Medi-Cal
271 beneficiaries. DPH-SAPC, DMH, and the two County health plans will use the care coordination
272 infrastructure established for the Cal MediConnect project to build the DMC ODS care coordination
273 infrastructure.

274

275 Bimonthly meetings of a Behavioral Health Steering Committee and Program Administration Team
276 comprised of leadership from the health plans and County partners provide overall policy and

277 programmatic leadership for the coordination of care across physical health, mental health, and SUD
278 service systems. Interdisciplinary care coordination teams comprised of clinical personnel from the
279 health plans and County partners meet regularly to discuss care coordination for beneficiaries with
280 multiple co-occurring conditions. Sharing of patient information is conducted with patient consent in
281 accordance with all applicable patient confidentiality requirements to support decisions on care
282 coordination involving the County-contracted SUD network providers, County health plan network
283 providers, and DMH specialty mental health network providers. The County-contracted SUD provider
284 network is already actively engaged in care coordination with mental health and physical health
285 providers through the infrastructure established for the Cal MediConnect project as described above.

286
287 DPH-SAPC coordinates with the County Medi-Cal managed care health plans to ensure beneficiaries
288 have access to and receive SUD services through health plan network providers for services
289 reimbursable by Medi-Cal but not included in the DMC ODS benefits, such as voluntary inpatient
290 detoxification services in general acute hospitals (ASAM Levels 3.7-WM, 4-WM), addiction medications
291 (acamprosate, buprenorphine, disulfiram, and extended release naltrexone), and Screening, Brief
292 Intervention and Referral to Treatment (SBIRT) services (ASAM Level 0.5) in primary care settings.

293
294 DPH-SAPC also has a well-established care coordination relationship with the Department of Health
295 Services, which provides physical health services for Medi-Cal beneficiaries under an agreement with LA
296 Care and also for the uninsured safety net population.

297
298 The expansion of SUD services available under the DMC ODS implementation plan greatly improves
299 access to SUD services for persons with co-occurring mental health and physical health conditions,
300 particularly in access to residential treatment services, which have historically been difficult to access for
301 medically indigent individuals due to limited County, State and federal funding.

302 303 **8. Coordination Assistance**

304
305 The following challenges have been identified for effective provision of coordinated and integrated
306 mental health, physical health, and SUD services for beneficiaries with multiple, co-occurring conditions:

- 307
308 • Patient Data Sharing Between Systems – The current requirements of 42 Code of Federal
309 Regulations (CFR) Part 2 make sharing of patient information between systems cumbersome.
310 State advocacy to revise or waive these requirements for the waiver demonstration would allow
311 more effective and efficient care coordination practices.
- 312
313 • Payment Reform – Current Medi-Cal payment systems for mental health, physical health, and
314 SUD services are cumbersome and discourage effective and efficient coordinated or integrated
315 care approaches. State advocacy to revise or waive federal Medicaid policies and State Medi-Cal
316 policies would support improved cross-system coordinated and integrated care. Payment and
317 provider enrollment incentives for Medi-Cal providers with coordinated and integrated care
318 approaches to service delivery would promote the adoption of such approaches as the standard
319 for Statewide service delivery.
- 320
321 • Cross-System Workforce Development – The workforces in mental health, physical health and
322 SUD service networks have limited expertise for identifying and addressing multiple co-occurring

323 conditions through a cross-systems care coordination or integrated approach. Workforce
324 training on best practices for patient screening, problem and risk identification, brief
325 intervention for alcohol problems, and patient engagement in seeking SUD services are needed
326 for the mental health and physical health workforces. Training in care coordination is needed by
327 all three workforces.

328

329 **9. Access**

330

331 • Anticipated number of Medi-Cal beneficiaries needing SUD services: of the 2.8 million Medi-Cal
332 eligible residents of Los Angeles County, approximately 314,727 beneficiaries are projected to
333 need SUD services. Of those, 66,358 are under 18 years of age, and 248,369 are 18 and older.

334

335 • Expected utilization of DMC services: approximately 98,232 beneficiaries are projected to utilize
336 DMC services at least once each year (17,312 under 18 years of age and 80,920 ages 18 and
337 older).

338

339 • Numbers and types of providers:

340

341 The County presently has Drug Medi-Cal (DMC) contracts with the following providers
342 distributed throughout the County:

343

344 ___ Outpatient Services providers at 86 sites and 20 Perinatal sites,

345 ___ Intensive Outpatient Treatment providers at 33 sites and 13 Perinatal sites, and

346 ___ Narcotic Treatment Program providers at 39 sites and 4 Perinatal sites.

347

348 In addition, the County has current contracts with the following providers for non-DMC services:

349

350 ___ Outpatient Drug Free Counseling providers at 93 sites and 14 Perinatal sites;

351 ___ Residential Treatment providers at 94 sites with a total of 954 contracted beds
352 (static capacity);

353 2 Residential Detoxification providers at 3 sites with a total of 25 contracted funded beds
354 (static capacity).

355

356 According to California Department of Health Care Services information, State-licensed
357 residential treatment and residential detoxification programs have a total of 5,895 beds
358 available, including those already contracted by the County. A total of 277 State-certified non-
359 residential treatment programs operate in the County, including those already contracted by the
360 County. Therefore, there exists a large inventory of outpatient services and residential beds
361 that presently remain not contracted by the County. While some of this capacity is likely
362 committed to other purchasers of services, such as the State correctional system and
363 commercial health insurance plans, it is likely that a substantial inventory remains unfunded and
364 demonstrates potential for DMC certification to support expanded service needs as DMC-ODS is
365 implemented.

366

367 The greatest concern for the County is the speediness with which the State is able to process
368 new DMC applications, particularly for residential services. Until its network providers of

369 residential services are DMC certified, these benefits will be limited to those funded under other
370 revenue streams or patients will be served in levels of care below what is determined to be
371 medically necessary. As a result, both the County and State may be at risk for liability in not
372 providing adequate medically determined levels of care.

373

374 • Hours of operation: all outpatient services will be operated at least six days a week during
375 regular business hours and on at least two weekday evenings, Monday through Saturday.
376 Residential programs will operate 24 hours per day, seven days a week.

377

378 • Language capability: services will be provided in all threshold languages as needed. Services in
379 Spanish will be offered by all network providers. Services in other languages may be offered by
380 specific programs that service specific cultural populations, such as Asian, American Indian, and
381 various other groups. The County also maintains a contract with Interpretation Services that
382 provides oral translation services in at least 12 languages that is accessible to all of its network
383 providers. These languages are: Arabic, Armenian (Eastern), Chinese (Traditional), English,
384 Farsi, Khmer (Cambodian), Korean, Russian, Spanish, Tagalog, Thai, and Vietnamese.

385

386 • Timeliness of services:

387

388 First face-to-face visit – The Access Line will establish appointments for initial intake
389 appointments with network providers at the time of screening. First appointments will be
390 scheduled as soon as possible and no longer than 72 hours from the initial request for services.
391 Accommodations will be made for urgent situations whenever possible.

392

393 Emergencies – For emergency situations where a life-threatening condition is present, the
394 Access Line or network provider will immediately contact emergency medical services for
395 intervention. Network providers will be required to establish procedures for appropriately
396 handling urgent conditions presented by actively enrolled beneficiaries.

397

398 Afterhours care – Network providers will be required to establish procedures for appropriately
399 handling afterhours care needs of actively enrolled beneficiaries.

400

401 • Geographic location of providers: a criterion for making referrals for placement in outpatient
402 services will be that the program should be within one hour travel time by personal or public
403 transportation to and from the beneficiary's residence. In some outlying semi-rural areas of the
404 County, such as in the Antelope Valley, the low population density may make this criterion
405 impossible to meet, particularly through public transportation. In such cases, every effort will
406 be made to accommodate the beneficiary to minimize excessive travel time.

407

408 Telehealth approaches will also be considered for adoption after the initial twelve-month
409 implementation period as a means to expand access to services for beneficiaries in outlying
410 areas and for those with transportation challenges.

411

412 All County-contracted SUD network providers will be fully compliant with the Americans with
413 Disabilities Act requirements as a contract provision.

414

415 **10. Training Provided**

416

417 All network provider will be required to establish and operate a training plan for their employees that
418 identifies training needs and describes steps to ensure that employees receive appropriate training
419 aligned with the needs assessment. Network providers will be monitored at least annually for
420 compliance with this contract requirement.

421

422 In addition, the Office of the Medical Director and Science Officer will be responsible for assessing
423 overall network clinical training needs and coordinating training sessions in alignment with needs
424 assessment findings. Contracts with the California Institute for Behavioral Health Services and the
425 Integrated Substance Abuse Programs at the University of California, Los Angeles, will serve as the
426 primary vehicles for the provision of clinical and program capacity building training and technical
427 assistance services for its network providers.

428

429 Current training topics identified under the DMC ODS implementation plan include the following:
430 application of ASAM placement criteria and determination of medical necessity, clinical documentation,
431 and evidence-based practices (Cognitive Behavioral Therapy, Medication Assisted Treatment, and
432 Motivational Interviewing). The County will use a train-the-trainers approach to build a cadre of highly
433 skilled medical directors and clinical supervisors within the provider network who in turn will train
434 employees within each network provider organization and monitor fidelity to adopted evidence-based
435 practices. To accommodate the diversity and size of the County-contracted SUD provider network and
436 its workforce, training will be continuous through the demonstration period.

437

438 **11. Technical Assistance**

439

440 The County requests technical assistance from the State on the following topics:

- 441 • Adolescents: Parental involvement and privacy concerns for minors and which services are
442 reimbursable (and for how long) if parental consent cannot be obtained.
- 443 • Reimbursable services (and perhaps the addition of codes) for SUDs under EPDST.

444

445 **12. Quality Assurance**

446

447 The County established a Quality Assurance/Utilization Management Plan in consultation with its
448 provider network and stakeholders and in compliance with DMC ODS requirements (see Attachment 5).

449 As a component of the County DMC ODS implementation plan, the DPH-SAPC will establish a series of
450 quality assurance processes in order to establish a structural framework for quality, accountability, and
451 oversight that will pertain to all publicly-funded SUD services. These processes will be multilayered in
452 order to best capture opportunities for quality improvement, and will be structured within the Quality
453 Assurance (QA) and Utilization Management (UM) programs. The QA and UM programs share
454 complementary goals of ensuring that SUD treatment is accessible, quality-focused, evidence-based,
455 developmentally/culturally/linguistically appropriate, and is the right service being provided at the right
456 time, in the right setting, and for the right duration. The QA and UM programs will also work closely
457 with the Clinical Standards and Training (CST) division of DPH-SAPC to ensure that the provider network
458 receives the educational tools and training in order to meet the quality standards that will be
459 established.

460 The purpose of the QA program is twofold: 1) to establish an infrastructure for quality-focused services
461 through the formation of a number of committees that focus on specific aspects of an organized delivery
462 system of SUD services and 2) to set standards in areas, including medical necessity criteria, clinical
463 practice (including medication-assisted treatment), and level of care guidelines, founded on criteria
464 established by the American Society of Addiction Medicine (ASAM). The components of these QA
465 standards will also focus on performance and outcome measures, care coordination, workforce
466 standards, risk management, Quality Improvement Projects (QIP) at the provider level, and a grievance
467 and appeals process. Substance use disorder (SUD) measures will monitor key quantitative and
468 qualitative characteristics of the system of care, including, but not limited, to:

- 469 - Timeliness of first face-to-face appointment.
- 470 - Timeliness of services for urgent conditions.
- 471 - Access to after-hours care.
- 472 - Responsiveness of the beneficiary access line.
- 473 - Strategies to reduce avoidable hospitalizations.
- 474 - Coordination of physical and mental health services with waiver services at the provider level.
- 475 - Assessment of the beneficiaries' experiences.

476 The QA program will establish various committees including: Quality Improvement/Risk Management
477 (QI/RM), Utilization Review, Research and Data Management, Professional Development, Compliance
478 Risk Management, Community Liaison (with subcommittees for providers and consumers), and Cultural
479 Competence. The QI/RM Committee will meet every other month and consist of DPH-SAPC
480 representatives from the Director's Office, Office of the Medical Director and Science Officer, Adult and
481 Youth Programs, Contracts, Strategic Planning, Information Systems, Finance, and the evaluation
482 services contractor who will be collaborating with DPH-SAPC on quality assurance and training activities.
483 Importantly, the QI/RM Committee will work closely with all other committees in order to incorporate
484 feedback into the continuous quality improvement process. The various roles and functions of the
485 QI/RM Committee will include:

- 486 ○ Ensure patient safety and satisfaction, quality of care, and organizational efficiencies
- 487 ○ Implement a comprehensive approach to quality
- 488 improvement/quality assurance that includes risk management.
- 489 ○ Review and approve Medical Necessity Criteria and Clinical
- 490 Practice Guidelines annually.
- 491 ○ Review and approve Clinical Practice Guidelines annually.
- 492 ○ Review and monitor clinical performance indicators across all provider sites.
- 493 ○ Review and approve all new provider quality improvement projects (QIPs) on annual
- 494 basis.
- 495 ○ Oversee annual formal evaluation of QA program.
- 496 ○ Review targeted clinical records, complaints, grievances, and appeals filed by clients
- 497 and/or providers.
- 498 ○ The designated SAPC staffs ensure a tracking and documentation system for all sentinel
- 499 events (defined as a client safety event that results in death, permanent harm, and/or
- 500 severe temporary harm and intervention required to sustain life), conduct investigations,
- 501 root cause analyses, follow up and implementation of corrective action, as appropriate.
- 502 ○ Oversee and monitor compliance with the applicable legal and regulatory obligations
- 503 that pertain to activities performed by the SAPC QA/UM programs.
- 504 ○ Identify opportunities to improve compliance and risk management processes.

- 505 ○ Review and evaluate QI activities, institute needed QI actions, and ensure follow up of QI
- 506 processes, including review data related to safety and sentinel events in order to identify
- 507 trends and patterns associated with risks or to identify problem areas.
- 508 ○ Provide guidance to educational processes for QI standards, in conjunction with the
- 509 Clinical Standards and Training division of the Office of the Medical Director and Science
- 510 Officer.
- 511 ○ Collaborate with all other committee activities to incorporate feedback into continuous
- 512 QI process.
- 513 ○ Identify opportunities to inform policy, improve QI processes and support other
- 514 organizational functions.
- 515 ○ Collaborate with relevant internal and external committees and parties to design,
- 516 implement, and ensure feasible measurement of interventions for improving quality,
- 517 care and performance.
- 518 ○ Identify relevant committees internal or external to the SAPC to ensure appropriate
- 519 collaboration and exchange of information to accomplish the goals of the QI Committee,
- 520 including obtaining input from providers, consumers and family members.
- 521 ○ Provide support to other organizational functions.

522 Quality Improvement Projects (QIPs) offer an opportunity for providers to examine and identify
523 challenges that affect their delivery of services, and to develop projects that uniquely address the
524 identified issues or problems. Provider agencies will be required to be involve in at least one QIP at all
525 times throughout the year, and these projects will be reviewed by DPH-SAPC on an annual basis. One of
526 the functions of QIPs is to instill a continuous quality improvement culture into each provider agency as
527 a result of the QIP development process. All QIPs should follow a continuous quality improvement
528 process that is similar to the Plan-Do-Study-Act (PDSA) model and target improvement in relevant areas
529 of clinical care, either directly or indirectly. Areas of focus may include, but are not limited to, improving
530 access to and availability of services, improving continuity and coordination of care, improving the
531 quality of specific interventions, and enhancing service provider effectiveness. Generally, an issue
532 selected for study should impact a significant portion of the beneficiary population served and have a
533 potentially significant impact on health, functional status or satisfaction. Over time, areas selected for
534 improvement focus should address a broad spectrum of care and services.

535 Similarly, peer reviews at the provider level will establish an educational and evaluative mechanism for
536 providers to identify opportunities for improvement. Provider agencies will establish and maintain a
537 formal process for practitioners to regularly review and discuss, in a professional and non-adversarial
538 manner, the quality and appropriateness of care/services provided by their colleagues.

539 The UM program helps to ensure quality services by monitoring adherence to the standards established
540 in the QA program. The UM program will assess how the DPH-SAPC provider network is delivering
541 services and how it is utilizing resources for eligible beneficiaries. The various responsibilities of the UM
542 program include the following: ensuring adherence to the eligibility and medical necessity criteria that
543 have been set; ensuring that clinical care and ASAM LOC guidelines are being followed; conducting
544 clinical case reviews (prospective/concurrent/retrospective) of requests for select services;
545 authorization and pre-authorization of services; random retrospective monitoring of a portion of
546 provider caseloads; and ongoing monitoring and analysis of provider network service utilization trends.

547 Monitoring within the UM program will occur using several mechanisms. All cases that require
548 authorization and pre-authorization will be reviewed by UM staff. Cases which require pre-authorization
549 will include residential services and instances in which methadone dosages exceed 40 mg total on the
550 first day of methadone administration. Authorization will be required for medication-assisted treatment
551 for individuals under the age of 18, as well as perinatal Opioid Treatment Program services.

552 Additionally, no less than 2 percent of provider agency caseloads will be randomly reviewed on at least
553 an annual basis. UM staff may also conduct focused chart reviews whenever concerns arise about a
554 particular provider or client. Such reviews may be conducted on site and without prior notice to the
555 provider.

556 In-depth root cause analyses will be performed in instances of sentinel events (defined as a patient
557 safety event that results in death, permanent harm, and/or severe temporary harm and intervention
558 required to sustain life), or to identify areas of potential QI. UM staff will recognize the importance of
559 flexibility in terms of clinical decision-making at the provider level, and UM activities will take into
560 account the individualized nature of each unique client case. Concerns that arise will be discussed with
561 providers and viewed as a learning opportunity for both UM staff and providers, with the shared goal of
562 improving the system of SUD care.

563 Case review considerations include, but are not limited to:

- 564 - Client/family/guardian identified goals and preferences.
- 565 - Care/service is necessary and clinically appropriate in terms of level of care, intervention,
566 frequency, timing, and duration, and considered effective to promote recovery.
- 567 - Care/service is consistent with generally accepted standards of clinical practice based on:
 - 568 o Credible scientific evidence published in peer-reviewed medical literature that is
569 generally recognized by independent clinical experts at the time the services are
570 provided.
 - 571 o Recommendations of a physician-specialty society.
 - 572 o The DSM and ASAM Criteria.
 - 573 o Case discussions with treating providers, when appropriate.
 - 574 o Any other relevant factors.
- 575 - Care/service is coordinated both across the continuum of SUD care and across relevant physical
576 and mental health systems, as clinically indicated.
- 577 - Regular client assessments ensure that care/service is provided in the least restrictive, most
578 cost-effective environment that is consistent with clinical standards of care.
- 579 - Care/service is not provided solely for the convenience of the provider, recipient, recipient's
580 family, or custodian (e.g., placing clients in a residential level of care primarily for housing
581 purposes).
- 582 - Care/service is not experimental, investigational, and/or unproven.
- 583 - Care/service is deemed necessary and furnished by or under the supervision of an appropriate
584 and authorized licensed practitioner, and in accordance with all applicable rules, regulations,
585 and other applicable federal, state, and local directives.

586 Given the continual evolution of the field of addiction treatment, the expectation is that the QA/UM
587 programs will evolve and change with the availability of new information and research, or changes in
588 regulatory mandates or contractual agreements. The DPH-SAPC QA/UM programs will work
589 collaboratively with our community providers, partners, and consumers, and comply with State and

590 federal regulations and guidelines. Stakeholder engagement in the development of QA/UM activities will
591 occur in a joint advisory workgroup that is currently attended by stakeholders, DPH-SAPC, and
592 evaluation services contractor. Ongoing stakeholder involvement will occur via the Community Liaison
593 Committee and its provider and consumer sub-committees, quarterly All Providers meetings, and the
594 quarterly DPH-SAPC Lecture Series.

595 The draft QA/UM plan currently being reviewed by the County and its stakeholders is in compliance with
596 Code of Federal Regulations (CFR) 438.200, 438.202, and 438.204. The Compliance Risk Management
597 Committee that is built into the QA program will conduct periodic reviews to ensure ongoing
598 compliance. The County will ensure compliance with CFR 438 Subpart E (External Quality Review
599 Organizations) by contracting with an External Quality Review Organization to conduct annual reviews of
600 the SUD services provided within its system of care, in addition to the various monitoring processes
601 described above.

602 In summary, the concept behind the QA activities in the County is to establish an infrastructure that
603 fosters a culture of quality and continuous improvement, to establish standards for the provision of
604 services, and to monitor the care that is being provided to ensure adherence to those standards.

605 **13. Evidence Based Practices**

606
607
608 The County will require that its network providers implement and use, at minimum, the evidence-based
609 practices of Cognitive Behavioral Therapy and Motivational Interviewing. In addition, network providers
610 will be encouraged to adopt additional evidence-based practices and promising practices tailored to the
611 needs of each provider's focus patient population. Implementation with fidelity will be monitored
612 through the contract compliance monitoring process.

613 **14. Assessment**

614
615
616 Beneficiaries will be first screened by the Access Line to establish the provisional LOC recommendation
617 and to initiate a referral to a contracted SUD treatment provider, when indicated. Upon referral by the
618 Access Line, the beneficiary will be assessed by the contracted SUD treatment provider for medical
619 necessity and appropriate LOC based on ASAM placement criteria. SUD treatment providers will be
620 required to have appropriate staff for determining medical necessity, and will be trained on and
621 required to use the ASAM criteria for placement decisions, continued service, and transfer/discharge.
622 The County will encourage all providers to use the ASAM Criteria Software, which at the present time
623 only pertains to the adult population, although paper-based assessment based on the ASAM criteria will
624 also be available for providers who are unable to use the ASAM Criteria Software.

625
626 Contract monitoring and the UM program will provide a multi-layered approach to ensuring that
627 beneficiaries are placed at the appropriate LOC. Case reviews conducted as part of the UM activities will
628 ensure appropriate LOC placement at the initial assessment and for purposes of continued service and
629 transfer/discharge.

630

631 **15. Regional Model**

632
633 Los Angeles County will implement a County-specific approach but will coordinate with other counties in
634 Implementation Phase 2 to promote continuity of care to the extent possible across counties.
635

636 **16. Memorandum of Understanding**

637
638 MOUs between the DPH-SAPC, the two Medi-Cal managed care plans (Health Net and LA Care), and the
639 Department of Mental Health (DMH) are in the process of execution and will be submitted within 90
640 days of the approval of the County implementation plan as required. The MOU will include all
641 conditions as required by the State. DPH-SAPC has already executed MOUs describing care coordination
642 policies and procedures with the health plans and DMH for the Cal MediConnect program.
643

644 **17. Telehealth Services**

645
646 Some County-contracted SUD providers currently offer telehealth services, including telepsychiatry. The
647 County will encourage all SUD providers to expand or introduce telehealth as an offered service, and will
648 explore telehealth as a means to expand the capabilities of medication-assisted treatments, physician
649 consultations, and services for special populations, among other services. The County will also explore
650 increased collaboration with the Department of Mental Health and Medi-Cal managed care plans in an
651 effort to expand this services. All telehealth services offered at County-contracted SUD providers will be
652 required to use special equipment and/or software that meets telehealth encryption standards and that
653 can ensure confidentiality. The telehealth equipment will be set up in a private room that is locked and
654 secure.
655

656 **18. Contracting**

657
658 The County establishes master agreements with qualified community-based SUD service providers
659 through a selective contracting process. Once master agreements are executed with providers that
660 meet County requirements, contracts are established with these legal entities for the provision of
661 specific types of services using a competitive work order solicitation process in which interested
662 providers must demonstrate their capabilities and capacities to provide specific types of services with
663 specific focus populations. Using this approach, the County ensures that its network providers each
664 possess the business, clinical, and focus population capabilities, capacities, and competence to
665 effectively provide the contracted services; and that the service network has the optimal capacity of
666 service providers to meet the needs of the County population. A listing of all contracted providers
667 including information on service modality and provider address is attached as required (see
668 Attachment 6).
669

670 Contract Term

671 All contracts will have a term of three (3) years, with the option to extend on an annual basis dependent
672 upon funding and need for services.
673

674 Appeals Process

675 Under Board Policy No. 5.055 (Services Contract Solicitation Protest), any prospective Vendor may
676 request a review of the requirements under a solicitation for a Board-approved services agreement.
677 Additionally, any actual Vendor may request a review of a disqualification under such a solicitation. The
678 appeal process will follow the LAC Protect Policy (available at:
679 http://mylacounty.info/listserver/pcs_contracts/cms1_192167.pdf).

680

681 Continuity of Services

682 Any current provider not awarded a contract will be notified at least thirty (30) days prior to the
683 contract termination. In accordance with existing contract language, Contractor shall make immediate
684 and appropriate plans to transfer or refer all participants served under this Contract to other agencies
685 for continuing service in accordance with the participant's needs. Such plans shall be approved by
686 Director before any transfer or referral is completed except in those instances, as determined by
687 Contractor, where an immediate participant transfer or referral is indicated. In such instances,
688 Contractor may make an immediate transfer or referral to the nearest Substance Use Disorder provider.

689

690 **19. Additional Medication Assisted Treatment**

691

692 In addition to medications used by Opioid (Narcotic) Treatment Programs (methadone), the County will
693 offer to its beneficiaries all addiction medications approved by the Federal Drug Administration as
694 determined medically necessary. These medications include acamprosate, buprenorphine, disulfiram,
695 naloxone, and naltrexone (oral and extended release forms). Addiction medications are administered by
696 qualified SUD network providers or through coordination with the beneficiaries' Medi-Cal managed care
697 health plan network pharmacy and primary care providers.

698

699 **20. Residential Authorization**

700

701 Initial Authorization: the County will establish written policies and procedures describing required prior
702 authorization for initial admission to DMC residential services within 24 hours of a network provider's
703 prior authorization request submission in compliance with DMC ODS requirements. An automated
704 tracking system operated by the Office of the Medical Director compiles information on the number,
705 disposition, percentage and timeliness of requests for prior authorization.

706

707 Continuing Authorization: The County will establish written policies and procedures for processing
708 requests for continuing authorization of DMC residential services. A request for continuing
709 authorization must be submitted at least 7 days in advance of the 90-day maximum stay for adults and
710 at least 7 days in advance of the 30-day maximum stay for adolescents. A one-time extension of 30 days
711 may be permitted based on medical necessity. For perinatal and criminal justice populations, a longer
712 length of stay of up to 6 months on an annual basis may be approved based on medical necessity, but
713 only 3 months with a one-time 30-day extension of the total episode can be funded under DMC. Length
714 of stay for adults is limited to two authorized non-continuous 90-day episodes in a one-year period. An
715 automated tracking system operated by the Office of the Medical Director compiles information on the
716 number, disposition, percentage and timeliness of requests for prior authorization.

717

718 **County Authorization**

719

720 Authorization of County Alcohol and Other Drug Program Director:

721

722

723

724

725 _____ Wesley L. Ford, Director

Los Angeles

County

_____ Date

726 Substance Abuse Prevention and Control

727 Department of Public Health

ADULT SUBSTANCE USE DISORDER (SUD) BENEFIT PACKAGE

6.6.15 Draft

Level Of Care (LOC)	ASAM Level	DHCS ASAM Description	Current DMC LOC	Current County LOC	Funding	Phase	Implementation Target Date
Early Intervention	0.5	Screening, brief intervention, and referral (as needed)	Funded by Health Plans not DMC-ODS				
Outpatient	1	Less than 9 hours of service per week for recovery or motivational enhancement therapies and strategies.	Yes	Yes	DMC	One	Upon plan approval
Intensive Outpatient	2.1	Nine (9) or more hours of service per week to treat multidimensional instability.	Yes	Yes	DMC	One	Upon plan approval
Partial Hospitalization	2.5	20+ hours of service per week for multidimensional instability. No 24-hour care.					
Low Intensity Residential	3.1	24-hour structure with available trained personnel and at least 5 hours of clinical service per week. Prepare for outpatient treatment.	No	Yes	DMC	Two	Within one year of DHCS granting licenses
High Intensity Residential Population Specific	3.3	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive and other impairments unable to use full active milieu. Prepare for outpatient treatment.	No	No	DMC	Three	Within two years of DHCS granting licenses
High Intensity Residential Non-Population Specific	3.5	24-hour care with trained counselors to stabilize multidimensional imminent danger for individuals able to use full active milieu. Prepare for outpatient treatment.	Yes (Perinatal)	No	DMC	One	Upon DHCS granting licenses
Intensive Inpatient Services Medically Monitored	3.7	24-hour nursing care with physician availability for significant problems with ASAM Dimensions 1, 2, or 3. Includes counselor availability for 16 hours per day.					
Intensive Inpatient Services Medically Managed	4.0	24-hour nursing care and daily physician care for severe, unstable problems with ASAM Dimensions 1, 2, or 3. Counseling available to engage patient in treatment.					
Ambulatory Withdrawal Management Without Extended On-Site Monitoring	1-WM	Mild withdrawal with daily or less than daily outpatient supervision.	No	No	?	Two	Within one year of plan approval
Ambulatory Withdrawal Management With Extended On-Site Monitoring	2-WM	Moderate withdrawal with all day withdrawal management and support and supervision. At night patient has supportive family or living situation.	No	No	?	Two	Within one year of plan approval
Residential Withdrawal Management Clinically Managed	3,2-WM	Moderate withdrawal but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment and recovery.	No	No	?	One	Upon plan approval
Inpatient Withdrawal Management Clinically Managed	3,7-WM	Severe withdrawal and needs 24-hour nursing care and physician visits. Unlikely to complete withdrawal management without medical monitoring.					
Inpatient Withdrawal Management Medically Managed and Intensive Services	4-WM	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.					
Opioid (Narcotic) Treatment Program	1-OTP	Daily or several time weekly opioid agonist medications and counseling available to maintain multidimensional stability for those with severe opioid use disorder.	Yes	Yes	DMC	One	Upon plan approval
Add'l Medication Assisted Treatment	N/A	Ordering, prescribing, administering, and monitoring all medications for SUDs. Includes: buprenorphine, disulfiram, methadone, naltrexone, acamprosate, and naloxone.	No	Yes (Long-acting Naltrexone)	DMC/Med i-Cal	One	Upon plan approval
Case Management	N/A	Aid in transition between LOC, communication and coordination of referrals, monitoring to ensure access and progress in services, advocacy and linkages.	No	Yes	DMC	One	Upon plan approval
Recovery Services (Post Treatment)	N/A	Individual and group counseling, recovery monitoring, substance abuse assistance, linkages to education, job skills, family support, support groups, ancillary services (minimum of one recovery monitoring contact per month for up to six months).	No	Yes	DMC	One	Upon plan approval
Physician Consultation	N/A	Communication between addiction medicine physicians/psychiatrists or clinical pharmacists with DMC physicians to address medication and LOC considerations.	No	No	?	One	Upon plan approval

Funded by Drug Medi-Cal, SAPT Block Grant, General Relief (County general funds), @alWORKS (County Welfare to Work funds), AB 109 and other sources.

** Key for Ranking LOC Feasibility: GREEN → High feasibility, YELLOW → Moderate feasibility, ORANGE → Lower feasibility

Grey Levels of Care → Offered, but not within SAPC network

Black Levels of Care → Not offered

ADOLESCENT SUBSTANCE USE DISORDER (SUD) BENEFIT PACKAGE

3/7/15 Draft

Level Of Care (LOC)	ASAM Level	DHCS ASAM Description	Current DMC LOC	Current County LOC	Funding	Phase	Implementation Target Date
Early Intervention	0.5	Screening, brief intervention, and referral (as needed).					
Outpatient	1	Less than 6 hours of service per week for recovery or motivational enhancement therapies and strategies.	Yes	Yes	DMC	One	Upon plan approval
Intensive Outpatient	2.1	Six (6) or more hours of service per week to treat multidimensional instability.	Yes	Yes	DMC	One	Upon plan approval
Partial Hospitalization	2.5	20+ hours of service per week for multidimensional instability. No 24-hour care.					
Low Intensity Residential	3.1	24-hour structure with available trained personnel and at least 5 hours of clinical service per week. Prepare for outpatient treatment.	No	Yes	DMC	Two	Within one year of DHCS granting licenses
High Intensity Residential Population Specific	3.3	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive and other impairments unable to use full active milieu. Prepare for outpatient treatment.					
High Intensity Residential Non-Population Specific	3.5	24-hour care with trained counselors to stabilize multidimensional imminent danger for individuals able to use full active milieu. Prepare for outpatient treatment.	Yes (Perinatal)	Yes	DMC	One	Upon DHCS granting licenses
Intensive Inpatient Services Medically Monitored	3.7	24-hour nursing care with physician availability for significant problems with ASAM Dimensions 1, 2, or 3. Includes counselor availability for 16 hours per day.					
Intensive Inpatient Services Medically Managed	4.0	24-hour nursing care and daily physician care for severe, unstable problems with ASAM Dimensions 1, 2, or 3. Counseling available to engage patient in treatment.					
Ambulatory Withdrawal Management Without Extended On-Site Monitoring	1-W/M	Mild withdrawal with daily or less than daily outpatient supervision.					
Ambulatory Withdrawal Management With Extended On-Site Monitoring	2-W/M	Moderate withdrawal with all day withdrawal management and support and supervision. At night patient has supportive family or living situation.					
Residential Withdrawal Management Clinically Managed	3.2-W/M	Moderate withdrawal but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment and recovery.					
Inpatient Withdrawal Management Clinically Managed	3.7-W/M	Severe withdrawal and needs 24-hour nursing care and physician visits. Unlikely to complete withdrawal management without medical monitoring.					
Inpatient Withdrawal Management Medically Managed and Intensive Services	4-W/M	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.					
Opioid (Narcotic) Treatment Program	1-OTP	Daily or several times weekly opioid agonist medications and counseling available to maintain multidimensional stability for those with severe opioid use disorder.					
Add I Medication Assisted Treatment	N/A	Ordering, prescribing, administering, and monitoring all medications for SUDs. Includes: buprenorphine, disulfiram, methadone, naltrexone, acamprosate, and naloxone.					
Case Management	N/A	Aid in transition between LOC, communication and coordination of referrals, monitoring to ensure access and progress in services, advocacy and linkages.	No	Yes	DMC	One	Upon plan approval
Recovery Services (Post Treatment)	N/A	Individual and group counseling, recovery monitoring, substance abuse assistance, linkages to education, job skills, family support, support groups, ancillary services.	No	Yes	DMC	One	Upon plan approval
Physician Consultation	N/A	Communication between addiction medicine physicians/psychiatrists or clinical pharmacists with DMC physicians to address medication and LOC considerations.	No	No	?	One	Upon plan approval

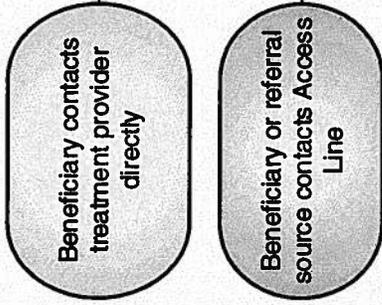
Funded by Drug Medi-Cal, SAPI Block Grant, General Relief/County general funds, CALWORKS/County Welfare Work funds, Juvenile Justice/Child Prevention Act, Title IV-E, and other sources.

** Key for Ranking LOC Feasibility: GREEN → High feasibility, YELLOW → Moderate feasibility, ORANGE → Lower feasibility

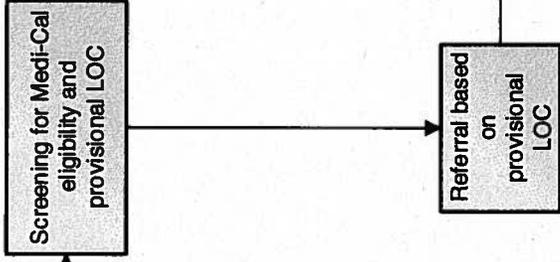
Grey Levels of Care → Offered, but not within SAPC network

Blank Levels of Care → Not offered

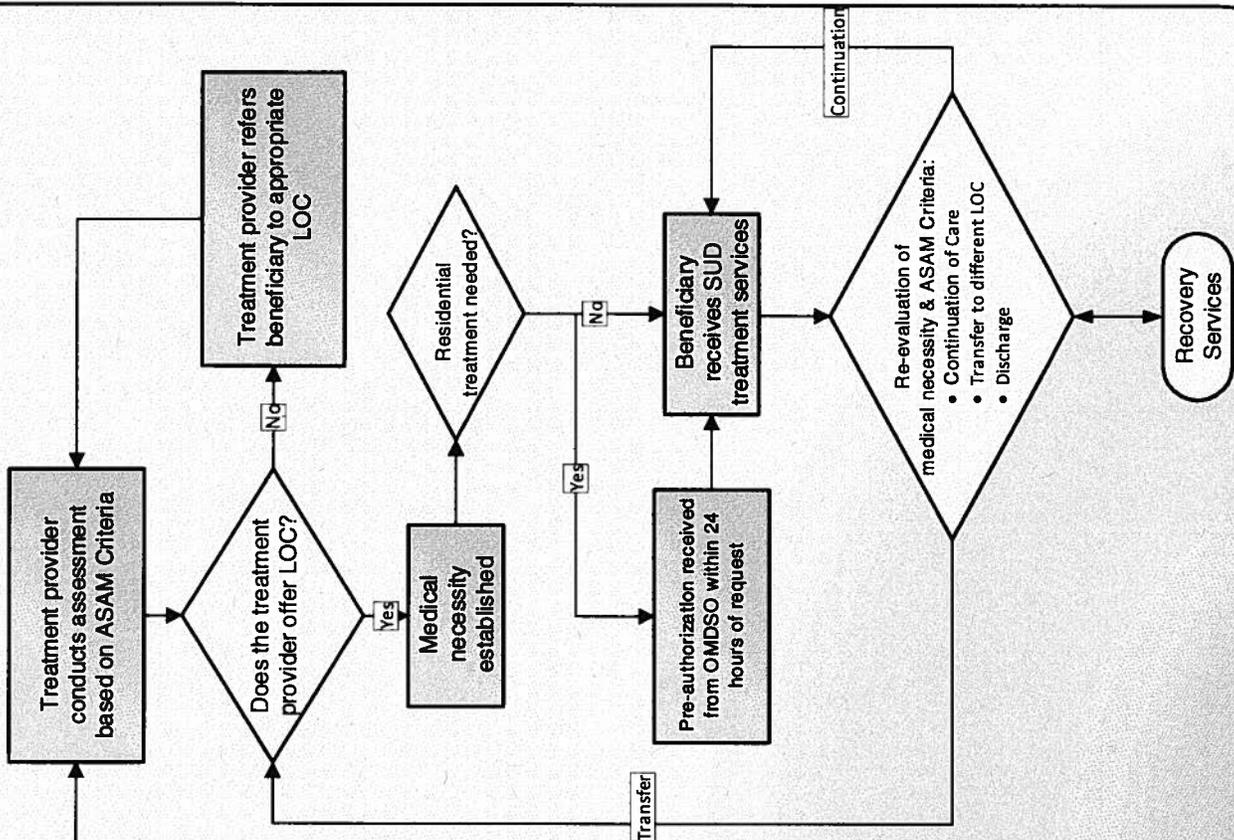
DMC Entry



Access Line



Treatment Provider



Key

- LOC = Level of Care
- ASAM = American Society of Addiction Medicine
- SUD = Substance Use Disorder
- OMDSO = Office of the Medical Director and Science Officer

Note: Special considerations may apply for adolescents regarding such issues as consent to treatment and confidentiality

**MEMORANDUM OF UNDERSTANDING
WITH HEALTH NET
ON PHYSICAL HEALTH AND SUBSTANCE USE DISORDER SERVICES**

**MEMORANDUM OF UNDERSTANDING
WITH L A CARE
ON PHYSICAL HEALTH AND SUBSTANCE USE DISORDER SERVICES**

**QUALITY ASSURANCE/UTILIZATION MANAGEMENT
PROGRAM PLAN**

**CONTRACTED SUBSTANCE USE DISORDER SERVICE PROVIDERS
FY 2014-15**