START-ODS

SYSTEM TRANSFORMATION TO ADVANCE RECOVERY AND TREATMENT

Los Angeles County's Substance Use Disorder Organized Delivery System

Minutes

SYSTEM OF CARE STAKEHOLDER WORKGROUP		
Topic	Residential Services	
Date	May 19, 2016 (Part I); June 16, 2016 (Part II)	
Time	9:30 AM – 12:00 PM	
Venue	Conference Room 8050, Building A-8 1000 South Fremont Avenue, Alhambra, CA 91803	
PARTICIPANTS		
Stakeholders	Asian American Drug Abuse Program	Patty Abrantes
	Asian American Drug Abuse Program	James Stinson
	Beacon House Association of San Pedro	Brent Mayhew
	Behavioral Health Services and People Coordinated Services	Windy Gaston
	California Hispanic Commission on Alcohol and Drug Abuse	Natasha Medina
	CLARE Foundation, Inc.	Jared Friedman
	CRI-Help, Inc.	Brandon Fernandez-Comer
	CRI-Help, Inc.	Marlene Nadel
	Didi Hirsch	Dulce Ruiz
	Live Again Recovery Homes	Theodore Herrington
	Los Angeles Centers for Alcohol and Drug Abuse	Caryl Lark
	Los Angeles Centers for Alcohol and Drug Abuse	Bill Tarkanian
	People Coordinated Services of Southern California, Inc.	Charlene Scott
	Phoenix House	Maja Trochimczyk
	SHIELDS for Families	Georgea Madeira
	Social Model Recovery Systems	Jim O'Connell
	Tarzana Treatment Centers, Inc.	Stan Galperson
	Part I Only	
	Amity	Jiandau Payza
	Antelope Valley Rehabilitation Center	Tony Hill
	Antelope Valley Rehabilitation Center	Suzanne Verreault
	Beacon House Association of San Pedro	Robert Davis
	Behavioral Health Services	Jim Gilmore
	Behavioral Health Services	Denise Shook
	Behavioral Health Services	Shirley Summers
	CLARE Foundation, Inc.	Natasha Rudar
	Department of Public Health-Chief of Staff Office	Sandy Song
	Didi Hirsch	Darin Rorrer
	His Sheltering Arms, Inc.	Gregory Senegal
	Little House, Inc.	Samantha Salmeron
	Los Angeles Centers for Alcohol and Drug Abuse	Gary Iannarelli
	MJB Transitional Recovery	Dennis Hughes
	People Coordinated Services of Southern California, Inc.	Virgie Walker
	Phoenix House	Erik Sherman
	Prototypes, Inc.	Lourdes Olivares
	Southern California Alcohol and Drug Programs, Inc.	Martha Cabrera
	Southern California Alcohol and Drug Programs, Inc.	Karl Calhoun
	SPIRITT Family Services	Sandra Aviles

	Part II Only Behavioral Health Services CLARE Foundation, Inc. Grandview Foundation, Inc. Los Angeles Centers for Alcohol and Drug Abuse Safe Refuge Southern California Alcohol and Drug Programs, Inc. The Salvation Army Hope Harbor The Salvation Army Hope Harbor Volunteers of America "Consultant"	 Celia Aragon Diana Cho Lindy Carll Juan Navarro Kathy Romo Kimberly Hendrix Daisy Hernandez Raul Villalobos Jim Howat Elizabeth Stanley Salazar
SAPC Staff	John Connolly, Loretta Denering, Timothy Dueñas, Michelle Gibson, Kristine Glaze, Christina Kaiser, Tina Kim, Yanira Lima, Elizabeth Norris-Walczak, Ashley Phillips, Glenda Pinney, Hyunhye Seo, Duy Tran, Gary Tsai, Way Wen *Part I Only:* Andrea Hurtado, Holly McCravey, Kevin Ong, Yeira Rodriguez *Part II Only:* Diana Baumbauer, Wesley Ford, Maribel Garcia, Julie Lo, Richard Lugo, Antonne Moore, Gregg Murakami, Christine Oh, Steven Reyes, Anna Rochin, Valerie Sifuentes	

MEETING PROCEEDINGS

Agenda Items	Discussion
I. Welcome and Introductions	Yanira Lima, Substance Abuse Prevention and Control (SAPC) Adult System of Care Interim Director, opened the meeting by welcoming all participants, asking everyone to introduce themselves and their respective agencies, and presented the meetings' agenda.
II. Stakeholder Process Overview	Michelle Gibson, SAPC Strategic Planning Director, explained how the stakeholder workgroup process started in August 2015 with the kick-off and subsequent regional meetings to gather feedback for the County's implementation plan, which is already in the process of getting revised based on comments provided by the California Department of Health Care Services (DHCS) and the U.S. Centers for Medicare and Medicaid Services (CMS). As the County prepares for the system of care transformation, she further explained that the subsequent stakeholder workgroup meetings will help define the County's standards of practice. Apart from System of Care, other workgroups include Integration of Care, Quality Improvement and Utilization Management (formerly LACES), System Operations, and System Innovations and Network Capacity Building. Residential Services is but one of 11 topics discussed under System of Care.
III. Member Expectations and Ground Rules	Yanira Lima laid out the workgroup rules that included each member reviewing meeting documents in advance, contributing to discussion, and focusing on system design and patient care.
IV. Document Review and Discussion	**Workgroup participants reviewed the Residential Services narrative and had the recommendations, comments and questions recorded below. SAPC also provided updates on some of the items raised from the prior first meeting, during the second meeting:** ▪ **<u>Recommendations</u>** - SAPC needs to advocate for allowing licensed Chemical Dependency Recovery Hospitals (CDRH) to likewise possess an SUD residential treatment license. - Group counseling and patient education services should be allowed to have more than 12 clients in a group due to the volume of clients being served at facilities in Los Angeles County. Providers requested SAPC to advocate to the State on allowing more than 12 clients in a session.

	- Patient education definition should be broadened. Add strength-based language such as “enhanced functioning, greater resiliency, and improved life skills.” Some patients also need special education (SPED) due to cognitive impairment. - Modify patient education phrasing by including promotion of sustained recovery. - Family education is a collateral service which can be billed under patient education, even if the patient does not attend. - Change “assist” to “observe” or “supervise” under the American Society of Addiction Medicine (ASAM) Level 3 Service Components section on Safeguarding Medications as described in the Waiver. - Follow up with the State regarding Multi-Family Therapy Group, as it differs from Family Therapy. - Change the term “counselor” to “personnel” since other LPHA can also provide services that stabilize patients and prepare patients for the lower level of care. Additionally, the provider requested to add “registered interns” since the providers need registered interns to provide services. - Change physical “examination” to “evaluation,” which may include lab exams. Providers suggested that “physical examinations’ needs to be differentiated from “physical health screening.” A physical health screening is where a patient is asked to answer a set of health-related questions upon admission, and the counselor reviews the answers and sign off on the physical screening. The counselor is expected to take appropriate actions in response to the patient’s answers. - SAPC needs to review the current residential treatment requirements and contract language to determine the timeline when physical examination/evaluation must be completed. - Instead of requiring physical and examination/evaluation prior to residential treatment, simply allow providers to indicate in the treatment plan that such has been scheduled, and then proceed with providing treatment. - SAPC’s Contract Program Auditors (CPA) need to be familiar with documentation forms to avoid issuing undue citations. - The providers’ electronic health records systems (EHR) are established by vendors. It may be worth forming a user group of Information Technology (IT) professionals servicing the providers in order to align everyone’s systems. - Define and differentiate between treatment plan “review” and “update”. For instance, treatment plan updates require an LPHA‘s review of necessary modifications made based on the patient conditions. The LPHA will sign the treatment plan approving the update. A review can be completed by a counselor without review by an LPHA. - Change “assessment” into “review and update” on the first sentence of the Assessment section. - A universal EHR shared by the network providers may be able to track patients’ number of episodes in a year. SAPC should look at existing systems that are able to do this, like the Casewatch one used by the Los Angeles County Department of Public Health’s Division of HIV and STD Programs (DHSP). Looking for a system to identify the number of services a patient has already used within 365 days. - Add “criminal justice client” into the definition section due to the specific issues affecting the population.

- Account for the juvenile justice patients' special circumstances and need for treatment services, specific to the County system's context. The Federal Standard Terms and Conditions (STC) do not specify between youth and adult under the criminal justice section.
- Length of stay for youth in residential treatment needs to be on par with adults'. Youths need more attention due to their usual disinterest in SUD treatment, especially at their age, when they are just getting started with drugs. Care should be patient-centered, and not determined based on age.

▪ **Comments**

- If residential patients are likewise receiving withdrawal management services, the level of staffing to monitor them is different from the regular residential treatment requirements. Residential treatment facilities may need an unofficial detox center with a specific license. Facilities will need to secure medication and increase the number of staff.
- Providers with a youth group home license still require ASAM designation. But now, under the Waiver, certification and designation will come in a bundle.
- In a non-medical residential facility, non-medical staff can discuss treatment options, such as Medication-Assisted Treatment (MAT) with patients. However, only licensed prescribers can complete the prescription.
- It is not reasonable for the treatment plan to be completed upon intake. Intake may spread over several sessions. Auditors should understand the treatment modality to avoid undue monitoring citations.
- Providers cannot bill for treatment without the treatment plan being in place. Providers, then, will need to complete it as soon as possible. The current contract states that the initial treatment plan is to be completed within 30 days. The contract language must be specific to reduce auditor misinterpretation.
- Per the SAPC Quality Improvement/Utilization Management (QI/UM) Plan, treatment plans will be updated every 30 days for the residential services. Providers stated that according to the State, treatment plan review should take place every 14 days and should be updated in 30 days. Activities need to be recorded on the progress note. An accompanying progress note should be written to state that the treatment plan was reviewed and/or updated. Youth participants will have a treatment plan for the 30 days they are in treatment.
- The treatment plan can be reviewed and completed by a counselor. However, it needs to be signed by an LPHA. Documentation should reflect that the patient participated in creating the treatment plan. Goals need to be in patient's own words. Plan needs to be signed by the patient, as well as the LPHA.
- Providers serving families need to build capacity to serve them, even if the State will not pay. There are ways of accommodating families in a residential setting.
- Requiring physical examination/evaluation prior to residential treatment can be problematic, and may create bottleneck issues. It is a barrier to enroll people into treatment. In an outpatient setting, the physical examination is done onsite, with a timeframe of 30 days.
- Tuberculosis (TB) tests and/or lab examinations must not be required prior to admission, but rather be completed within 30 days. The TB test and physical exam appointment is set up at the time of intake. More than 50 percent of patients need a physical exam in order to meet the State and Joint Commission on

Accreditation of Healthcare Organizations (JCAHO) requirements. The general rule is for all of the patients to get a physical exam. Medical appointments are often backed up; appointments are scheduled and documented in the patients' progress notes.

- Managed care plans allow granting of service authorizations quickly over the phone. The 24-hour turnaround for authorization approval is an obstacle to care.
- The Assessment section is unclear. It may be a problem when CPAs monitor the programs. We need to stay consistent with the State standards.
- It is against the law to limit patients' residential admissions to two episodes per year. Managed care plans do not set any limit. Such limitation sets our system up for failure and potential lawsuits since it is in violation of the Parity Law. However, the State's position is that the Parity Law does not apply here.
- The last bullet, under Youth Length of Services, is inaccurate. It is better to have it removed. The youth of today are more reckless with their drug use.
- It will not help the youth's recovery to shorten their allowable number of days in residential treatment. They need to have a longer residential stay. Once the youth is settled in the residential treatment environment including registered in a school, it is better to have them in treatment for a longer period of time to keep them from the environment where it got them into the addiction in the first place. It is disruptive to their treatment/recovery if they are taken out of the treatment because of the short length of stay.

▪ **<u>Questions</u>**

- **What shall we do, as non-medical facilities, needing to deal with administering medications to residential patients? Should residential facilities then need to become detoxification centers as well?**
  - *Per residential providers that currently offer MAT, the key issue is that MAT need not be administered in residential settings, but only made available for patients to self-administer. This distinction avoids issues with residential facilities currently being considered non-medical facilities. While this will change with Assembly Bill 848, which allows residential facilities to provide incidental medical services, this legislative change will not be implemented until 2018. Until that time, allowing patients to access and self-administer their prescribed medications, including MAT, is permissible.*
  - *Additionally, it is important to mention that MAT is not limited to withdrawal management (aka: detox), but also includes maintenance therapy (longer term treatment with MAT). Maintenance therapy with MAT with non-methadone medications such as buprenorphine and long-acting naltrexone do not require an ASAM designation so long as these medications are not being used for withdrawal management. Methadone for the treatment of addiction must be prescribed in an Opioid Treatment Program (OTP) setting.*
- **If a residential facility decides to offer MAT, how different would the licensing and certification requirements be?**
  - *The only situations in which a residential facility would require additional licensing and certification to offer MAT would be if they want to offer MAT for withdrawal management (which would require that it be designated as ASAM levels of care within the withdrawal management ASAM level of care continuum), or if the residential facility is aiming to offer methadone, which would require it to be licensed and certified as an Opioid Treatment Program (OTP) given that methadone for addiction treatment can only be provided in*

OTP settings. Aside from these situations, there are no additional licensing or certification requirements at the facility level in order for residential facilities to offer MAT, as described above (allowing patient access to their medications so they can self-administer them). At the physician level, buprenorphine is the only MAT that requires a physician to receive a specific waiver to be able to prescribe this medication for the treatment of addiction. Other MAT can be prescribed without additional requirements at the physician/prescriber level.

- **Is MAT only for addressing alcohol and opioid addiction?**
  - *The pharmacology is evolving. For now, we only have it for alcohol and opioids, but we will expand accordingly, as more medications are approved by the Food and Drug Administration (FDA).*
- **The residential narrative uses several labels: clients, patients, and residents. DMH calls them consumers. Which one do we use?**
  - *Patients. However, it is the quality of services that we provide that will make us a legitimate system, and not mere choice of terminology.*
- **Could independent psychiatric hospitals provide residential services with the necessary license and certification?**
  - *The question will be posed at the next State conference call.*
- **How is the 24-hour structure defined for ASAM Level 3.1? How about accountability? The licensing requirements do not require staff to be awake at night, while the older regulations are loose.**
  - *SAPC will check the regulations, but the group consensus was to keep the language in the narrative.*
- **Should we use the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the ASAM assessment during intake?**
  - *Both are required for establishing medical necessity: which is one DSM substance abuse-related and addictive disorders, with the exception of the tobacco-related disorders, and placement in a level of care based on ASAM criteria.*
- **Can group counseling only have a maximum of 12 people? The Residential Service narrative definition section still indicates so.**
  - *Yes, 2 to 12 people. Medi-Cal disqualifies reimbursement for 13 and more. The 12-person limit is set by the State and not SAPC. The Federal STC document does not distinguish between residential or outpatient. SAPC will continue discussing with the State. Also, the limit of 12 is determined according to an evidence-based practice (EBP), and is approved by both the State and Federal levels. Parameters for psychoeducation may change, but not for group counseling.*
- **What caps are being placed on patient education?**
  - *DHCS will not allow a change in the patient education rate.*
- **Is the same-day transfer within residential services unlimited?**
  - *It is allowable, but the stay has a 90-day limit, with a one time 30-day extension annually. It does not need to be on the same level of care (LOC). A transfer can maximize the 90-day authorization for residential services.*

	- **Why don't we change family therapy to counseling or education?**
	  - *According to the State, family education is a collateral service billed under a corresponding code. Family therapy, on the other hand, is its own category.*
	- **Are there ways of accommodating families in residential treatment? Some women residential service programs require to have children on site, and they must meet child care licensing requirements.**
	  - *Child care is not an allowable cost. There is no financial incentive to include child care and housing for families in the residential treatment LOC. Facilities may also have limits to the number of people on the property.*
	- **What suggestions are there to transition patients who have relapsed to a different LOC instead of discharging them from the program?**
	  - *A network should be established to offer services when patients are in this situation. Providers can systematically work together to coordinate treatment instead of discharging patients from the program. For recovery support services, they can be reimbursed after a patient is discharged from treatment.*
	- **Can we bill for transportation services? What if a patient needs to be sent to General Relief (GR) and other collateral services as part of treatment?**
	  - *Yes, transportation is reimbursable for patients in residential treatment, if it is for accessing treatment that is articulated in the treatment plan and the patient meets the medical necessity criteria. No, it is not reimbursable for transporting children who stay with their parents. Providers can bill using transportation codes already in place.*
	- **Can we bill for patients' laboratory examinations?**
	  - *Yes.*
	- **To what extent are we communicating patient information to the next provider? Are we calling the staff or just transferring documents?**
	  - *Details will be discussed at the future Case Management stakeholder workgroup meeting.*
	- **If a patient steps down to any LOC and transfers to another provider, that is considered one episode used, correct?**
	  - *Yes. However, episode requirements apply only to residential LOCs. There is no limit on treatment episodes for outpatient services.*
	- **How would billing be like for patients stepping down to a different LOC?**
	  - *Per the State, each residential LOC (i.e., 3.1, 3.3, and 3.5) has a different rate and corresponding billing code.*
	- **Under the Waiver, how will the documentation templates developed by SAPC integrate into the providers' existing EHR system so that modifications and alignment do not become cost-restrictive for them?**
	  - *SAPC will have to work with its IT unit to support proper workflow.*
	- **How are the documentation templates reflecting other certifying groups' standards like the Joint Commission's, which may have higher levels of expectation?**

- *SAPC has considered regulatory and certifying requirements. However, the SAPC developed templates may not satisfy all the requirements. The providers are responsible for complying with all the applicable standards.*

- **Regarding documentation, the providers' fear is to be inundated with paperwork resulting in less time for patients and services they need like counseling, in-depth treatment planning, etc. How do we address that?**
  - *Documentation will be essential as we move forward with the Waiver. Documentation records and serves as proof for services provided. The new DMC proposed rates are set high enough to enable the providers to expand on its staffing to ensure the services delivered meets the requisite clinical standards.*
- **Currently, CPAs prefer not to look at the online version of treatment plans. Can we do anything about it?**
  - *SAPC will communicate this observation to the CPAs. They know that we are moving towards the EHR system under the Waiver.*
- **CPAs need to understand the clinical soundness of stepping patients down to any LOC. How will that be addressed?**
  - *The QI/UM unit will assess the patient transition during medical records review that accompanying the requests for authorization for residential services and verification for DMC eligibility.*
- **The narrative indicates a limit of only two residential admission episodes per year. What if the patient only stayed for 10 days the first time, and then two days following that? Does that mean the patient has reached the limit for the year?**
  - *Yes, per Waiver/STC.*
- **Is the one-year period indicated under Adult Length of Services pertaining to calendar or fiscal year?**
  - *The year begins on the date of admission.*
- **Who will track how many episodes and treatment days the patients have had in a year?**
  - *It will be the responsibility of both SAPC' and the providers. At SAPC's level, we regularly review data on patient admissions and discharges.*
- **Will there be additional residential authorization needed after the 60-day length of stay?**
  - *Yes, providers will need to submit a request for authorization twice for the 90 day episode: one for the initial 60 days and another for the remaining 30 days. The provider may request a one-time 30 day extension annually.*
- **Are there any discussion conducted with the Los Angeles County Department of Public Social Services (DPSS) to expedite Medi-Cal eligibility?**
  - *There have been backlogs in approving applications due to the Medi-Cal expansion, with the bulk of new enrollees coming from Los Angeles County.*

- **If a patient becomes DMC-ineligible while in treatment, will providers end up absorbing the cost of services? Are there any safeguards for the providers?**
    - *Providers check the patient's Medi-Cal eligibility monthly. The coverage should be valid at least until the end of the month. Patients can apply for Medi-Cal on the spot. Medi-Cal will retroactively reimburse for services when a patient becomes eligible. Providers will not be able to bill DMC if patients are not beneficiaries. However, other programs like My Health LA or General Relief may be able to pay for the services. The priority goes to low-income individuals. SAPC will have to look for other funding sources, provided medical necessity is met. Case management will be key to refer patients to other needed services.*
- **For now, Probation agents refer criminal justice patients to treatment. Will this remain the same under the Waiver?**
    - *Patients can come into the system through different ways. If patients present themselves at a provider site and meet medical necessity and are DMC eligible, DMC will pay for the DMC reimbursable services. If the services needed are beyond what DMC reimburses for and the patient is part of the Assembly Bill (AB) 109 population for example, AB 109 will pay for the services.*
- **Some judges order the patients to stay up to a year in residential treatment. How does that affect our forthcoming SUD system's requirements?**
    - *SAPC has been talking to judges, district attorneys, etc. regarding our new standards and requirements. It is a cultural shift for the criminal justice system.*
- **What happens if the youth needs more than 30 days in residential treatment?**
    - *DMC only reimburses for the indicated maximum, however, it is possible that other funding sources could cover the cost of a continued stay if medical necessity is met. DMC outpatient, however, is unlimited. Providing field-based services may be another alternative.*
- **Will there be an appeals process for providers regarding reimbursements?**
    - *Yes, it will be discussed at the QI/UM Operational Workgroup meeting.*
- **What would service reimbursement be like when we refer patients residing in Los Angeles County to providers in other counties?**
    - *If the county opted into the Waiver, the referred individual should have access to that County's approved benefit package. If the county did not opt into the Waiver, only the current DMC benefits would be available. The cost of services could be billed back to Los Angeles County and thus coordination needs to happen between counties in terms of billing and treatment authorization.*

▪ **<u>Updates</u>**

- Per the State, CDRH facilities are able to have residential treatment license, with an additional requirement of ASAM designation approval for the LOC provided.
- Further discussion on the appropriateness of requiring physical examination/evaluation prior to residential treatment will be conducted at the QI/UM meetings.

	- Per the State, the cost of accommodating the child or children of residential treatment patients will not be reimbursed. SAPC will then have to see how the service can be supported outside of DMC. - Per the State, transportation to social service sites, schools, etc., where patients need to go while in residential treatment are billable for as long as such were included in their treatment plan and were considered medically necessary.
V. Next Steps	Additional feedback may be sent through SAPC's website or email at SUDTransformation@ph.lacounty.gov. Meeting notes will be posted online, and SAPC will update the Residential Services narrative as appropriate.