

Los Angeles County

DMC-ODS

Drug Medi-Cal Organized
Delivery System

JUNE 2026
Version 11.0



Substance Use Disorder Treatment Services

PROVIDER MANUAL

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Note: Given the continual evolution of the field of addiction treatment, the Provider Manual is a living document that will evolve with the availability of new information and research, changes in policy, regulatory mandates, and/or contractual agreements. As a result, this document is subject to ongoing review and revision at the discretion of the County.



SECTION 1: MODERNIZING SUBSTANCE USE DISORDER TREATMENT

Transforming the Treatment System of Care

California's Drug Medi-Cal Organized Delivery System (DMC-ODS) transformation, coupled with further system advancements for physical health, mental health, and substance use disorder (SUD) services under California Advancing and Innovating Medi-Cal (CalAIM), provides for a more robust and effective system of care for individuals enrolled in or eligible for Medi-Cal, select County-funded programs, as well as other eligible safety net populations.

Additionally, it offers an opportunity for the County to achieve the following:

- Establishing a single benefit package for publicly funded SUD services regardless of referral source or insurance plan;
- Providing the right service, at the right time, in the right setting, for the right duration;
- Raising SUD quality standards to improve health outcomes;
- Integrating physical and mental health service needs with SUD services; and
- Emphasizing SUD's status as a chronic health condition rather than as an acute condition.

These enhancements enable SUD clients to receive quality services tailored to their individualized needs and preferences, thereby improving health and social outcomes.

The Los Angeles (LA) County Department of Public Health (DPH), Substance Abuse Prevention and Control Bureau's (SAPC) Substance Use Disorder Treatment Services Provider Manual, along with other Federal, State, and local regulations¹, govern the delivery of SUD treatment services in LA County. The Provider Manual is specifically designed for use by all administrative and direct service staff to ensure an understanding of the SUD system of care's core values. Additionally, it outlines the clinical and business expectations to ensure quality and outcome-based service delivery.

Substance Use Disorders as Chronic Conditions

SUDs are often chronic, relapsing brain conditions that cause compulsive substance seeking and use, despite harmful consequences to individuals and their social network². A chronic disease, such as cancer, diabetes, or heart disease, cannot be easily or simply cured, but instead needs to be treated, managed, and monitored over time. For example, while an ear infection is considered an acute or episodic condition that requires a fixed period of treatment to obtain a cure, SUDs generally require treatment and management over a much longer period and, at times, throughout a lifetime. While some individuals may develop an SUD and achieve recovery after minimal intervention over a brief period, most will exhibit a more chronic and relapsing course.

¹ [42 CFR Part 2 - Confidentiality of SUD Patient Records](#); [42 CFR Part 438 - Managed Care](#); [Health Insurance Portability and Accountability Act \(HIPAA\)](#); [Title 9 CCR Chapter 8 - Certification of Alcohol and Other Drug Counselors](#); [Title 22 CCR § 51341.1 - DMC SUD Services](#); DMC-ODS Special Terms and Conditions (STCs); State-County Intergovernmental Agreement; DHCS Behavioral Health Information Notices (BHINs); [DHCS's Substance Use Disorder Perinatal Practice Guidelines \(November 2025\)](#); [DHCS's Adolescent Substance Use Disorder Best Practices Guide \(October 2020\)](#); START-ODS Implementation Plan and Finance and Rates Plan; and the DPH SAPC Contract including but not limited to the Specific Services to be Provided, Information Notices (INs) and Bulletins.

² American Psychiatric Association. (2022). Diagnostic and Statistical Manual of Mental Disorders (5th ed., text rev.). <https://doi.org/10.1176/appi.books.9780890425787>.

The chronic nature of SUDs frames the approach necessary to treat these conditions effectively. Chronic conditions need to be managed via a model of care that offers a continuum of services tailored to an individual's needs at that point in time. As an individual advances along their recovery journey, the type and intensity of treatment services they receive should change and reflect the severity and nature of the client's SUD. This approach highlights the importance of care coordination and access to a full continuum of care tailored to meet client needs. As a result, a key goal of SUD treatment is to provide the right service, at the right time, in the right setting, for the right duration.

Wagner's "Chronic Care Model" identifies the essential elements of a healthcare system that encourage high-quality chronic disease care. Effective care of chronic conditions, such as SUDs, is characterized by collaboration with engaged clients, their families and caregivers, and a skilled team of service providers, including counselors and other health professionals. Chronic care systems:

- Create a culture of and mechanisms for providing safe, high-quality care.
- Deliver effective, efficient clinical care and self-management support.
- Promote clinical care that is consistent with scientific evidence and client preferences.
- Organize client and population data to facilitate efficient and effective care.
- Empower and prepare clients to manage their health and healthcare.
- Mobilize community resources to meet the needs of clients.

Defining Client-Centered Care

Treatment retention is crucial to the success of SUD care, as an individual cannot benefit from treatment if they do not participate. Furthermore, one critical component of engaging SUD clients in treatment is the ability to deliver client-centered care that eliminates unnecessary barriers to client enrollment and retention.

Client-centered care is a collaborative approach to SUD service delivery that emphasizes respect for the client and is responsive to an individual's preferences, needs, well-being, and values. Client-centered care does not mean always doing exactly what the client wants. There will be instances when clinical judgment is in the client's best interest yet does not align with every client's ask. However, providers should consider client preferences and values throughout the decision-making process.

Client-centered care requires flexibility from both the providers and the program delivering the services. By cultivating an environment in which clients' individualized needs are prioritized in all aspects of care delivery, SUD programs are better able to engage their clients and better positioned to deliver high-quality care.

Ensuring a Standard Quality of Service

The specialty SUD system is a core component of the more extensive healthcare system. As such, it needs to maintain minimum standards and expectations to ensure high-quality services for the client population served. Similar to managing other chronic conditions, these minimum standards for SUDs ensure a reasonable degree of consistency across provider agencies, while allowing for sufficient flexibility to deliver services tailored to the client's individualized needs. For example, an individual with diabetes may receive slightly different services depending on the provider (i.e., recommendations about dietary/lifestyle changes). Still, certain best practices and clinical standards guide the treatment and management approach.

Similarly, SUD services need to be guided by best practices and clinical standards, including Evidence-Based Practices (EBPs) such as Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT). Standards-based care and individualized care are not mutually exclusive. Provider agencies can offer individualized, client-centered care that meets certain minimum best practices and clinical standards.

Integration and Coordination of Care

A key goal of the specialty SUD system is to better integrate SUD care into healthcare and social service systems and vice versa to better serve the comprehensive needs of its client population. In addition, the specialty SUD system needs to be better organized and coordinated so that clients can effectively access the entire continuum of SUD services and the Level of Care (LOC) available to them.

Integrated care is the routine, systematic coordination of health services to comprehensively and cohesively address clients' diverse needs. An example of care integration is an SUD program that combines primary care and mental health services, all housed within the SUD treatment facility, to address clients with multiple healthcare needs in one location. Integrating social services, such as housing assistance, is also important. Integrated care should make it easier for clients to receive the care they need by making health services more accessible.

Care Coordination is the deliberate organization of client care activities and the sharing of information among care providers to ensure that clients' needs are addressed comprehensively across all their areas of need. Care Coordination needs to be client-centered and driven by a combination of client needs and preferences. It should also be based on clinical judgment, so that the information shared and the care coordinated are in the client's best interests. The primary goal of Care Coordination is to ensure that while multiple health and social service providers may be involved in an individual's care, the services (as listed in [Table 1: Examples of Care Coordination Activities](#)) are organized and coordinated to collectively provide timely, comprehensive, appropriate, and effective care to the client.

Table 1: Examples of Care Coordination Activities

Assessing client needs and goals
Creating a proactive care plan
Monitoring and follow-up, including responding to changes in client needs
Helping with transitions of care
Supporting client self-management goals
Linking to community resources
Working to align resources with client and population needs
Communicating/sharing knowledge
Establishing accountability and agreeing on responsibility

In summary, both integrated and coordinated care can improve outcomes for clients and providers.

SECTION 2: CLIENT SERVICE STANDARDS

Substance Use Disorder Benefit Package

LA County's SUD Benefit Package includes:

- Addiction Medication Services (also known as Medications for Addiction Treatment [MAT] Services)
- Early Intervention
- Intensive Outpatient (IOP)
- Opioid Treatment Program (OTP)
- Outpatient (OP)
- Recovery Bridge Housing (RBH)
- Recovery Housing (RH)
- Recovery Services (RS)
- Residential
- Withdrawal Management (WM)

Services are free of charge to fully covered members and eligible individuals. This comprehensive continuum of care effectively addresses each unique individual's treatment and recovery needs. Further, provider agencies assist clients in transitioning between LOCs as medically necessary to provide care in the least restrictive environment.

Eligibility Determination and Establishing Benefits

Covered Members and Eligible Individuals

The LA County specialty SUD system is available to the safety net population, specifically individuals who are:

- Residents of LA County; **and**
- Medi-Cal enrolled or in the process of enrollment due to presumed eligibility, including those transferring benefits from another County; **or**
- Uninsured individuals who are ineligible for Medi-Cal but meet income requirements; **or**
- Individuals eligible for other State and County programs, specifically:
 - [Assembly Bill \(AB\) 109](#) (including Proposition 36 (2024), Proposition 47, Proposition 57, and PEN 1210)
 - California Department of Health Care Services (DHCS) Women and Children's Residential Treatment Services (WCRTS) – for pregnant and/or parenting women (PPW) residential service providers and clients only
 - California Work Opportunity and Responsibility to Kids (CalWORKs)
 - Clients Ineligible for Federal Funding (CIFI)
 - Drug Court
 - General Relief (GR)
 - Juvenile Justice Crime Prevention Act (JJCPA) program
 - Recovery Support Court (RSC, formerly Family Dependency Drug Court or FDDC)

Medi-Cal Eligibility and Enrollment Changes Under H.R.1

DHCS has issued an implementation plan outlining significant federal changes to Medi-Cal eligibility and enrollment processes under [H.R.1](#). These changes are expected to affect member eligibility, renewal frequency, and coverage continuity, beginning in 2026 and continuing through a phased implementation.

Key changes include, but are not limited to:

- Modifications to eligibility criteria for certain populations
- Increased frequency of Medi-Cal eligibility renewals
- New reporting and verification requirements for eligibility and continued coverage
- Reduced retroactive Medi-Cal coverage and reimbursement periods
- Additional program integrity and data verification requirements

While SUD populations are exempt from work and co-pay requirements, these changes are expected to increase administrative requirements for eligibility determinations and may adversely affect members' ability to maintain continuous coverage.

Provider Agency Considerations

While eligibility determinations are administered at the State and County levels, provider agencies play an important role in supporting members' continued access to care.

Provider agencies should:

- Be aware of potential changes to members' eligibility and coverage status
- Encourage clients to respond to eligibility notices and renewal requests in a timely manner
- Support clients in maintaining engagement in services during periods of eligibility transition
- Coordinate with Managed Care Plans, counties, and SAPC, as appropriate, when eligibility-related issues impact service delivery

Communication and Outreach

DHCS will continue to provide guidance, training, and communication materials to support implementation of these changes. SAPC will share additional information with provider agencies as it becomes available.

For full details regarding eligibility and enrollment changes, provider agencies should refer to the DHCS implementation plan and associated guidance.

County of Responsibility and Residence

Services are eligible for reimbursement only if they are delivered to individuals whose County of Residence or County of Responsibility is LA County and who are treated at a contracted provider agency site.

In accordance with State policy, LA County's SUD Benefit Package follows a County of Residence model of service delivery. This means that individuals need to reside in LA County, and the DHCS Medi-Cal Eligibility Data System (MEDS) file, which is sent to SAPC by DHCS and updated monthly, needs to show LA County as

either the County of Residence or County of Responsibility to receive services. As outlined in [BHIN 24-001](#) and [BHIN 24-008](#), claims are eligible for approval as long as either designation (Residence or Responsibility) is LA County, providing greater flexibility in situations such as inter-county transfers (ITCs) and other specific exceptions, including temporary relocations.

If a new referral or existing member does not reside in LA County and does not intend to move, they need to be referred to a provider in their County of Residence, unless the member is an out-of-county foster youth referred for treatment or being released from jail, prison, or a youth correctional facility (CF). In all other instances, the Provider Agency needs to share the appropriate county's contact information (see www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx).

Provider Agencies should follow the eligibility determination procedures listed in [Table 2: Eligibility Requirements for Specialty SUD Services in LA County](#) or the ICT process shown in [Figure 1: Key Inter-County Transfer Steps](#) to identify the County of Residence and/or Responsibility.

Note: The County of Residence / County of Responsibility rule does not apply to Narcotic Treatment Program (NTP) dosing, individual and group counseling services (H0004, H0005, H0020, S5000, and S5001) if these service codes are claimed with modifiers UA (ASAM OTP/NTP) and HG OTP, see [DHCS's DMC-ODS Billing Manual \(Version 3, July 2025\)](#).

Out-of-County Treatment Facilities

Provider agencies that operate a DMC-certified site in an adjacent county (e.g., Kern, Orange, San Bernardino, Ventura) may apply to add those location(s) to their SAPC contract. In most cases, locations in non-adjacent counties will not be approved unless there are significant service gaps that cannot be filled within the county. This Provider Manual and other contract requirements still apply to out-of-county contracted sites.

Note: Provider agencies that intend to deliver services to non-County residents need to contract with the County where those members reside to be reimbursed.

Opioid Treatment Programs Courtesy Dosing

SAPC allows reimbursement for courtesy dosing of methadone and buprenorphine for up to 30 days for Medi-Cal members who are temporarily in LA County for business or leisure travel. This applies when individuals do not qualify for, or are unable to bring, enough take-home doses to cover the entire duration of their trip. To provide courtesy dosing, provider agencies need to obtain a courtesy dosing order from the individual's home OTP clinic. This order needs to be:

- Signed by the medical director, designated program physician, advanced practice registered nurse, nurse practitioner, or physician assistant.
- Include the dose, duration, and any special instructions (such as take-home doses).

To receive reimbursement, provider agencies need to complete the Courtesy Dosing Reimbursement Form and submit it securely via email to SAPC's Finance Services Division (SAPC-FSD) at Finance@ph.lacounty.gov with the subject line "Courtesy Dosing". This includes the individual's full name, date of birth, Social Security Number (SSN), Medi-Cal Client Index Number (CIN), County/State of residence, home

clinic, dates of service, medication type, Healthcare Common Procedure Coding System (HCPCS), amount billed, and the reason for courtesy dosing. Individuals who receive courtesy doses are not entered in Sage, SAPC's electronic health record (EHR), and no additional data collection is required. Claims need to be submitted after the final dose is administered or dispensed to the individual.

Eligibility Determination Process

Before providing services, provider agencies need to verify that the individual is eligible for LA County's SUD Benefit Package and should follow the steps outlined in [Table 2: Eligibility Requirements for Specialty SUD Services in LA County](#).

Table 2: Eligibility Requirements for Specialty SUD Services in LA County

	Eligibility Requirement	Source of Verification
Step 1	Resident of LA County	Proof of residence (e.g., identification card, utility bill, etc.)
Step 2	Medi-Cal or County Program Eligibility Need to meet at least one (1) of the following: • Medi-Cal enrolled or in the process of enrollment due to presumed eligibility, including those transferring benefits from another county; or • Medi-Cal ineligible but meets income requirements; or • Clients in programs listed under the Covered Members and Eligible Individuals section.	• Utilize the 270/271 real-time Medi-Cal Eligibility Verification process in Sage, to verify Medi-Cal status through the State system. This process automatically updates the Financial Eligibility status in Sage if the member is enrolled in Medi-Cal. • Medi-Cal application submitted or Medi-Cal verification via Automated Eligibility Verification System (AEVS) file or MEDSLITE. • Once Medi-Cal is active, update the Financial Eligibility form in Sage with the client's Medi-Cal Eligibility Data System Identification Number (MEDS ID), policy number, and coverage effective date. • Participation in other qualified County-funded programs/projects.
Step 3	Meet medical necessity criteria to initiate specialty non-residential SUD services (see Determining Medical Necessity section).	• Services are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain (California WIC § 14059.5(a)). • For OTPs, a history and physical exam conducted by a Licensed Practitioner of the Healing Arts (LPHA) at admission, pursuant to Federal and State regulations, qualify for the determination of medical necessity.
Step 4	Meets medical necessity access criteria for specialty SUD services (see Determining Medical Necessity section).	ADULTS (AGE 21 AND OVER) • Complete an American Society of Addiction Medicine (ASAM) CONTINUUM™ assessment* for non-WM, non-recovery service LOCs within the timeframes outlined in Table 4: Service Connection Process; and • Document clinical justification for WM through the ASAM CONTINUUM™ Assessment or through directly documenting the client's withdrawal features, during the WM episode. • Need to meet criteria for at least one (1) diagnosis from the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, except for Tobacco-Related Disorders and Non-Substance-Related Disorders; or • Meet criteria for at least one (1) diagnosis from the current DSM for Substance-Related Disorders and Non-Substance-Related Disorders prior to being

	Eligibility Requirement	Source of Verification
		incarcerated or during incarceration, as determined by substance use history. YOUTH (AGE 17 AND UNDER) AND YOUNG ADULTS (AGE 18-20) - Youth (age 17 and under): Complete the Assessment Tool - Youth (Paper Version) found on the SAPC website, which serves as the youth ASAM assessment*, is required; Parental consent <u>is not</u> required for services delivered to youth age 12 and over, but <u>is</u> required for services delivered to youth age 11 and under. - Young Adults (age 18-20): Complete the ASAM CONTINUUM™ Assessment* within the timeframes outlined in Table 4: Service Connection Process and Meet criteria for the DSM criteria specified for Adults (age 21 and over). - For Youth and Young Adults being admitted to early intervention services, meet Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) criteria to ameliorate or correct a substance misuse-related condition and submit a completed ASAM screener for Youth and Young Adults within the specified timeframes. Services need not be curative or completely restorative to ameliorate a substance use condition, including substance misuse and SUDs. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services. For additional information, see Definition of Early Intervention Services for Youth and Young Adults section.

*Admission to WM services does not require a full ASAM assessment. RS requires the completion of ASAM CO-Triage® Tool for Adults (age 21 and over) or ASAM Screener for Youth (age 17 and under) and Young Adults (age 18-20).

Note: Provider agencies need to use the 270/271 process to determine a client's Medi-Cal eligibility before admission or authorization for services. Failure to do so may result in non-payment for claims submitted or services rendered to clients under the 30-day policy.

The Real Time Inquiry (270) Request Form in Sage allows provider agencies to request Medi-Cal eligibility directly from DHCS in real-time. Once submitted, provider agencies will receive an immediate response via the 271 file to determine a client's current or previous Medi-Cal eligibility status. The 271 results will display the County of Responsibility code, gender, date of birth, and Primary Aid Code, which are updated as of the date the 270 is run. However, the 271 does not contain the County of Residence code. If the County of Responsibility shown is not LA County (19), this may require filing for an ICT, and provider agencies will need to determine whether the client's County of Residence is LA County (19) using BenefitsCal. If there are additional questions after using BenefitsCal, provider agencies may also contact SAPC to verify the information using the MEDS/MEDSLITE systems. For assistance, contact SAPC's Eligibility Support Team (EST) at SAPC-EST@ph.lacounty.gov and ensure that Protected Health Information (PHI) is sent by encrypted email.

After the 271 responses are posted in Sage, the aid code and eligibility information will be updated in the MEDS file, and the Financial Eligibility forms to reflect the most current data. Provider agencies need to run the Real Time Inquiry (270) Request on a monthly basis to ensure Medi-Cal eligibility remains current in SAPC's system. For guidance on interpreting the 271 eligibility results, see [SAPC's Sage - Other Training Resources webpage](#).

It is the provider agencies' responsibility to assist clients in maintaining their Medi-Cal benefits if they remain eligible by using the Care Coordination benefit. If a client becomes no longer eligible for Medi-Cal while in treatment, and the treatment duration extends beyond the end of the month in which the termination occurred (as services would continue to be reimbursable by DMC during this period), the following should occur:

1. Determine if the client is eligible for programs listed under the [Covered Members and Eligible Individuals](#) section:
 - a. If **YES** – client's treatment would be moved to the secondary funding source; this would apply to any LOC listed in the most current version of the SAPC Information Notice (IN) for the Rates Matrix.
 - b. If **NO** – continued SAPC payment will depend on the LOC:
 - i. Residential (ASAM 3.1, 3.3, 3.5) – If the Provider Agency elects to continue providing services to the client beyond the service authorization period, it needs to be on a sliding-scale basis with no financial participation by SAPC.
 - ii. OP (ASAM 0.5 Early Intervention Services, 1.0, 2.1) – SAPC ceases payment for services. In instances where the Provider Agency elects to continue providing services to the client, it needs to be on a sliding-scale basis. Medi-Cal-eligible members may NOT be charged sliding-scale or flat fees.
 - iii. Withdrawal Management (ASAM 1-WM, 2-WM, 3.2-WM, 3.7-WM, 4-WM) – Contact SAPC's Utilization Management Section (SAPC-UM), as this situation is very rare since the maximum duration is 14 days.
2. If the client remains in treatment, modify the Financial Eligibility to reflect the funding source change.
3. If the client remains in treatment and is qualified for the Client Ineligible for Federal Programs (CIFP) the current and open CalOMS Admission record needs to be discharged using the end date of the Medi-Cal program. Then, open a new CalOMS Admission form identifying CIFP under Other Funding Program. This is for internal management of funding sources and to facilitate the coordination of State CalOMS data submission. For additional information, see [Data Reporting Requirements](#) section.

Establishing and Transferring Benefits

Provider agencies must use the Care Coordination benefit to:

- Assist individuals to obtain Medi-Cal if qualified, if benefits are not active at the time of first contact. Provider agencies need to initiate the process on or before the date of the treatment service to better ensure reimbursement for delivered services.
- Assist LA County residents in transferring Medi-Cal benefits to LA County if assigned to another County on or before the date of the first treatment service. Reimbursement will be denied for service claims for non-County residents.
- SAPC's recommended means of managing Medi-Cal enrollment is to assist the client in enrolling in a BenefitsCal account. A new Medi-Cal application can be submitted via the BenefitsCal portal, and access to all notices and requirements for maintaining established benefits is available.

Eligible clients cannot be denied services while their Medi-Cal enrollment is being established. Provider agencies may not charge sliding-scale or flat fees to individuals eligible for Medi-Cal or other County-funded programs. For additional information, see [Applying for Medi-Cal](#) section.

Provider agencies also need to meet access to care requirements, which necessitates that the date of the first service or intake appointment occurs no later than 10 business days from the date of referral or screening for all LOCs except OTPs, which need to occur no later than three (3) business days from the date of referral or screening for these individuals as well.

Medi-Cal Inter-County Transfers

When an individual resides in LA County, but their Medi-Cal benefits are assigned to another county, Provider agencies need to conduct the screening/assessment and admit the member for medically necessary services while the ICT process is underway. **Members cannot be delayed or denied admission for eligible (i.e., Medi-Cal, [AB 109](#)) SUD treatment services due to an incomplete or pending application, or because their Medi-Cal benefits are assigned to another County.** As long as the individual has active Medi-Cal coverage, they are considered a Medi-Cal member, and the Sage Financial Eligibility form needs to list DMC as the primary guarantor at the time of admission.

When Medi-Cal members move to LA County and seek treatment, the receiving Provider agency needs to initiate care and concurrently begin the ICT process, as demonstrated in [Figure 1: Key Inter-County Transfer Steps](#).

Figure 1: Key Inter-County Transfer Steps

Preferred Option 1: Using BenefitsCal Website	Assist the client in creating a new account or signing into an existing account on the BenefitsCal website. With client consent, complete the MC382/383 form to allow the provider to serve as an authorized representative on the client's behalf, facilitating further updates. Once completed, upload it into the client's BenefitsCal account and the client's chart in Sage. Link the client's case from the originating county to LA County. Medi-Cal benefits will show as pending in LA County. If a DPSS Case # or demographic information is needed to complete the linkage, contact SAPC's EST at DPH-SAPC-EST@ph.lacounty.gov. It will become active once the County of Responsibility has transferred. After completing the updated residence in BenefitsCal, download or print the resulting Change Report Summary (CRS) and upload it to the client's chart in Sage. SAPC-UM will honor the CRS effective date as meeting funding requirements when approving the Member Service Authorization Request (SAR).
Option 2: Working with DPSS	Contact the local LA County Department of Public Social Services (DPSS) office and report the change of residence. Any contact with DPSS regarding a transfer of residence could potentially result in a delay of several weeks if the transfer of residence is coupled with the transfer of responsibility, which requires additional time. Or call the DPSS Customer Service ICT Hotline at (866) 613-3777. Press 1 for English; after the recording, press 5 for Disability Accommodation and Other Hotlines; then press 3 for Benefits Transfer Request. Notify the DPSS Eligibility Worker (EW) that your client needs to transfer their existing DPSS case from the originating county to LA County. Conducting the transfer in this manner may associate the transfer of residence with the transfer of responsibility, which could cause a delay of several months. A Notice of Action (NOA) confirming the county transfer and effective date will be mailed via USPS to the client at their recorded address. Upload the NOA to the client's chart, as SAPC-UM will use the effective date to authorize the treatment Start Date. While not recommended, the client may also contact DPSS in person via phone. Please note that this method may initiate a transfer of both County Responsibility and Residence, which can take one (1) to three (3) months to transfer to LA County and will not be retroactive to the request date.
Provider Agency	Complete a Care Coordination Progress Note in the client's chart for all actions taken to support the ICT process. After one (1) to three (3) weeks, contact DPH-SAPC-EST@ph.lacounty.gov to confirm the transfer of residence or wait until AEVS provides confirmation that the County of Responsibility is LA County, which generally takes one (1) to three (3) months. Submit a SAR using the effective date on the NOA or CRS or with confirmation of County of Residence 19 in MEDS or MEDSLITE as the Start Date. Select DMC as Guarantor in the Financial Eligibility form and enter the Effective Date in the Coverage Effective Date found on the NOA/CRS, the date found on the client's Medi-Cal card, or the Issue Date indicated in MEDSLITE. While the transfer of residence is being processed, the provider may use any non-DMC funding available under Other Funding Programs in CalOMS for which the client qualifies. In that case, select non-DMC as the guarantor and bill accordingly. Once the County of Residence is transferred to County 19 and all claims to the non-DMC funding source have been submitted, change the guarantor to DMC and bill accordingly. To access the DHCS Provider Portal, follow the AEVS General Instructions and register as a treatment service provider.

In some cases, Medi-Cal members may become incarcerated while their benefits are active. Per [DHCS Letter No. 22-26](#), Medi-Cal benefits are placed in suspension at the time of incarceration. Upon release, the member's release date may not be automatically updated in the DPSS electronic system. As a result, the DHCS Provider Portal may continue to indicate that the member is incarcerated. To restore benefits, the member needs to contact DPSS to ensure their release date and suspend end date are accurately entered into the system. Once this information is updated in the DPSS electronic system, Medi-Cal benefits will be reinstated effective the date of release, allowing the member to receive Medi-Cal billable services upon admission to a provider agency.

For additional information, see DHCS's [Definitions of Incarceration Date, Release Date, Suspend Date, and Suspend End Dates Table](#).

Applying for Medi-Cal

As outlined in [SAPC IN 23-01](#), the "Applying for a Medi-Cal" benefit allows provider agencies to receive reimbursement in advance for eligible clients who are in the process of applying for Medi-Cal. This supports the requirement that provider agencies do not deny admission or services to individuals who are presumed to meet the Medi-Cal eligibility criteria.

To support timely access to care, SAPC may reimburse provider agencies for up to 30 calendar days of treatment services when all of the following conditions are met:

- Client has been admitted and assessed;
- Real Time Inquiry (270) Request has been submitted;
- Authorization has been obtained;
- CalOMS/LACPRS has been completed for clients who appear to meet Medi-Cal eligibility criteria; **and**
- Client has submitted a Medi-Cal application, has been assigned a CIN, and the application has not been processed by the 30th day or was ultimately denied by the State.

Note: Only one (1) 30-day reimbursement is allowed per client, per Fiscal Year (FY) system-wide, regardless of agency or LOC. This does not apply to clients who lose Medi-Cal coverage during a treatment episode and submit a new application.

When using this benefit, provider agencies need to enter "Applying for Medi-Cal" as the primary guarantor on the Financial Eligibility form in Sage. This designation can only be used when the client does not have active Medi-Cal at the time of admission and cannot be used to indicate an ICT.

When Medi-Cal benefits are approved, SUD treatment services are reimbursable effective the first day of the month in which eligibility is established. In some cases, coverage may be applied retroactively for up to three (3) prior months. Effective January 1, 2027, retroactive coverage will be limited to one (1) prior month for individuals who were newly eligible for Medi-Cal after the Affordable Care Act (ACA) and two (2) prior months for those who were previously eligible for Medicaid prior to the ACA (ACWDL-26-07).

To minimize gaps in coverage and reimbursement, providers should initiate the Medi-Cal application process as close to the first date of service as possible, although applicants may request retroactive coverage for up to one year from the month Medi-Cal services were received. Provider Agencies must also ensure the following:

- Clients may step up or step down to a different LOC whenever clinically appropriate, with documentation of medical necessity (e.g., from WM to OP). This supports continuity of care and allows additional time to secure Medi-Cal eligibility; **and**
- When there is a change in LOC, the initial care coordinator communicates the status of the client's benefits application to the new care coordinator. The initial Provider Agency will rely on the subsequent Provider Agency to help the client complete any remaining paperwork to ensure both parties can be reimbursed once the application is approved.

Table 3: Financial Eligibility Form Process for Medi-Cal Eligible

Status	Financial Eligibility	Financial Eligibility Form	Authorization Process	Claiming Information
Medi-Cal Eligible or Enrolled:	When applying for Medi-Cal (i.e., Medi-Cal is pending).	Select: 1. "Applying for Medi-Cal" as primary guarantor; and 2. "LA County - Non-DMC" as secondary guarantor.	Authorizations will be granted for no more than 30 days.	Submit claims for services provided up to the 30th day of treatment.
	Once approved for Medi-Cal	1. Update "Applying for Medi-Cal" to "California Department of Alcohol and Drug" for the primary guarantor. 2. Make sure "LA County - Non-DMC" is selected as a secondary guarantor.	Once a client is approved for Medi-Cal, the provider should submit subsequent reauthorizations utilizing DMC as the funding source. A new authorization is not required prior to the end of the existing authorization.	Once Medi-Cal has been approved and the Financial Eligibility Form has been updated, submit claims following the usual process.
	If a client has been denied Medi-Cal but is eligible for programs listed under Covered Members and Eligible Individuals section.	1. Delete "Applying for Medi-Cal" as the primary guarantor. 2. Update the primary guarantor to "LA County - Non-DMC" . It is required that all payor sources a client qualifies for are identified and updated on their CalOMS.	Authorizations will be granted for the full period of time for the type of service being requested within the eligibility period.	Once Medi-Cal has been denied and the Financial Eligibility Form has been updated, submit claims following the usual process.

Definitions of Eligible Plans

Medi-Cal Managed Care

Medi-Cal Managed Care Plans (MCPs) in LA County include LA Care Health Plan (and its delegated partners: Anthem Blue Cross and Blue Shield Promise), Health Net Community Solutions (and its delegated partner: Molina Healthcare), and Kaiser Foundation Health Plan. Other Medi-Cal specialty health plans serve specific populations, such as Positive Health Care California (for individuals with Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome [HIV/AIDS]) and SCAN Health Plan (a Medicare Advantage plan for seniors).

Most Medi-Cal members are required to enroll in an MCP. A complete list of LA County Medi-Cal MCPs is available on the [DHCS Health Plan Directory website](#). Treating Providers can verify members' Medi-Cal plan through the Medi-Cal eligibility portal if members do not have a physical member card. All public MCP members are entitled to receive LA County's SUD Benefit Package. Treating Provider Agencies are responsible for coordinating care, as appropriate, with the member's primary care physician and informing the member's Health Plan of any referrals to covered services.

Note: Some MCPs, such as Kaiser and Anthem Blue Cross, offer both private commercial and Medi-Cal plans. Clients cannot be turned away solely on the basis of their health plan name; instead, provider agencies need to verify whether individuals are enrolled in Medi-Cal MCP plans. Staff need to always verify Medi-Cal eligibility before determining coverage.

Medi-Cal and Medicare: "Medi-Medi"

Individuals who are dually eligible for Medi-Cal and Medicare, often referred to as "Medi-Medi" members, are entitled to the full DMC benefit package, including any County-specific supplemental services such as RBH. Medicare must be billed before Medi-Cal, including Medicare or the Medicare Advantage insurance plan. If the service is denied or partially paid, the service can then be billed to SAPC.

When determining if a service requires billing to Medicare, Treating Provider Agencies must follow the criteria as outlined by DHCS, described below.

The Rates Matrix includes the column, "Medicare COB Required" on the Billing Rules tab. This column indicates whether the code is required to be billed to Medicare prior to billing DMC.

- If the service is not required to be billed to Medicare before Medi-Cal, this column will indicate "No":
 - The service delivered to a Medi-Medi client can be billed directly to SAPC.
 - The claims do not require denial information from Medicare.
- If the service is required to be billed to Medicare before Medi-Cal, this column will indicate "Yes".
 - The service delivered to a Medi-Medi client must be billed to Medicare before billing to SAPC.
 - The claims must indicate allowable denial or partial payment information; otherwise, the service will be denied by Medi-Cal.
 - An **exception** is if the service was delivered by a practitioner who does not meet Medicare requirements, in which case the service can be billed to Medi-Cal first if the claim includes the HL or GC modifier to override DHCS's requirement for billing Medicare:

- Use “HL” modifier for all licensed-eligible LPHAs, Licensed Professional Clinical Counselors (LPCCs) that do not meet Medicare’s requirements, or Licensed Marriage and Family Therapists that do not meet Medicare’s requirements.
- Use “GC” for physician residents.

Medicare education requirements for LPCCs and Licensed Marriage and Family Therapists (LMFTs) differ from those for Medi-Cal. For LPCCs and LMFTs, Medi-Cal allows for Medicare billing to be overridden with the use of the HL modifier if part of the individual’s 3,000 hours or two (2) years of clinical supervised experience were accrued before the individual obtained the applicable doctor’s or master’s degree.

For more information on billing for Medi-Medi clients, please review the [SAPC Other Health Coverage Provider Billing Manual](#). If assistance is needed in determining whether Medicare is required to be billed prior to Medi-Cal, please open a Sage Help Desk ticket using the [Request Billing Assistance Form](#).

Medi-Cal and Private Insurance

If an individual has private insurance (e.g., employer-sponsored, small-group, or individual commercial insurance) and is enrolled in Medi-Cal, the private insurance (OHC) coverage must be fully utilized before Medi-Cal coverage can be accessed. Medi-Cal is the payor of last resort.

Medi-Cal and Share-of-Cost

Some Medi-Cal members are required to contribute to the cost of their treatment through a share-of-cost. These individuals need to pay out of pocket until their monthly share-of-cost (deductible) is met. This “spend down” clears the client’s share-of-cost liability. Once the share-of-cost is met, the client becomes eligible to receive Medi-Cal-covered services for the remainder of that month.

As a reminder, health plans often have commercial and Medi-Cal lines of business. It is possible that a well-known commercial plan (e.g., Kaiser, Anthem) covers members who are also eligible or enrolled in Medi-Cal. Provider Agencies need to serve all eligible or enrolled clients in Medi-Cal, including those enrolled in Medi-Cal through the health plans in LA County, including LA Care, Health Net, Kaiser, Anthem, Blue Shield, and Molina.

Non-Medi-Cal Eligible Clients

The specialty SUD system in LA County also serves individuals enrolled in County- and State-funded safety net programs. As a result, there may be instances where individuals who are not eligible for Medi-Cal, often due to income above Medi-Cal limits, seek treatment services through the SUD system.

Admission is permitted for individuals who participate in any of the programs listed under the [Covered Members and Eligible Individuals](#) section, even if they are not Medi-Cal eligible. These individuals are eligible to receive the full SUD benefit package at no cost, provided their CalOMS admission data reflects participation in one (1) of the eligible programs.

SAPC does not provide reimbursement for services for individuals who have commercial insurance, are not eligible for Medi-Cal, and are not enrolled in one (1) of the programs listed under the [Covered Members and Eligible Individuals](#) section. In these cases, SUD providers may choose to serve the individual and may collect payment directly from the client using the Client Fee Determination Scale (sliding scale).

Note: Sliding-scale or flat fees are not permitted for individuals with Medi-Cal or for those enrolled in permitted County-funded programs.

Access to Care

Access to care includes both biopsychosocial and physical access to the locations where treatment services are provided. Barriers to access may prevent or delay individuals from receiving care. Common access barriers include:

- **Timely access:** Delays in conducting the initial screening and assessment or placing prospective clients on unofficial waitlists instead of assisting with connections to another appropriate and available Provider Agency.
- **Physical:** Facilities that are not accessible to individuals with mobility limitations, such as buildings with stairs but no ramp or elevator.
- **Communication:** Lack of capabilities to engage with non-English monolinguals or those with Limited English Proficiency (LEP), hearing, or visually impaired people, or those who do not answer the phone lines during business hours as listed on the SBAT.
- **Privacy:** Lack of soundproofing in counseling areas or insufficient privacy in assessment rooms.
- **Business operation:** Staff attitudes that reflect stigma or bias, limited cultural or linguistic diversity among staff, restricted operating hours, or lack of opportunities for client feedback in treatment planning or program design.
- **Geographic:** Program locations that are inaccessible by public transportation, distant from where clients live, or situated in areas where clients do not feel safe.

Provider agencies are expected to implement practices that address and reduce the barriers outlined above, including minimizing geographic limitations, to improve access to care. These efforts must align with all applicable Federal, State, and local regulations. Importantly, access to medically necessary services, including all United States Food and Drug Administration (FDA) approved medications for opioid use disorder (OUD), cannot be denied for members who meet criteria for DMC-ODS services. Placing members on waitlists is strictly prohibited. Access to care begins at the first point of contact. There are three (3) main ways individuals can enter LA County's specialty SUD system, with various resources to facilitate service access:

- Substance Abuse Service Helpline (SASH): Toll-free line at (844) 804-7500
- Client Engagement and Navigation Services (CENS)
- Direct-to-provider self-referrals

Resources to support referrals into the specialty SUD system include:

- **SBAT:** Web-based, filterable provider directory of specialty SUD services and bed availability contracted through SAPC, see [SUDhelpLA.org](https://www.SUDhelpLA.org).
- **RecoverLA:** Mobile-friendly platform offering information on available SUD services throughout LA County, including a mobile version of SBAT. See www.RecoverLA.org using a mobile browser for best performance.

Ensuring timely access and reducing barriers to care are fundamental priorities for the specialty SUD system. Provider agencies need to make every effort to reduce the time between the initial eligibility verification, clinical need determination, referral, and the first clinical encounter.

Service Connection Portals

LA County operates two (2) service connection portals to facilitate efficient entry into the SUD system of care:

- **SASH:** SUD Counselors are available 24/7, 365 days a year to provide screening, assessment, and referrals for youth, adults, and collateral callers.
 - Conduct the ASAM Screener for Youth (age 17 and under) and Young Adults (age 18-20), or the ASAM CO-Triage® Tool for Adults (age 21 and over), to determine the appropriate provisional LOC.
 - Assess all callers, including collateral callers, for an appropriate LOC and provide an intake appointment when screening criteria are met (e.g., eligibility, client willing to enter treatment).
 - Facilitate a successful referral and linkage to treatment.
 - Provide language assistance and Teletype (TTY) services at no cost.

Note: SASH and the Los Angeles County Department of Mental Health (DMH) ACCESS Helpline now comprise a centralized behavioral health call center called the Los Angeles County Help Line for Mental Health and Substance Use Services. Callers can access either mental health or substance use service assistance by dialing (800) 854-7771. For substance use services, select option 2 after the language prompt. To ensure uninterrupted access to substance use services, the dedicated SASH phone number – (844) 804-7500 – will remain active and automatically route to the centralized call center.

- **CENS:** SUD Counselors are co-located at various County facilities, permanent supportive housing (PSH), interim housing (IH), and area office sites during varying hours.
 - Conduct the ASAM Screener for Youth (age 17 and under) and Young Adults (age 18-20), or the ASAM CO-Triage® Tool for Adults (age 21 and over), to determine the appropriate provisional LOC.
 - Facilitate a successful referral and linkage to treatment.
 - Additional services include: outreach and engagement, eligibility determination and benefits enrollment, SUD educational sessions, service navigation, and referrals to ancillary supports.

Each of these portals follows standardized procedures for screening, referrals, and follow-up. Provider agencies are expected to respond consistently to referrals and intake requests, regardless of the originating portal.

Summary of Service Connection Portals Referral Process

Table 4: Service Connection Process

	Action	Description
1	Initial Contact	SASH • Caller phones the helpline and selects 2 after the language menu for substance use • Begin screening, assessment, and referral to treatment CENS • External referrals should attempt same-day contact and schedule screening if needed. • Notify the referring entity • Individuals may also self-initiate and begin the process immediately.
2	Interpretation & Accommodation Needs	• Connect to interpreter during call/visit • Confirm any accommodations (e.g., sensory impairment)
3	Emergency Screening	Is the individual experiencing a medical or psychiatric emergency? • Yes, call 911, remain until responders take over or transfer to DMH line • No, continue the referral process
4	Eligibility & Income Verification	• If eligible: Continue the referral process • If <u>not</u> eligible: Check eligibility for other covered programs, see Covered Members and Eligible Individuals section.
5	Screening for Provisional LOC	• Adults (age 21 and over): ASAM Co-Triage ® • Youth (age 17 and under) & Young Adults (age 18-20) (if needed): Youth and Young Adult Screener • If the individual refuses referral: Provide supportive resources and information on RecoverLA. • If “negative results” but reasonable suspicion exists, refer to non-residential LOC for assessment during engagement period. • If individual declines treatment, alternative options (e.g., prevention, CENS Adult At-Risk Services) need to be provided in the community or offered by the Medi-Cal MCP, if applicable.
6	Identify Treatment Provider Options	• Use SBAT directory to identify the appropriate provider site • Confirm availability (beds, intake slots) • If the individual has used Opioids within 30 days, offer OTP/MAT referrals
7	Scheduling & Timely Access	• Provide up to three (3) provider choices • Contact providers with the individual present (phone/in-person) • Schedule intake according to SAPC Access and Services Delivery Standards ◦ 10 business days for RES and OP ◦ Three (3) business days for OTP ◦ 48 hours for WM • If preferred LOC is unavailable: offer lower LOC temporarily • Refer eligible Out-of-Network requests if appropriate
8	Documentation	Enter all encounter details into the Sage Service Connections Log.

Provider Agency Responsibilities for Service Connection Portals and Direct Referrals

Provider agencies have the following responsibilities regarding referrals from SASH, CENS, and other provider agency referrals:

- Update the SBAT at least daily to reflect the number of available beds/or intake appointments, and other required information.
- Contact your SAPC Contract Program Auditor (CPA) to complete an SBAT survey within five (5) business days when updates need to be made to:
 - Days;
 - Hours of operation;
 - Specialized expertise such as language capability or populations served; and
 - New site locations.
- Respond timely to all service connection portals.
- Provider agencies are required to ensure the phone number listed on the SBAT is answered at all times during normal business hours and during intake appointment times; see [Hours of Operation](#) section. This ensures that an appointment can be scheduled while the individual is on the line or at the screening interview, whenever possible.
 - Voicemail and extensive prompt systems are not acceptable alternatives to an individual answering the phone.
- When a caller leaves a message for a provider with a SASH entryway portal, Provider Agencies must document their client callback attempts in the Referral Connection/Appointment Disposition Log in Avatar.
- Care coordination should be conducted directly by the provider site to refer clients within the provider network; provider staff should not use entryway portals to find client placement.
- Provider Agencies should utilize the client pull-forward option in Avatar to view the ASAM Co-Triage screening results conducted by the referring entryway. Additional screening questions must not duplicate previously collected information and should be limited to under 10 minutes to maintain patient engagement.

For provider agency referrals to another treatment provider agency, the following outlines the requirements:

- If there is no answer or the calls go straight to voicemail, staff can proceed to the next provider agency site that meets the individual's needs and preferences.
- Ensure the capability to assess and admit clients who require language assistance services, and/or have sensory (visual/hearing) limitations, even if facility staff cannot perform this responsibility, and/or have mobility limitations, including the ability to accommodate service animals.
- Limit additional screening questions to only allowable programmatic restrictions (e.g., arson or registered sexual offender status, tobacco use), refrain from duplicating questions from the ASAM CO-Triage® Tool for Adults (age 21 and over) or the ASAM Screener for Youth (age 17 and under) and Young Adults (age 18-20) to create a more client-friendly experience, and support efforts to limit total call-time to 10 minutes or less.
- Schedule intake/assessment appointments within three (3) calendar days of the call, and subsequent immediate admission if medical necessity is established.

- Conduct a reminder call in advance of the appointment, and if the appointment is missed, whenever the individual provides a contact phone number.
- Schedule an appointment with another appropriate provider agency after the in-person assessment if it indicates a different recommended LOC and:
 - A bed/slot is not available within five (5) business days at an assessing provider agency site, or it does not offer that LOC; **or**
 - A bed/slot is not geographically convenient to the individual or does not meet preference; **and**
 - Using the SBAT tool, provide at least two (2) referral options whenever possible and contact the selected provider agency to schedule an appointment on behalf of the individual.
- Use the Care Coordination benefit to assist enrolled clients in transitioning between treatment LOCs and successfully connecting with the receiving provider agency. Management of these transitions is the responsibility of the referring provider agency.
- All providers making referrals to another provider agency must complete the Referral Connection Form documenting the client's appointment status, scheduled date, and time as applicable, full ASAM assessment status, admitted LOC if different from the provisional LOC, treatment admission details, and admission counselor's name.

Additional Responsibilities of the CENS

- Educate the individual on the benefits of signing a Release of Information (ROI) that includes each Provider Agency, not just the specific provider agency receiving the referral, for Care Coordination purposes, and obtain a signed release if agreed upon. Also, obtain an ROI with the referring and other applicable entities to allow communication for Care Coordination and reporting purposes, if necessary.
- Provide ancillary service referrals for vocational rehabilitation, educational needs, housing, and other public social services when identified as a need.
- Coordinate transportation as necessary to support the individual's ability to attend the appointment.
- Conduct a reminder call in advance of the scheduled appointment and reschedule if requested by the individual.
- Follow up with the selected provider agency to ensure documentation of whether the client did or did not attend the assessment appointment within the SUD Treatment Referral Tracking Form.
- If an ROI is signed and as directed by SAPC, report back to the referring entity through relevant data entry systems on the status of the individual's connection to services.

Member Support

SAPC's Member Support team is available during normal business hours to assist clients in understanding their benefits and rights, as well as in submitting complaints/grievances or appeals. Member Support collaborates with providers to enhance the client experience at their sites, including providing technical assistance on how to effectively utilize member orientation videos and the member handbook. To contact the Member Support team, members can email MemberServices@ph.lacounty.gov at any time or call (888) 742-7900 and press 7, Monday through Friday, from 8:00 a.m. to 5:00 p.m.

Client Engagement and Navigation Services

Since many youths, young adults, and adults are referred for SUD treatment by State, County, city, or other government entities, ensuring successful connections for these multi-systems involved individuals is important. Often, prospective clients may require more hands-on assistance to maximize treatment admission and retention, as well as the likelihood of positive outcomes, including employment, income benefits, health benefits, housing, reunification with children, and satisfaction of probation requirements or pre-plea/post-plea diversion from the court system. CENS counselors are, at a minimum, State-registered or Certified SUD Counselors who serve as liaisons between individuals, their case workers, and the specialty SUD system. CENS counselors provide services, in-person or via phone, to facilitate access to and completion of SUD treatment.

CENS conducts various activities, including screening and referrals to SUD services, client education, Medi-Cal eligibility and enrollment assistance, and navigation services. In accordance with State guidance, [BHIN 23-001](#), effective November 30, 2023, SAPC issued [SAPC IN 23-13](#), directing the CENS providers to bill DMC for services provided to Medi-Cal members via their applicable DMC-ODS contract with SAPC. To bill DMC for CENS activities, providers will deliver the RS benefit to Medi-Cal-enrolled individuals. The services need to be provided at approved co-located CENS sites or at a DMC-certified CENS Area Office site for OP treatment services. All CENS activities that are delivered to individuals not enrolled in Medi-Cal will continue to be billed under the CENS Staff Hour contract. Billing for DMC reimbursable activities will be submitted through Sage. **All CENS services that are reimbursable to DMC must be billed to DMC rather than billed under the CENS Staff Hour contract. SAPC will be monitoring this CENS requirement is followed to ensure compliance.**

For additional information, please refer to the CENS Standards and Practices available on the SAPC website under the “Manuals & Guides” section on SAPC’s [Manual, Bulletins, and Forms](#) webpage.

CENS: Regional Network Meetings

CENS providers are responsible for convening quarterly regional meetings with the SUD treatment provider network and other partners (including ancillary referral agencies and County referral partners) operating within their SPA. These meetings provide an opportunity for the network to address referral challenges and promote collaborative discussion to identify and eliminate or reduce client barriers, ensuring a successful transition from CENS to SUD treatment. They are designed to strengthen the SAPC provider network by establishing and maintaining key partnerships among the CENS, provider agencies, non-SUD ancillary service providers (e.g., employment, food, housing), and relevant governmental entities.

To participate in CENS Regional Network Meetings or request more information, providers may contact their local [CENS Area Office](#) or email SAPC’s Systems of Care Division (SAPC-SOC) at SAPC-SOC@ph.lacounty.gov.

CENS: Outreach and Engagement

Although most clients are referred to a co-located CENS site, some underserved individuals may be engaged by CENS in the field (e.g., streets, encampments, shelters, jails, etc.). Outreach and engagement may require frequent contact over an extended period of time to develop a rapport and a trusting relationship, which ultimately motivates the individual to engage and participate in treatment. Clients who are finally ready to accept SUD treatment must be immediately linked to services. Client outreach and engagement are conducted based on need and at the direction and approval of SAPC.

CENS: Eligibility Determination and Benefits Enrollment

CENS counselors conduct eligibility determinations and income verification to determine Medi-Cal eligibility and facilitate enrollment. CENS assists clients in entering data in the statewide [BenefitsCal website](#) for Medi-Cal enrollment. If the individual is eligible for Medi-Cal, CENS counselors initiate the necessary application/paperwork and refer the client to a qualified provider to continue the benefits enrollment process through approval. This includes assisting with transferring Medi-Cal benefits when a client moves from another State or County and has established residency in LA County.

If a client referred to CENS is not eligible for Medi-Cal or the other County-funded programs listed under the [Covered Members and Eligible Individuals](#) section. CENS counselors may provide referrals to SUD providers that accept clients on a sliding scale basis. Moreover, if a client who is not eligible for Medi-Cal is covered by a County-funded program (e.g., [AB 109](#) or others mentioned above). CENS counselors will refer the client to SUD providers and remind such providers that SUD treatment services are available and free of charge for the client.

CENS: Educational Sessions

When necessary and beneficial, CENS counselors provide clients with a basic overview of SUDs and the treatment system to increase the likelihood of follow-through with treatment initiation. Frequently, clients referred to CENS for an SUD screening may not understand the severity of their substance use problem. CENS counselors use MI and CBT techniques to engage and facilitate behavioral change in clients and encourage them to be more amenable to SUD treatment.

CENS counselors also:

- Discuss coping strategies with clients, including the steps to take in the event of a relapse.
- Provide HIV/AIDS education and referrals for HIV testing and treatment.
- Discuss the availability of addiction MAT medications for any Alcohol Use Disorders (AUDs) and OUDs, and tobacco use disorder (TUD).
- Discuss the availability of naloxone for overdose prevention.

CENS: Screening, SUD Treatment Referral, Appointment Scheduling, Reminders, and Follow-Up

CENS counselors screen clients using the appropriate screener to determine whether a referral to treatment is necessary. If treatment is needed, CENS counselors schedule an assessment appointment with the agreed-upon network provider per the guidelines, as outlined in the [Summary of Service Connection Portals Referral Process](#) section. A CENS counselor calls the individual to remind them of the upcoming appointment. They also call individuals if they fail to show up for their assessment appointment. CENS also contacts the Network Provider to determine the linked individual's admission and treatment status.

For justice-involved clients, the appropriate LOC and interventions should be determined by a qualified counselor or clinician, not by justice partners. SUD treatment must be individualized and based on medical necessity. For clients who are incarcerated, SUD screening should be based on the client's substance use status 30 days prior to incarceration.

CENS: Service Navigation, Ancillary Referrals, and Linkages

CENS serves as a liaison between the referring State, County, city, and community partner entities, as well as SUD treatment agencies. This helps ensure the referring entities are aware of their client's treatment status, including treatment location and anticipated completion date. For example, CENS counselors co-located at the LA Superior Courts serve as liaisons during regular court appearances or at the request of the bench officer and may provide client status reports on behalf of the treatment agency.

Navigation assistance and linkages to health and social service resources are important CENS functions, particularly when referring entities do not or cannot provide these needed connections. Navigation and linkage services must include assistance with:

- Eligibility determinations
- Completing paperwork
- Appointment reminders and rescheduling missed appointments
- Providing or arranging transportation to appointments
- Accompanying clients to their appointments to ensure optimal attendance and treatment retention

To support these functions, CENS establishes and maintains cooperative linkages with other providers (e.g., public, private, and other social, economic, health, legal, vocational, and mental health partners) to make appropriate referrals that address unmet client needs. CENS counselors maintain a working knowledge and an up-to-date resource directory that includes, but is not limited to, all SUD providers (via the SBAT), mental health providers, physical health providers, HIV/AIDS and Sexually Transmitted Infection (STI) providers, and Medi-Cal MCPs.

CENS: Adult At-Risk Services for Prevention and Early Intervention

The Adult At-Risk Program is a no-cost opportunity for eligible individuals to learn about SUD through engaging, interactive educational sessions. CENS provides early intervention services for Adults (age 21 and over):

- Whose ASAM CO-Triage results do not meet the criteria for SUD treatment services,
- Who engage in SUD high-risk behaviors or do not meet medical necessity for SUD treatment but may benefit from an intervention based on high-risk behaviors.

CENS: Locations

To improve access to SUD services, CENS has Area Offices located in each of the eight (8) Service Planning Areas (SPAs). CENS are also co-located at various State, County, city, and community sites to facilitate client entry into and navigation through the specialty SUD system.

CENS are co-located at the following SAPC-approved sites:

- DMH Psychiatric Emergency Services (PES) and Urgent Care Centers (UCCs)
- Court Compliance and Services Program offices
- Family Solutions Centers
- Homeless Encampments
- IH and PSH sites
- Juvenile Halls
- LA Superior Courts (e.g., Community Collaborative Court and Proposition 47)
- Medical facilities, including Federally Qualified Health Centers (FQHCs) and selective private and public hospital medical emergency rooms (ERs)
- LAC-Probation (e.g., [AB 109](#) HUBS and Adult Area Offices)
- Los Angeles County Sheriff's Department (LASD) (e.g., Community Re-entry and Resource Center (CRRC), Twin Towers)
- Other approved co-locations, as necessary

Target populations serviced at these co-located sites include individuals who are involved in the juvenile or criminal justice system, uninsured, underinsured, PEH, and individuals with co-occurring disorders (CODs), among other vulnerable conditions.

Direct-to-Provider

Individuals seeking specialty SUD services can contact or walk into a provider agency directly without going through SASH or CENS. Many people find SUD provider agencies through personal referrals or by using the SBAT or the [RecoverLA.org](#) application on mobile devices.

Provider Agency Process and Responsibilities in Receiving Direct Self-Referrals

When individuals call or arrive at a treatment site seeking SUD services, the following steps are required to determine what LOC is needed and to initiate admission:

- **Comply** with the requirements outlined under provider agency Responsibilities for SASH, CENS, and Direct Referrals.
- **Identify** the right LOC through screening/assessment:
 - If the Provider Agency **offers the full SUD continuum of care**, triaging clients via the screening is less critical because the individual can access any needed LOC. Therefore, these provider agencies can choose to complete the screening or proceed directly to the full ASAM CONTINUUM™ Assessment or Assessment Tool - Youth (Paper Version) provided the client can be admitted timely into the identified LOC.
 - If the Provider Agency **does not offer the full SUD continuum of care**, the agency must administer either the ASAM Screener for Youth (age 17 and under) and Young Adults (age 18-20) or ASAM CO-Triage® Tool for Adults (age 21 and over) to prevent clients from completing the full ASAM assessment to determine that the needed LOC is not offered that meets the client's needs.
- Connect to the right LOC to initiate admission within timely access standards (see [Table 5: SAPC Access and Services Delivery Standards](#)):
 - Provide the individual with an appointment and contact information; **or**
 - Identify an appropriate provider agency to arrange an appointment if the LOC is not offered by the provider agency or it is but not within timely access standards:
 - For Young Adults (age 18-20) and Adults (age 21 and over), use the SBAT to identify and connect the client to an appropriate provider agency that has current availability for the needed LOC.
 - For Youth (age 17 and under), use the SBAT to identify and connect the client to an appropriate OP youth provider agency; and for those reporting opioid use within the past 30 days also identify and connect the client to OTP/MAT services.
 - Identify and contact a minimum of three (3) other provider agencies. Identify an intake appointment date within 10 business days for all LOCs except OTP, which is within three (3) business days, and urgent services within 48 hours. If the recommended provisional LOC is unavailable after reasonable attempts, a lower LOC may be used in the interim, as needed.
 - Assist the client in successfully connecting with the receiving provider agency or site, including instances where the assessing provider agency's sites do not meet the individual's geographic and other preferences. Management of these transitions through Care Coordination is the responsibility of the last treatment provider.
 - When a screening does not result in an admission (e.g., the provider refers the client to another agency), providers may bill SAPC for the screening under the provider agency's RS Provider Authorization (PAuth).
- **Document** all Direct-to-Provider encounters in the Referral Connection Form when a referral contact was attempted and/or successfully made (including when it is a provider self-referral). This requirement is for both Primary and Secondary Sage users.

For additional information, see [Intake and Enrollment – Required Process – Assessment](#) section.

Referral Connections and Appointment Disposition Requirements

To support monitoring of timely access from initial request through appointment completion and follow-up, provider agencies must document referral activity and appointment outcomes in accordance with [SAPC IN 25-11](#) and applicable State and federal requirements.

Referral Connections Form Requirements

As outlined in SAPC IN 22-13 and this Provider Manual, all initial client encounters that occur directly at SAPC-contracted provider agency sites, including walk-ins, requests for service, and external referrals—and not through SASH or CENS—require the provider agency to:

- Screen prospective clients; **and**
- Document attempts to schedule an appointment using the Referral Connections Form in Sage-EHR / PCNX

Note: This requirement applies to both internal referrals (within the same agency) and external referrals (to another provider agency).

Appointment and Referral Disposition Requirements

To ensure compliance with timely access requirements, provider agencies must document the outcome of all initial appointments.

Effective September 1, 2025, provider agencies are required to complete an Appointment and Referral Disposition Form in Sage-EHR / PCNX for all appointments resulting from initial client encounters.

The Appointment and Referral Disposition Form requires documentation of:

- Whether the client attended the scheduled appointment
- The date the appointment was rescheduled, if applicable
- The outcome of the appointment

Provider agencies must complete the Appointment and Referral Disposition Form within three (3) calendar days following the appointment date.

System Functionality

Information from the Referral Connections Form and Service Connection Log (completed by SASH or CENS) will prepopulate relevant data fields in the Appointment and Referral Disposition Form and be accessible to provider agencies through system widgets.

Monitoring and Compliance

SAPC will monitor provider agencies' completion of the Referral Connections Form and the Appointment and Referral Disposition Form on a regular basis and will follow up with provider agencies, as needed, to ensure compliance with these requirements.

Service & Bed Availability Tool and Provider Directory

SBAT is a web-based directory and dashboard that shows available SUD services across LA County, including RH, RBH, and DUI programs. SBAT supports a more organized SUD delivery system by simplifying the process of finding appropriate SUD providers and allowing users to tailor their search using filters for LOCs, languages spoken, and types of services delivered.

Providers are required to complete the SBAT Survey with accurate and full responses when adding a new DMC-certified treatment site to the SBAT or modifying an existing SBAT listing, and submit to the assigned CPA with” copy to SAPCMonitoring@ph.lacounty.gov.

SASH, CENS, and the public rely on SBAT to identify services at treatment provider agencies and locations for referrals. For this reason, all treatment provider agencies must update and verify intake slots and bed availability daily using the SBAT Provider Log-In Site:

<https://sapccis.ph.lacounty.gov/SBATProviderSite/Account/Login.aspx>.

The SBAT New User Form can be accessed at:

www.publichealth.lacounty.gov/sapc/NetworkProviders/Sbat/SBATUserRegistrationForm.pdf.

Intake Slot Availability

SBAT allows provider agencies to enter daily availability for:

- OP services (including IOP)
- Residential services (across all LOCs)

Note: *Intake slot and bed availability automatically reset to zero (0) 24 hours after the last Provider Agency update. Provider agencies need to update this information daily for each site. For detailed instructions on using the SBAT, see the [SBAT User Manual](#).*

Network Adequacy Compliance

To meet the requirements under [42 CFR Part 438](#), licensed practitioner information in SBAT is updated monthly through the Network Adequacy Certification Application (NACA) submissions. For additional information, see [Network Adequacy Certification Submissions](#) section.

Timeliness and Access Standards

Ensuring timely access to services and engaging clients when they are ready to initiate treatment are essential to improving outcomes in the specialty SUD system. All DMC-ODS services are to be delivered with reasonable promptness in accordance with Federal Medicaid requirements and as specified in the contract and herein.

In addition to time, the distance to access treatment has been shown to be linked to client outcomes. Generally, the shorter the distance between a client and their treatment site, the better the client's outcome. Unless otherwise requested by the client, every effort needs to be made to refer the client to a treatment

program that is within 30 minutes of travel time by personal or public transportation, **or** within 15 miles of the client's preferred location, see [Table 5: SAPC Access and Services Delivery Standards](#). If it is not feasible, every effort should be made to minimize the likelihood that commute or transportation issues will be a barrier to accessing treatment. If the client prefers to have some aspect of treatment delivered in a different region than where they reside or work, this preference needs to be considered and documented in their clinical record.

Table 5: SAPC Access and Services Delivery Standards

Service	Due Date
Distance Standards for Referrals	Every effort needs to be made to refer clients to a treatment program within: 30 minutes of travel time by personal or public transportation; or 15 miles from the client's location of choice.
Screening for Provisional LOC ³	Date of first contact (walk-ins only) In instances where clients were screened for admission but not admitted, provider agencies need to provide two (2) alternate referral agencies and connect the client within 48 hours to these agencies. Within 72 hours of admission, agencies should administer the ASAM CO-Triage® Tool for Adults (age 21 and over) or the ASAM Screener for Youth (age 17 and under) and Young Adults (age 18-20) to clients admitted to residential LOC, except for WM LOC, if the applicable Assessment Tool (below) has not been administered during this timeframe, to support the client's placement in an appropriate LOC.
Urgent Appointment for WM	When a prospective client is experiencing active withdrawal symptoms and their provisional or assessed LOC determination supports WM levels 3.2, 3.7, and/or 4.0, it is imperative that the provider takes the following action within 48 hours: - Directly initiate the appropriate WM service (WM levels 3.2, 3.7, or 4.0); or - Ensure enrollment in the appropriate WM service at another provider agency.
Intake Appointment – Scheduled	Immediately, but no longer than three (3) calendar days of screening/referral. Note: SASH may move to the next provider agency if there is no immediate response or available appointment.
Intake/Assessment Appointment – Conducted	Within 10 business days of screening/referral for non-OTP settings and three (3) business days for OTP settings.
County Residency Eligibility Verification	Date of first service intake/appointment.
Medi-Cal Eligibility Verification	
Member Handbook and Member Orientation Video Provided	
ASAM CONTINUUM™ Assessment or Assessment Tool - Youth (Paper Version) found on the SAPC website and Medical Necessity Determination	For clients in residential treatment settings: Within seven (7) calendar days of first service or first intake appointment in residential settings for Young Adults (age 18-20) and Adults (age 21 and over); or Within 14 calendar days of first service or first intake appointment in residential settings for Youth (age 17 and under).

³ If the provider agency does not offer the provisional LOC or a slot/bed will not be available within timeliness standards, referrals must be provided (**no waitlists allowed**).

Service	Due Date
	For clients in non-residential treatment settings (e.g., OP, IOP, OTP, RS): • Within 30 calendar days of first service or first intake appointment for Adults (age 21 and over); or • Within 60 calendar days of first service or first intake appointment for Youth (age 17 and under) and Young Adults (age 18-20), and all Adults (age 21 and over) who are documented as a PEH⁴. For additional information, see Initial Engagement Authorizations section. Note: If every attempt has been made to complete and finalize the ASAM Assessment and establish medical necessity within the above timeframes, but the client was unable to fully participate, the provider agency needs to include a Progress Note detailing the reason(s) this did not occur and the attempts made.
Data Submission (CalOMS/LACPRS) & AWOL Policy	• Admission Data: submit <u>within seven (7) calendar days</u> of a client's entry into treatment. • Discharge Data: submit <u>on the day</u> of discharge. • Annual Updates: ○ For clients who continue receiving the same LOC at the same facility for more than one (1) year from their CalOMS admission date ○ <u>Submit no later than 12 months</u> from the client's admission anniversary date. May be submitted up to 60 days prior to the anniversary date. • All Clients and LOCs: CalOMS data must be reported for all clients, regardless of funding source (e.g., private pay, commercial insurance), and for all LOCs. • Absence Without Leave (AWOL) Policy: Clients may leave treatment without notice, resulting in inconsistent AWOL practices across provider agencies. These inconsistencies can delay client admissions and the timely submission of CalOMS/LACPRS data, particularly for subsequent providers. To support efficient client transitions and ensure timely CalOMS admissions across the network, the following standardized AWOL policy is established: ○ For Non-OTP LOC (ASAM 0.5, OP, IOP, WM, Residential, RS): If a client misses their next appointment, the provider must attempt to reengage the client within 14 calendar days before discharging the client from CalOMS and the treatment program. Accordingly, CalOMS should be discharged 14 calendar days after the next missed appointment. If another provider contacts the original agency to open a CalOMS/LACPRS record for the client, indicating the client has started services elsewhere, the original agency must discharge the client promptly. The discharge date must correspond to the date of the client's last face-to-face or telehealth treatment session or addiction medications service. This actual discharge date must also be entered as the "Discharge Process Date" on the appropriate CalOMS Discharge forms. ○ For OTP: If a client misses their next appointment, the provider must attempt to reengage the client within 30 calendar days before discharging the client from CalOMS and the treatment program. Accordingly, CalOMS should be discharged 30 calendar days after the next missed appointment. If another provider contacts the original agency to open a CalOMS/LACPRS record for the client, indicating the client has started services elsewhere, the original agency must discharge the client promptly. The discharge date must correspond to the date of the client's last face-to-face or

⁴ Documentation of homelessness status must be indicated in a Progress Note.

Service	Due Date
	telehealth treatment session. This actual discharge date must also be entered as the "Discharge Process Date" on the appropriate CalOMS Discharge forms. <i>For questions regarding CalOMS data submission, see SAPC's CalOMS Resource webpage or email hoda_caloms@ph.lacounty.gov.</i>
Initial Problem List (for non-OTP Services) Initial Treatment Plan (for OTP Services)	Problem Lists for clients in <u>residential</u> treatment settings: • Within seven (7) calendar days of first service or first intake appointment in residential settings for Young Adults (age 18-20) and Adults (age 21 and over); or • Within 14 calendar days of first service or first intake appointment in residential settings for Youth (age 17 and under). Problem Lists for clients in <u>non-OTP</u> treatment settings (e.g. OP, IOP, RS): • Within 30 calendar days of first service or first intake appointment for Adults (age 21 and over); or • Within 60 calendar days of first service or first intake appointment for Youth (age 17 and under). Treatment Plans for clients in <u>OTP</u> treatment settings: • Within 28 calendar days of admission, Treatment Plan needs to be completed and signed by the client and LPHA. • Treatment Plans for clients receiving OTP services prior to the completion of the ASAM CONTINUUM™ Assessment or Assessment Tool - Youth (Paper Version) found on the SAPC website) must describe the plan for obtaining this assessment within the required 30- or 60-day timeframe described above. • If every attempt has been made to complete and obtain signatures on the Treatment Plan, but circumstances do not allow for full completion, then the provider needs to: ○ Include a Progress Note with justification detailing what prevented completion within the timeframe. ○ The appropriate LPHA or Medical Director needs to then legibly sign the Treatment Plan within 15 calendar days of the client signing.

To optimize access to SUD services, SUD provider agencies need to implement an ongoing, systematic evaluation process to identify physical and/or psychosocial access issues that may impede SUD treatment and to identify potential barriers. The evaluation process should identify counselor/staff attitudes around substance use, client transportation, or any other accessibility issues. Provider agencies also need to consider client and stakeholder feedback during this process.

Once barriers are identified, provider agencies should develop a plan detailing how to address them. The plan may be a Quality Improvement Project (QIP) (see [Quality Improvement Expectations](#) section), which specifies the barrier(s) and action(s) that will be taken to eliminate or reduce the impact of the barrier, along with the timeline for completing these specific actions.

Table 6: Hours of Operation by Benefit

Benefit	Applicable LOCs	Minimum Hours of Operation*
Early Intervention Services <i>For Youth (age 17 and under) and Young Adults (age 18-20)</i>	Early Intervention Services (ASAM 0.5)	- Need to operate at least 8 hours per day, 5 days a week, including either: - One (1) 8-hour day on Saturday or Sunday; or - One (1) 4-hour day on Saturday <u>and</u> 4-hour day on Sunday; and - At least two (2) days need to include evening hours (5:00 p.m. – 9:00 p.m., at a minimum)
Outpatient LOC	- Outpatient (ASAM 1.0) - IOP (ASAM 2.1) - Ambulatory-Withdrawal Management (Outpatient) without extended on-site monitoring (ASAM 1-WM) - Ambulatory-Withdrawal Management (Outpatient) with extended on-site monitoring (ASAM 2-WM)	- Need to operate at least eight (8) hours per day, five (5) days a week, including either: - One 8-hour day on Saturday or Sunday; or - One 4-hour day on Saturday <u>and</u> 4-hour day on Sunday; and - At least two (2) days need to include evening hours (5:00 p.m. – 9:00 p.m., at a minimum)
Residential and Inpatient LOC	- Clinically Managed Low-Intensity Residential Services (ASAM 3.1) - Clinically Managed Population-Specific High-Intensity Residential Services (ASAM 3.3) - Clinically Managed High-Intensity Residential Services (ASAM 3.5) - Clinically Managed Residential-Withdrawal Management (ASAM 3.2-WM) - Medically Monitored Inpatient Withdrawal Management (3.7-WM) - Medically Managed Intensive Inpatient Withdrawal Management (4-WM)	- Need to operate 24 hours per day, seven (7) days a week; and - Need to accept intakes at least during regular weekday business hours (9:00 a.m. – 5:00 p.m., at a minimum)
Opioid Treatment Program	Opioid Treatment Programs (1-OTP)	- Need to operate at least eight (8) hours per day, five (5) days a week (including either: - One (1) 8-hour day on Saturday or Sunday; or - One (1) 4-hour day on Saturday and 4-hour day on Sunday
Recovery Bridge Housing	Recovery Bridge Housing	- Need to operate 24 hours per day, seven (7) days a week; and - Need to accept intakes at least during regular weekday business hours (9:00 a.m. – 5:00 p.m., at a minimum)
Recovery Housing	Recovery Housing	- Need to operate 24 hours per day, seven (7) days a week - Need to accept intakes from SAPC staff at least during regular weekday business hours (9:00 a.m. – 5:00 p.m., at a minimum)
*Hours of operation standards do not apply to approved Field-Based Services (FBS) locations.		

Holiday Closure Pre-Approval

The minimum and maximum number of hours per week remain unchanged for weeks that include a Federal, State, local, or religious holiday. Provider agencies need to obtain SAPC approval when an OP facility is scheduled to be closed to observe Federal, State, local, or religious holidays. **Provider agencies must submit written notification to SAPC annually by the beginning of each FY (July 1st) if there are changes for that FY (July 1st – June 30th).** New provider agencies must submit their current FY request for holiday closures no later than 60 days after contract execution. Consistent with other health services, OP sites cannot be closed for days other than actual recognized holidays (Federal, State, local, or religious). Requests need to be emailed to SAPC's Contracts and Compliance Division (SAPC-CCD) at SAPCMonitoring@ph.lacounty.gov and to the assigned CPA.

Note: For IOP programs, the rate may be lowered to the OP rate for any claims associated with an individual who does not receive the minimum number of service hours/units in any week.

Out-of-Network Policy

Individuals may be eligible to receive medically necessary DMC-ODS services from Out-of-Network (OON) provider agencies in certain circumstances. All OON provider agencies must meet specified requirements, including, but not limited to, those required by DHCS. Individuals may be eligible to receive OON services under the following circumstances:

- **Indian Health Care Provider (IHCP):** American Indian and Alaska Native (AI/AN) individuals are entitled to receive DMC-ODS services from an IHCP for whom they are eligible, whether or not the IHCP chooses to become part of the DMC-ODS network, in accordance with [BHIN 22-053](#) and, as well as other Federal and State regulations.
 - Effective March 2025, [BHIN 25-007](#) and [BHIN 25-036](#) expanded the DMC-ODS benefit to include Traditional Health Care Practices (i.e., interventions provided by qualified Traditional Healers and Natural Helpers) for eligible members, which can only be provided through IHCPs.
- **Alternate Access Standards (i.e., services outside of time/distance access standards):** When an area of the County does not fall within time/distance access standards, individuals may be approved (depending on any alternative standard that may be approved by DHCS) to receive services from an OON provider closer to them.
- **Transition in Care:** Under certain conditions (risk of serious health, hospitalization, or institutionalization), an individual who is transferring to LA County from another DMC-ODS or State Plan DMC County is permitted to retain their current provider for a period of time as an OON provider to ensure access to services.

When a service meets one (1) of the above requirements, then the primary service connection portal staff are responsible for informing the individual about the availability of OON provider agencies. Entryways include SASH and CENS.

Provider agencies who receive a request from an eligible member and service connection portal staff should refer OON requests to SAPC-CCD at (626) 299-4532 or email SAPCMonitoring@ph.lacounty.gov. Requests for OON providers cannot be denied based on travel time or transportation costs.

Network Adequacy Certification Submissions

Overview

DHCS sets forth the requirements for counties' certification of network adequacy. SAPC's network capacity and timely access standards are reviewed regularly to ensure that all required services covered under DMC-ODS are available and accessible to DMC-ODS enrollees in accordance with the applicable state and federal regulations, including those outlined in [42 CFR § 438.68](#) and [California WIC § 14197](#).

The Network Adequacy Certification Tool (NACT) and the newly required 274 Standard Process are completed by DMC-ODS Counties and used by DHCS to assess whether the County Plan:

- Offers an appropriate range of services for the anticipated number of members; **and**
- Maintains a network of provider agencies, operating within the scope of practice under State law, that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members.

Notifications and Provider NACT Coordinator

As required by DHCS and outlined in [BHIN 23-042](#) and [BHIN 25-013](#), DMC-ODS counties are required to submit provider network data on a monthly basis. NACT Coordinators will be responsible for ensuring that provider agency information in the SAPC NACA is updated by the last week of each month.

DHCS still requires that Counties submit annual network adequacy certifications. SAPC will notify provider agencies of the timelines for these annual submissions and timelines for updating any additional information using the SAPC NACA. The timeline will include training, office hours, deadlines, and other relevant information.

Provider agencies must inform SAPC and update their contact information in the NACA whenever there is a change in the designated NACT coordinator assignments, including the name and contact details. The NACT coordinator is the representative from the provider agency who works with SAPC to coordinate efforts and ensure accurate, timely submissions. Each provider agency is required to designate a NACT coordinator and a backup who will be responsible for submission and attending NACT-related meetings and trainings related to network adequacy. All agency portal access must be conducted using the coordinator's assigned credentials.

Providers are expected to actively participate in all required quarterly meetings. These meetings are an essential component of program oversight, communication, and continuous improvement.

Network Adequacy Certification Application

Network Adequacy Certification Application (NACA) is SAPC's database for obtaining and verifying NACT and 274 Standard Process data. The database allows provider agencies to review, update, and validate the required information about their organization more easily. This information includes, but is not limited to, the following:

- Organization information such as:
 - Contract effective and expiration date
 - Name of Chief Executive Officer (CEO) and Chief Financial Officer (CFO)
 - Website URL of agency (if available)
 - Primary, secondary, and alternate NACT Coordinators
- Active service location information, such as:
 - General site information, site address, and hours of operation
 - Maximum and current number of Medi-Cal members by age group and modality
 - Additional LOCs for Residential
 - American with Disabilities Act (ADA) compliance
 - TTY/TDD (Telecommunications Device for the Deaf), and/or Video Relay Device (VRD) equipment available
 - Language capabilities
 - Age groups served
- Staff (practitioner) information, such as:
 - Personal identifiable information, including gender, race, DOB, and email address
 - Provider Type, Licensing entity, and certification number
 - Contact effective (hire) date and expiration date (if open-ended employment, indicate N/A)
 - Age groups served
 - Practitioners' current caseload and maximum number of clients practitioners will accept by age group and modality
 - Language capabilities
 - Telehealth capabilities
 - Cultural Competency training and the number of hours completed

Note: Certain components of the NACA database are used to update information in the SBAT.

To ensure SAPC meets the DHCS NACT and 274 Standard Process submission deadline, provider agencies need to have completed and validated all data in the NACA by the last week of every month, unless otherwise notified by SAPC. Failure to meet the specified deadline may result in consequences, including, but not limited to, the denial of augmentation requests and contract amendments. NACT Coordinators need to finalize their submission by selecting the "Confirm Monthly Submission". An auto-email notification will be sent to the primary and backup coordinators confirming the submission.

For assistance with NACA access or credential questions, contact SAPC_NACT@ph.lacounty.gov.

Initial Engagement Authorizations

SAPC covers clinically appropriate non-residential treatment services for Adults (age 21 and over) who are not experiencing homelessness for up to 30 days following the initial date of service, whether or not a diagnosis for Substance-Related and Addictive Disorders from the current DSM is established, and for up to 60 days for Youth (age 17 and under) and Young Adults (age 18-20), or if a provider documents that the client is experiencing homelessness and therefore requires additional time to complete the assessment. Providers who exercise these flexibilities to initiate care prior to completing an ASAM assessment and establishing an SUD diagnosis should submit initial engagement authorizations, as described below. **The initial engagement authorization precedes but does not replace medical necessity.**

- If the provider can complete all medical necessity documentation and member has valid financial eligibility coverage, providers may **skip** this type of authorization and submit a standard authorization for the requested LOC.
- Initial Engagement Authorizations are available for non-residential and non-WM LOCs.
- Providers can request an Initial Engagement Authorization(s) **prior** to the establishment of medical necessity.
- To receive an Initial Engagement Authorization, providers need to submit an SAR with a provisional LOC (i.e., ASAM 0.5, 1.0, 2.1, or OTP).
- Providers need to document in the medical necessity justification Progress Note that the request is for an Initial Engagement Authorization.
 - For Adults (age 21 and over), providers should indicate whether this is a person who is experiencing homelessness.
 - 30-day Initial Engagement Authorization can be given for Adults (age 21 and over) who are not experiencing homelessness.
 - 60-day Initial Engagement Authorization can be given for Adults (age 21 and over) who are experiencing homelessness.
- Youth and Young Adults (under age 21) Authorization will be limited to 30 days for those utilizing the Applying for Medi-Cal benefit, regardless of the member's age and/or homelessness status.
 - For members who are eligible for a 60-day Initial Engagement period, the provider could submit service authorization for the remaining 30 days if:
 - Member has secondary non-DMC funding.
 - Medi-Cal is approved for covered services within the requested timeframe.
- If there is no existing eligibility verification period, a new eligibility verification period will be established and will align with the start date of the Initial Engagement Authorization.
- In cases where the eligibility verification period does not cover the entire initial engagement authorization, a new eligibility verification will be established.
- A standard authorization should be submitted after initial engagement authorization for ongoing care, including documentation of medical necessity.
 - For additional information, see [Checklist of Required Documentation](#).
 - If a member meets medical necessity, authorization will be approved for the remainder of the current eligibility period.
- The Initial Engagement process can restart if the member leaves treatment prior to the establishment of medical necessity.

Determining Medical Necessity

Medical necessity is a standard applied to justify the provision of services as reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care. Medical necessity must be consistently applied to ensure equitable access to services, established to demonstrate and maintain DMC eligibility, and established for the services provided (e.g., residential treatment, RBH).

Medical necessity to initiate non-residential services means that services are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain ([California WIC § 14059.5\(a\)](#)). For OTPs, a history and physical exam conducted by an LPHA at admission, pursuant to Federal and State regulations, qualifies for medical necessity determination.

Medical necessity for most LOCs (except for WM, RS, and Early Intervention services for Youth [age 17 and under] and Young Adults [age 18-20]) can only be determined **after** a full Assessment Tool - Youth (Paper Version) found on the SAPC website, which includes an SUD diagnosis from the current edition of the DSM, is finalized. Screenings do not generally include sufficient information to determine medical necessity for most LOCs because they do not include a DSM diagnosis determination or contain sufficient information regarding the six (6) ASAM dimensions to constitute a comprehensive biopsychosocial ASAM assessment. RS requires the completion of ASAM CO-Triage® Tool for Adults (age 21 and over) or ASAM Screener for Youth (age 17 and under) and Young Adults (age 18-20). The ASAM Screener for Youth (age 17 and under) and Young Adults (age 18-20) may be used to establish medical necessity for Early Intervention (0.5) services.

Definition of Medical Necessity

To meet medical necessity criteria, clients need to meet the following two (2) criteria:

1. Diagnostic and Statistical Manual of Mental Disorders – 5th Edition – Text Revision (DSM-5-TR) diagnosis

- Youth (age 17 and under) and Young Adults (age 18-20)
 - Meet criteria for at least one (1) diagnosis from the current DSM for Substance-related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders; **or**
 - Meet EPSDT criteria to ameliorate or correct a substance misuse-related condition.
 - For additional information, see [Definition of Early Intervention Services for Youth and Young Adults](#) section.

Note: Parental consent *is not* required for services delivered to youth age 12 and over, but *is* required for services delivered to youth age 11 and under.
- Adults (age 21 and over)
 - To begin service delivery prior to completion of the full assessment:
 - Services are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain ([California WIC § 14059.5\(a\)](#)); **or**
 - For OTPs, a history and physical exam conducted by an LPHA at admission, pursuant to Federal and State regulations, qualifies for the determination of medical necessity.

- To fully establish medical necessity:
 - Meet criteria for at least one (1) diagnosis from the current DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-related Disorders.
 - Meet criteria for at least one (1) diagnosis from the current DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-related Disorders, prior to being incarcerated or during incarceration as determined by substance use history.

2. ASAM treatment criteria for services

- DMC-ODS providers need to ensure clients meet the ASAM treatment criteria for services after completing the initial assessment period (30-60 days after first service, depending on the population), including the ASAM adolescent treatment criteria, when applicable. Medical necessity encompasses all six (6) ASAM dimensions and considers the extent and biopsychosocial severity of the various dimensions within the required full ASAM CONTINUUM™ Assessment or Assessment Tool - Youth (Paper Version) found on the SAPC website. Medical necessity is not limited to acute care needs or narrow medical issues (e.g., withdrawal severity in Dimension 1, physical health needs in Dimension 2, or psychiatric concerns such as suicidality in Dimension 3).

Definition of Early Intervention Services for Youth and Young Adults

Youth (age 17 and under) and Young Adults (age 18-20) in the specialty SUD system are eligible for Early Intervention services under EPSDT. Eligibility for EPSDT broadens the definition of medical necessity for youth and young adults to include individuals who need services to ameliorate or correct a substance misuse-related condition and makes the full LA County's SUD Benefit Package available to Youth (age 17 and under) and Young Adults (age 18-20) without any caps or limitations. Early intervention services are covered DMC-ODS services for members under the age of 21 who are screened and determined to be at risk of developing an SUD and thus may receive any service component covered under the OP LOC as Early Intervention services. Parental consent is not required for services delivered to youth aged 12 and over but is required for services delivered to youth age 11 and under.

Note: Federal EPSDT requirements supersede state Medi-Cal requirements, and DMC-ODS does not override EPSDT.

Assessment

Assessments are client evaluations, measurements, and documentation used to determine diagnoses and service needs. In the treatment of individuals with SUDs, assessments are an ongoing process and are essential for identifying client needs and helping the provider tailor their services to best meet those needs. Assessments are also important opportunities for client engagement and developing a Plan of Care.

Assessments are typically conducted during the initial phases of treatment, although not necessarily during the initial visit. A full assessment or initial provisional referral tool for preliminary LOC recommendations is not required to begin receiving DMC-ODS treatment services. Comprehensive, validated, standardized assessment tools, and their corresponding documentation form the foundation of high-quality SUD services.

Assessments based on the required ASAM Criteria® ensure a standardized structure for collecting necessary clinical information to make appropriate SUD LOC determinations. Assessments need to be appropriately documented (see [Clinician Consultation Services - Licensed Clinician Consultation Process - Documentation](#) section), reviewed, and updated regularly, including at every care transition, to promote engagement and meet the client's needs and preferences.

If the provider determines that adequate progress toward treatment goals has been made during the assessment, plans to build upon these achievements should be made, which may include transitioning to other services and implementing recovery-focused strategies. Similarly, reassessments of the diagnosis, treatment modalities/intensity/goals need to be performed if progress toward agreed-upon goals is not being made within a reasonable timeframe.

LPHAs, whose scope of practice includes behavioral health assessments, and SUD counselors need to have appropriate experience and training before conducting screenings, assessments, and medical-necessity determinations. The scope of practice of Registered Nurse (RN), Licensed Vocational Nurse (LVN), Licensed Psychiatric Technician (LPT), Licensed Occupational Therapist (LOT), and Registered Pharmacist (RP) practitioners does not include determining medical necessity for SUD treatment. Training is available through SAPC-CST; see the [SAPC Trainings and Events webpage](#) on SAPC's website and refer to the training calendar to register for upcoming sessions.

Process for Determining Medical Necessity

Verification of Medical Necessity

Medical necessity must be verified by a diagnosing LPHA through an in-person review, telehealth, or telephone consultation with the individual conducting the assessment (e.g., a SUD counselor). At a minimum, the in-person or telehealth review needs to involve the LPHA verifying and signing off on medical necessity in an in-person, telehealth, or telephonic collaboration with the SUD counselor who conducted the assessment. The review may include the client, although it is not required.

The LPHA is required to document separately from the Problem List (non-OTP settings) or the Treatment Plan (OTP Settings) the basis for the diagnosis in the form of a Medical Necessity Justification Progress Note within 30 calendar days of each client's treatment admission date. The basis for documenting a diagnosis made by an LPHA should align with the scope of practice for making diagnoses as regulated by that LPHA's relevant licensing board. The basis for the diagnosis, or qualification under EPSDT, should include a statement that the client's personal, medical, and substance use history was reviewed. The Medical Necessity Justification Progress Note needs to be signed and finalized by a diagnosing LPHA, dated, and then submitted in the client record in Sage. For additional information on LPHA categories, see [Table 17: Types of Licensed Practitioners of the Healing Arts](#).

Timeliness of Medical Necessity Determination

The LPHA needs to determine medical necessity as outlined in [Table 5: SAPC Access and Services Delivery Standards](#). For clients enrolled in 1.0 Outpatient or 2.1 Intensive Outpatient, providers may submit an Initial Engagement Authorization when Medical Necessity cannot be met within the established timelines.⁵ For additional information, see [Initial Engagement Authorizations](#) section.

Providers need to make every effort to complete the assessment as soon as is feasible for the client. The initial assessment with the client needs to be performed in-person or via telehealth (where the client is in the community or at home) by an LPHA, licensed-eligible LPHA, or registered/certified counselor, as this will ensure admission to the appropriate LOC. If the completed assessment findings indicate no qualifying SUD diagnosis (except under EPSDT as defined above) to establish medical necessity, services are reimbursable under DMC within the 30- or 60-day initial assessment period timeline by documenting an appropriate diagnosis code outlined in [Reimbursement and Diagnosis Codes](#) section below.

Providers need to include a Progress Note in the individual client record, which details:

- If applicable, reason(s) that the client was unable to participate in an assessment within the above timeframes; **and/or**
- Basis for the status of the diagnosis and establishment of medical necessity; **and/or**
- Homelessness status if seeking up to 60 days to complete the initial assessment for non-residential LOCs.

If a client withdraws from treatment prior to establishing a DSM diagnosis for SUDs, and later returns, the 30- to 60-day time period starts over. Assessments need to be updated as clinically appropriate and based upon medical necessity when the client's condition changes.

Reimbursement and Diagnosis Codes

Diagnoses must be established and updated as clinically appropriate by an LPHA, within their scope of practice, when a client's condition changes to accurately reflect the client's needs. During the initial assessment period (ranging from 30 to 60 days, depending on the population), provisional diagnoses are used prior to the determination of a definitive diagnosis or in cases where a suspected SUD has not yet been confirmed. Diagnoses are documented using a Centers for Medicare & Medicaid Services (CMS)-approved International Classification of Diseases, Tenth Revision (ICD-10) diagnosis code.

Providers may use the following ICD-10 diagnosis options during the assessment phase of a client's treatment when an SUD diagnosis has yet to be established:

- ICD-10 codes Z55-Z65, "Persons with potential health hazards related to socioeconomic and psychosocial circumstances," may be used by all practitioners during the assessment period prior to diagnosis and do not require certification as, or supervision of, and LPHA. For a list of applicable diagnosis codes that can be documented by any DMC-ODS practitioner, see [Appendix D. ICD-10 Clinical Modification Codes Z55-Z65 \(Social Determinants of Health-Related Z Codes\)](#).

⁵ Documentation of homelessness status must be indicated in a Progress Note.

- ICD-10 code Z03.89, “Encounter for observation for other suspected diseases and conditions ruled out,” may be used by an LPHA during a member’s treatment assessment phase when a diagnosis has yet to be established.
- LPHAs may use any clinically appropriate ICD-10 code. For example, these include codes for “Other specified” and “Unspecified” disorders, or “Factors influencing health status and contact with health services.”

Each client entered in Sage is required to have an Admission Diagnosis entered on the Diagnosis form in PCNX. Claims submitted for patients without an Admission diagnosis will be denied, including claims for non-DMC clients and non-DMC services such as RBH and screenings that result in no admission.

Claims for covered services are reimbursable⁶ even when:

- Services are provided prior to the determination of a diagnosis or prior to the determination of whether access criteria are met;
- The assessment determines that the member does not meet the DMC-ODS access criteria after the assessment;
- Prevention, screening, assessment, treatment, or RS were not included in an individual Treatment Plan (in OTP settings) or lack of client signature on the Treatment Plan in OTP settings; **and/or**
- The member has a co-occurring mental health disorder.

Timeliness of Medical Necessity Re-verification

For each client to receive ongoing SUD services, the LPHA must monitor each client’s response to SUD treatment to determine medical necessity for continued services no later than six (6) months after the client’s treatment admission date or from the last re-verification. The justification of medical necessity must be documented in a Medical Necessity Justification Progress Note signed and dated by the LPHA and include information on the following:

- Description of the continued functional impairment in the domains of current use or risk for relapse, medical issues, cognitive-behavioral challenges, motivation for change, and current barriers, social and environmental factors
- Most recent physical exam
- Progress Notes, Problem Lists (for non-OTP settings), and Treatment Plan goals (for OTP settings)
- LPHA’s recommendation for continued treatment
- Client progress toward treatment goals

Screening Tools

Screenings are abbreviated evaluations of individuals that allow for a provisional determination about whether and what types of additional SUD services are necessary and appropriate. These abbreviated assessments are less comprehensive than full assessments and therefore do not replace them; they are intended to provide a reasonable estimate of the type and intensity of SUD services necessary to meet an individual’s needs.

⁶ [California WIC § 14184.402\(f\)](#)

Screenings do not contain sufficient information to determine medical necessity because they do not include a DSM diagnosis determination and contain insufficient information regarding the six (6) ASAM dimensions to constitute a comprehensive biopsychosocial ASAM assessment.

The only exceptions are in determining medical necessity for Early Intervention (ASAM 0.5) Services (using the Youth ASAM screening), RS, and WM.

Allowable Screening Tools

- Youth (age 17 and under) and Young Adults (age 18-20)
 - Parent Screener for Youth developed by SAPC (paper-based)
 - Youth and Young Adult Screener (in PCNX) required to qualify for Early Intervention Services
 - ASAM Screener for Youth and Young Adults (paper-based, use only during Sage downtime)
- Adults (age 21 and over)
 - ASAM CO-Triage® Tool
 - SAPC-approved paper-based brief ASAM triage assessment (use only during Sage downtime)

Assessment Tools

Full ASAM assessments include a comprehensive evaluation of the six (6) dimensions of the ASAM Criteria®, in addition to other important clinical elements captured during the assessment interview.

Minus the exceptions listed above, medical necessity must be determined by a full ASAM CONTINUUM™ Assessment or Assessment Tool - Youth (Paper Version) found on the SAPC website and not solely by a screening tool except for Early Intervention Services, which can be determined using the ASAM screener for Youth (age 17 and under) and Young Adults (age 18-20) or the ASAM CO-Triage® Tool for Adults (age 21 and over) in the CENS Adult-At-Risk Program. Full ASAM assessments determine whether an individual meets the diagnostic criteria for an SUD from the current DSM. A full ASAM assessment does not need to be repeated unless the individual's condition changes.

Allowable Full ASAM Assessment Tools

- Youth (age 17 and under) and Young Adults (age 18-20)
 - Assessment Tool - Youth (Paper Version) found on the SAPC website
- Adults (age 21 and over)
 - ASAM CONTINUUM™ (validated electronic tool)
 - SAPC-approved paper-based full ASAM assessment

Intake and Enrollment

Establishing a comprehensive and standardized intake and enrollment process that balances the need for information with the need to create a streamlined and client-centered experience is important. The sections below describe essential components of the intake process.

Required Forms

Member Rights

Client rights ensure that all clients preserve their basic rights to independence, expression, decision-making, and action, as well as concern for personal dignity and human relationships. As a cornerstone of a client-centered and effective treatment system, SUD providers need to share an individual's member rights with them in writing, either collectively or individually.

[SAPC's Member Rights Poster](#) can be used and posted in visible areas throughout facilities.

Member Handbook and Client Orientation Video

In accordance with federal and State regulations, including [BHIN 25-042](#), LA County's [Behavioral Health Services Member Handbook \(February 2026\)](#) and any subsequent iterations outline the DMC-ODS and Specialty Mental Health Services (SMHS) plans, including information on eligibility, accessing provider agencies that meet the member's needs and preferences, rights and responsibilities, and the complaints/grievances and appeals process.

The Member Handbook is available in all threshold languages and needs to be provided to the member, at no charge, upon admission in one (1) of the following ways:

1. Provide a printed copy in person, **or**
2. Mail a copy of the printed copy to the member's mailing address; **or**
3. Provide via electronic format (e.g., email, or text message that includes a hyperlink or QR code to the handbook on the SAPC webpage), after obtaining the member's agreement to communicate by email; **and**
4. Direct the member to the SAPC webpage.

If at any time the member requests a printed copy of the member handbook after being directed to the County website, the provider agency must provide it at no charge to the member within five (5) days of the request. Providers are responsible for informing current clients whenever a new version of the Member Handbook is available by issuing a Notice of Significant Change. SAPC will notify provider agencies whenever there is a change in the Member Handbook.

Provider Responsibilities: Notice of Significant Change to the Member Handbook

In accordance with [BHIN 25-042](#), current clients need to be notified of any significant changes to the information contained in the member handbook at least 30 days prior to the effective date of the change. Significant changes are typically due to regulatory updates or other modifications. When changes are issued, SAPC will notify provider agencies and provide a copy of the updated document, along with the “Notice of Significant Change.” Providers need to take the following steps:

- Notify all current clients of changes to their Member Handbook, effective as of the stated date.
- Use one (1) or more of the following methods to notify members (this does not require documentation):
 - Provide a printed copy in person or mail a copy with the “Notice of Significant Change” to the client’s mailing address; **and/or**
 - Email an electronic copy with the “Notice of Significant Change” after obtaining the client’s agreement to communicate by email; **and/or**
 - Direct the client to the handbook available on [SAPC’s website](#) and provide the member with the “Notice of Significant Change” during regularly scheduled sessions.

The Member Orientation Video provides clients with a user-friendly summary of the Member Handbook and a description of key benefits under the DMC-ODS. Provider agencies are required to demonstrate that new and existing clients have viewed the video in its entirety within a specified number of days of the first service. The Member Orientation Video is available on SAPC’s website with subtitles in all threshold languages.

The [Member Handbook and Member Orientation Video Acknowledgment Form](#) provides the client with a summary of the benefits and confirms that they have viewed the client orientation video and/or received the Member Handbook. The Member Handbook and Client Orientation Video Acknowledgment Form is available via the link above or within Sage, under “Patient Handbook and Orientation Video Acknowledgment.” Provider agencies are required to do the following:

- Obtain the client’s signature upon admission.
- Provide a copy of the signed document to the client.
- Ensure the signed document is placed in the client record or completed in Sage, within 5 days of admission.
 - For Primary Sage Users who use the paper form, it needs to be uploaded to Sage via Provider File Attach. Use the following title: “Client Handbook Summary ##-##-##” that includes the date signed (e.g., Client Handbook Summary (04-01-25)).

Note: If a client requests the form in another language, the paper form is available in other threshold languages and should be uploaded to Sage as instructed above.

Notice of Privacy Practices

The [Notice of Privacy Practices](#) (available in English, Spanish, and other languages) is a required document to be provided to clients that informs them about their privacy rights and the provider agency’s legal duties regarding client health information. The law requires that each client’s PHI be kept private and secure. This notice must be provided to all new and continuing clients at their first service appointment.

Client Informing – Consent for Treatment and Information Sharing

The foundational principle of consent for treatment is that individuals must give permission before receiving any type of health treatment, test, or examination. Informed consent generally includes:

- Nature of the decision, treatment, and/or procedure
- Reasonable alternatives to the proposed intervention
- The relevant risks, benefits, and uncertainties related to each alternative
- Assessment of client understanding
- Acceptance of the intervention by the client

It is crucial that provider agencies thoroughly describe and explain the recommended services to equip clients with the necessary information to make informed decisions about the proposed care.

Additionally, the intake process needs to include education on the client consent information-sharing process and purposes. Sharing information with other SUD, physical, and mental healthcare provider agencies is essential to delivering coordinated care in clients' best interests. As such, clients need to be provided with thorough information on confidentiality regulations (HIPAA and 42 CFR Part 2) to obtain informed consent that balances the need for information sharing with the requirement to maintain privacy to support high-quality, coordinated care.

To be valid, the consent process needs to be free of coercion and voluntary, and the client giving consent must have decision-making capacity and be deemed competent to make the decision at hand.

Note: *Parental consent is not required for services delivered to youth aged 12 and over, but is required for services delivered to youth aged 11 and under.*

Why Encourage Information Sharing?

The SUD system encourages appropriate information sharing with physical and mental health systems, as well as social service systems, to improve care coordination and health outcomes. It is important to support appropriate information sharing as SUD clients often have other health conditions as well as social service needs that complicate care and can prevent long-term achievement of recovery goals if un/under-treated.

Confidentiality & Release of Information

SUD records are protected under both Federal standards established by HIPAA and the more stringent requirements of 42 CFR Part 2. Specialty SUD records receive this added level of protection due to the recognition that stigma associated with SUDs may result in negative outcomes if a client's health information is disclosed in a manner that does not support or advance the client's health or wellbeing. While sharing health information among SUD, physical health, mental health, and social service providers through care coordination can improve care integration and client outcomes, SUD PHI must be handled and disclosed in accordance with Federal and State regulations, and only with appropriate client consent.

Provider agencies within the SAPC SUD system must ensure that clients are informed of confidentiality requirements and practices related to SUD records, and that they are supported in providing informed consent for the release of their information. To provide informed consent, clients must be clearly informed of both the potential benefits of information sharing and the associated risks.

To ensure the appropriate sharing of SUD health information, providers must use ROI forms that comply with the requirements of [42 CFR Part 2](#). SAPC has developed a set of standardized ROI forms for use across the SAPC SUD Network. These forms comply with [42 CFR Part 2 Final Rule](#) and are designed to meet the clinical and operational needs of the network.

Clients may consent to share information using the following SAPC ROI forms.

Release of Information Forms

There are four (4) ROI forms used within the SAPC network:

SAPC Payment & Operations ROI Form

- **Purpose:** Authorizes SAPC-contracted providers to share information necessary to bill SAPC as the LA County Specialty Behavioral Health Plan for Substance Use, as well as DHCS, as the state Medi-Cal entity for the SUD clinical services delivered to the client. Also authorizes providers to share information necessary for routine clinical operations (e.g., denial resolution, audits & compliance activities, etc.).
- **Required:** Yes. This form is required for providers to have authorization to submit claims to SAPC. Both primary and secondary Sage Users are required to complete this form.
- **If not signed by client:** SAPC-contracted providers will not be able to bill SAPC for clinical services rendered. Clients will be responsible for arranging payment for services received

LA County Universal (LAC-UROI) ROI Form

- **Purpose:** Supports care coordination across LA County departments, including the DPH, Department of Health Services (DHS), DMH, Department of Homeless Services and Housing (HSH), DPSS, and other named entities within the form. Also allows sharing within the SAPC provider network, with MCPs, and Health Information Exchanges (HIEs) to further improve care coordination and meet state reporting requirements.
- **Required:** No. While SAPC encourages providers to discuss the potential Care Coordination benefits that this form enables, clients are not required to sign the LAC-UROI.
- **If not signed by client:** Clients may still receive services, but additional consents may be required for providers to support care coordination.

SAPC Treatment and Care Coordination ROI Form

- **Purpose:** Authorizes sharing of information either with the entire SAPC SUD Network and/or specifically named entities, including those outside of the SAPC provider network.
- **Required:** No.
- **If not signed by client:** Providers will not be able to share information for care coordination unless another appropriate ROI is in place.

SAPC Legal Proceedings ROI Form

- **Purpose:** Authorizes disclosure of information for any civil, criminal, or administrative legal or court proceedings. Under the [42 CFR Part 2 Final Rule](#), consent for legal proceedings cannot be combined with any other ROI forms.
- **Required:** No.
- **If not signed by client:** Providers will not be able to release information for the purpose of legal proceedings.

Clients Rights and Consent

Providers must discuss the benefits, risks, and alternatives of each ROI option with clients to support informed decision-making. Clients may revoke consent at any time by providing written notification to their SUD provider. Once consent is revoked, providers may not make future disclosures under that authorization. However, once disclosed, SUD records cannot be recalled. Under the [42 CFR Part 2 Final Rule](#), once SUD information is disclosed, it may be redisclosed in accordance with HIPAA without additional consent. The exception is that SUD information cannot be redisclosed for legal proceedings against the client without a separate, specific consent.

Additional ROI Requirements

- With the exception of the LAC-UROI form, ROI forms are agency-specific. Clients must complete new ROI forms when transferring to a different SAPC provider agency.
- SAPC Payment & Operation ROI Form must be collected by each provider agency to ensure authorization to bill for service.
- Sage ROI forms apply at the agency level and are valid across all sites by the contracted provider.
- Provider agencies must ensure ROI and consent forms are updated as needed when forms expire or become inactive, in accordance with Federal, State, and SAPC policies.

For additional information on utilizing different SAPC ROI Forms, see [SAPC's Sage-PCNX webpage](#) for the most current version of the Sage-PCNX Release of Information Job Aid.

Client Informing – Complaint/Grievance and Appeal Process

All clients receiving services within LA County's specialty SUD system have access to a complaint/grievance and appeal process to express dissatisfaction or request reconsideration of an action taken by either the provider or the County (e.g., denial of a requested service). Clients must be informed about their rights and the availability of due process for filing complaints/grievances and appeals, both at the provider agency level and when concerns are more appropriately addressed to the County. Clients should be given a form to sign indicating they have been informed of their rights. This signed form should be maintained in the client file.

Provider Agencies also need to ensure that this information is visibly posted in a public area at each treatment site and is available in the client's preferred language. These complaints/grievances and appeals may be filed by the client, practitioner, or another designated entity. For additional information, see [Complaint/Grievance Process](#) and [Appeals Process](#) sections.

Required Processes

Admission

When individuals interact with provider agencies, they may need to be entered into Sage to access forms such as screenings or for eventual billing purposes. Historically, Sage admissions have been limited to one (1) episode per client, per agency, for which they are never discharged. This made it difficult to identify “active clients.” To help address this gap, providers are required to complete the Provider Site Admission form. This form must be completed by all treatment providers within Sage when a client is admitted or re-admitted to a specific contracting provider site for any LOC, including RBH and RS, if provided as a standalone service.

When a client is concurrently enrolled in services, the Provider Site Admission form is completed for each LOC. For example, if a client is enrolled in ASAM 1.0 and RBH at the same agency, there needs to be two (2) Provider Site Admission forms.

Assessment

Part of the intake process involves assessing the client by using a full ASAM CONTINUUM™ Assessment to determine medical necessity and confirm LOC placement. For additional information, see [Access to Care – Determining Medical Necessity – Assessment](#) section.

Problem List Development and Updates in Non-OTP Settings

Non-OTP provider agencies must prepare individualized Problem Lists in coordination with the client, based on information obtained during the intake and assessment process, and update them on an ongoing basis as the client’s progress within treatment is noted. The provider staff(s) responsible for the client’s care creates and maintains the Problem List.

The minimum timeframes for completing, reviewing, updating, and obtaining LPHA signatures on Problem Lists depend on the LOC in which treatment is delivered. Problem List updates need to be completed by practitioners delivering services to the client whenever a problem is added, modified, or removed from the Problem List and finalized by LPHAs within the timeframes outlined in [Table 18: Problem List Minimum Requirements for non-OTP Settings](#).

The Problem List is a list of symptoms, conditions, diagnoses, social drivers, and/or risk factors identified through assessment, psychiatric and other diagnostic evaluations, crisis encounters, or other service encounters. A problem identified during a service encounter may be addressed by the documenting practitioner (within their scope of practice) during that service encounter, and subsequently added to the Problem List. The Problem List needs to be updated on an ongoing basis to reflect the client’s current presentation.

The Problem List includes, but is not limited to, the following:

- Diagnoses identified by a provider staff acting within their scope of practice.
- Associated diagnosis-related specifiers from the current DSM, when applicable.
- Current ICD-CM codes.

- Problems identified by a provider staff acting within their scope of practice.
- Problems or illnesses identified by the client and/or significant support person, if any.
- Name and title of the provider staff who identified, added, or removed the problem, and the date the problem was identified, added, or removed.

Note: Provider staff need to add to or remove problems from the Problem List when there is a relevant change to a client's condition.

Care Planning in Non-OTP Settings

Care planning is an ongoing, interactive component of service delivery rather than a one-time event. Non-OTP provider staff need to engage in ongoing collaboration with clients to identify and prioritize problems, explore EBPs and care options, identify action steps to address problems, and review the effectiveness of these action steps with a client-centered and culturally sensitive approach, which is an integral part of SUD treatment. Standalone Treatment Plans are not required in non-OTP settings. The plan of care should be clearly documented in all clinical documentation.

Treatment Plan Development and Updates in OTP Settings

OTP provider staff need to prepare individualized written Treatment Plans in coordination with the client and based on information obtained during the intake and assessment process.

Treatment Plans need to be completed upon intake and submitted within the timeframes outlined in [Table 19: Treatment Plan Minimum Requirements for OTPs](#). Every attempt must be made to complete and obtain client and LPHA/Medical Director signatures within the stated timeframe. However, given that it may take time for the client to sign and print their name on the Treatment Plan, the provider staff needs to obtain both the client's and LPHA's signatures no later than 28 days after the first service/first intake appointment. The LPHA or Medical Director sign and print their name on the Treatment Plan within 15 days of the client signing. These are the maximum time frames, but it is best to complete and sign the Treatment Plan as soon as possible, ideally close to the treatment admission date.

Note: Treatment Plan updates need to be completed and signed by both the client and the LPHA, as well as the counselor, if applicable.

Treatment Plans must include:

- Statement of problems to be addressed that are consistent with the qualifying diagnosis
- Goals to be reached that address each problem
- Action steps to be taken by the provider staff and/or client to accomplish identified goals
- Target dates for the accomplishment of action steps and goals
- Description of services, including the type and frequency of counseling to be provided and steps taken to complete the physical exam
- Proposed type(s) of interventions/modalities that include frequency and duration

- Specific, quantifiable goals and treatment objectives (e.g., SMART goal: Specific, Measurable, Attainable, Realistic, and Time-bound) related to the client's SUD diagnosis and multidimensional assessment
- DSM diagnosis for OUD and any other SUDs
- Assignment of a primary therapist or counselor
- Physical exam goal or documentation

Physical Examination

Physical examinations are required to ensure that clients are medically stable and receive the necessary physical health services to facilitate their biopsychosocial well-being. Clients are required to have a physical examination within the last 12 months on file, and the Physician, Nurse Practitioner (NP), or Physician Assistant (PA) is responsible for reviewing documentation of the most recent (within the last 12 months) physical examination within 30 calendar days of the client's date.

In accordance with [CCR Title 22](#), if the physician, NP or PA is unable to acquire or review a client's physical exam conducted in the last 12 months, the provider staff (registered or certified counselor or LPHA) needs to include a Progress Note detailing efforts made to obtain this documentation; and it needs to be conducted within 30 calendar days of the client's admission, and again it needs to be documented in the clinical notes with the goal of obtaining a physical examination with a specified completion date.

Data Reporting Requirements

Provider agencies are required to collect and submit CalOMS/LACPRS data and Drug and Alcohol Treatment Access Report (DATAR):

- **CalOMS/LACPRS:** Includes data elements that gather information on client characteristics, social factors, physical and mental health, employment, and criminal justice involvement, as well as drug use and treatment. Importantly, CalOMS/LACPRS includes data elements that serve as SUD treatment and/or recovery outcome measures, obtained by measuring changes in client responses from admission to discharge.
 - CalOMS/LACPRS admission data is required as follows:
 - New admissions
 - Any changes in services/LOC
 - Any changes in location
 - All clients, regardless of funding source(s) (e.g., private pay, commercial insurance)
 - No concurrent CalOMS/LACPRS allowed for the same type of services/LOCs
 - ASAM 0.5, RS (except standalone services), and "OTP – Detoxification" answer only the core questions that are pre-programmed in CalOMS forms
 - Use the treatment LOC (e.g., OP) when RS are provided concurrently
 - When a client transitions from one (1) residential LOC to another within the same residential facility (3.1 to 3.3 to 3.5 or reverse order), a new CalOMS Admission is not required; and CalOMS discharge status updates per [BHIN 25-001](#):

- Standard Discharge statuses one (1), two (2), and three (3) definitions have been updated to allow for a standard discharge with the client has made satisfactory progress in treatment, discharge planning has commenced, but experiences a life circumstance that prevents them from completing the discharge interview and/or last treatment service and notifies the program; and the treatment program has the information and client file documentation necessary to accurately complete the discharge questions without having to guess the responses.
 - Discharge Status 1: completed Treatment Plan & Goals (Referred/Standard)
 - Discharge Status 2: completed Treatment Plan & Goals (Not Referred/Standard)
 - Discharge Status 3: left Before Completion with Satisfactory Progress (Referred/Standard)
 - CalOMS Requirement for CIFP
 - New Admissions:
 - If a client's status qualifies for the CIFP, ensure to select "Client Ineligible for Federal Programs (CIFP)" under *Other Funding Program* when you submit CalOMS Admission data
 - Existing Admissions:
 - If a client was initially admitted with Medi-Cal, but no longer eligible while remaining in treatment, and is now qualified for the Client Ineligible for Federal Programs (CIFP):
 - ◇ The existing CalOMS Admission record needs to be discharged using the end date of the Medi-Cal program/last date of clinical services under Medi-Cal as the Discharge Date.
 - ◇ Open a new CalOMS Admission form identifying CIFP under *Other Funding Program*, using the CIFP start date as the Admission Date
 - This is for internal management of funding sources and to facilitate the State CalOMS data submission.
 - CalOMS/LACPRS Submission Deadlines:
 - Admission Data: Full (100%) data needs to be submitted **within seven (7) calendar days** of a client's entry into treatment.
 - Discharge Data: Full (100%) data needs to be submitted **on the day of discharge** from the treatment.
 - Annual Updates: Full (100%) data needs to be submitted **no later than 12 months** from the client's admission anniversary date; and no earlier than 60 days before the client's admission date anniversary.
 - The Non-Compliance Open Admissions reports for missing CalOMS Annual Updates are sent to provider agencies on the first business day of each month, and all non-compliant annual updates need to be submitted by the 10th of the same month.
 - If a provider agency plans to be temporarily inactive or will not be in operation for the next month and thus **not expecting any CalOMS submissions**, providers need to promptly email SAPC's Health Outcomes and Data Analytics Division (HODA) CalOMS Team at hoda_caloms@ph.lacounty.gov to report Provider No Activity (PNA).

- CalOMS/LACPRS Data Quality Report (DQR) includes:
 - Alerts on missing records/data fields, timeliness related to CalOMS/LACPRS data reporting.
 - Selected monthly and year-to-date capacity building and incentive metrics.
 - Notification on the 15th of each month (or the following business day if the 15th falls on a weekend or a LA County holiday)

For questions regarding CalOMS/LACPRS data submission, visit SAPC's CalOMS Resources webpage or email hoda_caloms@ph.lacounty.gov.

- **DATAR:**

- **Overview:** Requires monthly data submission on:
 - Total and public capacity, availability at the end of reporting month, and number of days enrollment exceeded 90% capacity.
 - Number on waiting list, total number of waiting days, and waiting list by applicant characteristics (e.g., injection drug users, pregnant women).
 - **Note: Expected practice is to refer client to a facility with available capacity unless the client specifically requests to wait for an opening at the provider agency/site.**
 - DATAR weblink: <https://datar.dhcs.ca.gov>
- **Submission Deadlines:**
 - DATAR monthly reports are **due on the 7th of the month** for the previous month's activities to meet the State's deadline on the 10th of the reporting month.
 - SAPC-HODA generates the state's monthly non-compliance report and cross-reference it with the state DATAR dashboard on the 8th of each month to identify delinquent provider agencies; and sends non-compliance emails mandating submission **no later than the 10th of the month**.
- **DATAR Modalities:** DATAR only displays contracted modalities (e.g., LOC) at a facility.
 - If a modality (e.g., LOC) listed on the report is not contracted with SAPC, email hoda_datar@ph.lacounty.gov.
 - For abbreviations of the types of services displayed on the DATAR form that are cross-referenced with the ASAM LOC, see [Table 7: ASAM Level of Care vs. DATAR Modalities](#).
- **Access to the DATAR Online Application:**
 - Submit a registration form to add, update, or delete provider staff.
 - The provider staff who registers is the "DATAR analyst" and is responsible for submitting monthly reports. Provider agencies should register additional staff for each provider number to serve as a backup.
 - Request and submit registration forms to hoda_datar@ph.lacounty.gov.

Table 7: ASAM Level of Care vs. DATAR Modalities

ASAM LOC	DATAR	
	Abbreviation	Description
ASAM 1.0 (Outpatient)	ODF	Outpatient Drug-Free
ASAM 2.1 (IOP)	IOT/DCR	Intensive Outpatient Treatment / Daycare Rehab
ASAM 3.1	RES	Residential Drug-Free
ASAM 3.3		
ASAM 3.5		
ASAM 3.2 - WM	RES DTX-NH	Residential Detoxification – Non-Hospital
ASAM 3.7 - WM	Other	Other
ASAM 4.0 - WM	Other	Other
ASAM 1 - OTP	MAINT NTP/OTP	Narcotic Treatment Program / Opioid Treatment Program - Maintenance
ASAM 1 - WM Ambulatory Withdrawal Management	ODF or IOT/DCR	Outpatient Drug-Free or Intensive Outpatient Treatment / Daycare Rehab
Recovery Services	N/A	N/A

Treatment Perception Survey

Providers are **required** to participate in the annual administration of the Treatment Perceptions Survey (TPS) to clients in October ([BHIN 25-025](#)).

- TPS is designed to measure client perceptions across domains of access, quality of care, satisfaction, care coordination, and outcomes.
- TPS is offered to every client aged 12 and older who receives services either face-to-face or via telehealth during the survey period. FBS are considered face-to-face treatment services.
- TPS is available in all threshold languages and can be completed either online or paper survey.
- The SAPC-HODA TPS team distributes online survey links customized by location, LOC, and age group, along with prefilled paper surveys including location, LOC, and provider numbers prior to the TPS data collection period.
 - Prior to designing both the online and paper surveys, the TPS team will send a validation form to confirm facility information (e.g., LOC, facility address) and survey needs (e.g., survey type, need for youth, Spanish, or paper copies). This form needs to be completed and returned by the deadline.
- The TPS Guide and training materials are available on SAPC's [Treatment Perceptions Survey Resources webpage](#).

For questions regarding the TPS, email hoda_tps@ph.lacounty.gov.

Service Benefit and Levels of Care

Addiction treatment is delivered across a continuum of services that reflects the severity of the SUD and the intensity of services required. One of the County's key goals is to facilitate SUD service delivery for the right service, at the right time, in the right setting, for the right duration.

Referral to a specific LOC needs to be based on a complete assessment of each client. The primary goal is to place the client in the least restrictive setting that supports the goals of recovery and resiliency, learning and development, and enhanced self-sufficiency. Initial referrals may be made using a brief screening tool, either the Youth and Young Adult Screener or the ASAM CO-Triage® Tool for Adults (ages 21 and over). Then, a more comprehensive assessment can be completed at the treatment program to confirm placement. In LA County, LOC determinations are based on the ASAM Criteria®. In general, the preferred and most appropriate LOC is one that is the least intensive while still safely meeting the unique treatment objectives of the client and treatment team.

LOC determinations begin with the full ASAM CONTINUUM™ Assessment, which provides a comprehensive evaluation of a client's risks, needs, strengths, skills, and resources. The ASAM assigns a rating for each of these dimensions. These ratings will help you to decide the correct LOC. If the client has physical or mental health conditions, the priority is to stabilize them immediately. If they have more than one (1) physical or mental health condition, the decision about how to stabilize them should be based on the most severe of these needs. That may mean they are placed within the SUD system of care (including OTPs), or in the physical or mental health systems. Treatment is best conceptualized as a flexible continuum, marked by different ASAM LOCs, with graduations of service intensities for OP, residential, and WM services; see [Table 8: ASAM Criteria Continuum of Care for SUD Treatment](#).

Table 8: ASAM Criteria Continuum of Care for SUD Treatment

Benefits	ASAM LOC	Description
Early Intervention Services	0.5	For Youth (age 17 and under) and Young Adults (age 18-20) who do not meet DSM criteria for an SUD but would benefit from psychoeducation and other services to correct or improve a substance-related health condition as part of the EPSDT benefits.
Outpatient	1.0	For clients who are stable with regard to acute intoxication/withdrawal potential, biomedical, and mental health conditions.
Intensive Outpatient	2.1	For clients with minimal risk for acute intoxication/withdrawal potential, medical, and mental health conditions, but need close monitoring and support several times a week in a clinic (non-residential and non-inpatient) setting.
Low-Intensity Residential (Clinically Managed)	3.1	For individuals who need time and structure to practice and integrate their recovery and coping skills in a residential environment.
High-Intensity Residential, Population Specific (Clinically Managed)	3.3	For clients with primarily cognitive functional limitations who require a slower pace of treatment and are unable to fully participate in the social and therapeutic environment.

Benefits	ASAM LOC	Description
High-Intensity Residential, Non-Population-Specific (Clinically Managed)	3.5	For clients who have specific functional limitations and need a safe and stable living environment to develop and/or demonstrate sufficient recovery skills to avoid immediate relapse or continued use of substances.
Opioid Treatment Program	1-OTP	For clients with OUDs who require methadone or other MAT.
Recovery Bridge Housing	N/A	For clients who are homeless or unstably housed, and are concurrently enrolled in an OP, IOP, OTP, RS, or Ambulatory-Withdrawal Management LOCs.
Recovery Housing	N/A	For clients who are homeless or unstably housed, and are voluntarily seeking to live in recovery-oriented housing. Residents are encouraged but not required to be concurrently enrolled in treatment.
Recovery Services	N/A	For clients in care, including CENS, during transition in setting or intensity of care, or following discharge from a treatment episode, who require additional support to organize internal and community resources for ongoing self-management.
Ambulatory-Withdrawal Management (Outpatient) <i>without</i> extended on-site monitoring	1-WM	For clients with mild withdrawal who require either daily or less than daily supervision in an OP setting (e.g., physician's office or clinic).
Ambulatory-Withdrawal Management (Outpatient) <i>with</i> extended on-site monitoring	2-WM	For clients with moderate withdrawal who require daytime WM and support. Includes daily assessments with daytime WM and support and supervision in a non-residential setting (e.g., day hospital).
Clinically Managed Residential-Withdrawal Management	3.2-WM	For clients with moderate withdrawal who require 24-hour support to complete WM and increase the likelihood of continuing treatment or recovery.
Medically Monitored Inpatient-Withdrawal Management	3.7-WM	For clients with severe withdrawal who require 24-hour inpatient care and medical monitoring with nursing care and physician visits.
Medically Managed Intensive Inpatient-Withdrawal Management	4-WM	For clients with severe, unstable withdrawal who require 24-hour nursing care and daily physician visits to modify WM regimen and manage medical instability.

Source: American Society of Addiction Medicine. (2013). The ASAM criteria: Treatment criteria for addictive, substance-related, and co-occurring conditions (3rd ed.). The Change Companies.

OTPs (also known as Narcotic Treatment Programs or NTPs) are an essential component of the continuum of care for SUDs. As with other LOC, ensuring a flow of appropriate referrals between OTPs and other SUD providers, and, when necessary, into other health systems, is critical to delivering high-quality OTP services. In addition to the various Federal and State requirements governing OTPs, the quality and resource management standards and requirements set by the SAPC's Quality Improvement Section (SAPC-QI) and SAPC-UM also apply to OTPs.

The ASAM Criteria® also outlines a continuum of care for WM for Adults (age 21 and over). Since severe withdrawal is less common in adolescents than in adults, WM for adolescents is unique. When an adolescent is in withdrawal and does not require emergency care, every effort should be made to provide WM services in the setting in which adolescent clients are receiving their SUD care. **WM for adolescent populations will be approved by SAPC on a case-by-case basis as clinically warranted and based on medical necessity.** When the recommended LOC is unavailable, providers need to arrange for clients to obtain the necessary services through an alternative program.

Effectiveness and safety should be the priority in these circumstances, which may require that clients be placed in higher LOCs than the ASAM Criteria indicates. In these instances, it is the providers' responsibility to advocate for the client and justify and explain the reason for the alternative LOC or intervention, based on the available clinical documentation.

Services provided at the various LOCs should reflect the client's clinical condition, including consideration for severity level and functional impairment. Services include but are not limited to individual counseling, group counseling, family therapy, patient education, psychosocial interventions, medication services, collateral services, Care Coordination, crisis intervention, care planning, Recovery Incentives-Contingency Management (RI-CM), RS, and discharge services.

As clients transition between LOCs, progress in all six (6) ASAM dimensions should be formally assessed at regular intervals to monitor for changes in the client's condition, in accordance with the client's severity level and functional impairment, as clinically indicated. These assessments help to ensure that clients are placed in an appropriate LOC based on medical necessity, as reviewed and verified by an LPHA. LOC transitions need to be based on clinical need as the client's condition changes, not on the type of health coverage the client has, or on what is available or more convenient for the provider.

Continuity of care and longitudinal follow-up are critical for SUD clients. Referrals and linkages to different services and LOCs within the SUD, physical, and mental health systems help to ensure that client needs are appropriately addressed. High-quality care is characterized by the seamless linking of different LOCs, both within the SUD system of care and between other healthcare systems. This streamlined system of care can be achieved through Care Coordination, role induction (preparing individuals for treatment by sharing the rationale of treatment, the treatment process, and their role in that process), warm hand-offs, and assertive outreach.

Provider agencies should also be familiar with additional requirements related to SUD treatment. These include [CCR Title 22](#), [CCR Title 9](#), [BHIN 17-017](#), provisions related to LA County's implementation of DMC-ODS and CalAIM, SAPC Bulletins and INs, and contracted Specific Services to be Provided and Definitions of Services. A brief overview of funded services and LOCs are outlined below. For a detailed description of ASAM LOCs, see [The ASAM Criteria textbook](#).

Care Coordination

Care Coordination, formerly referred to as Case Management, links clients with appropriate health and social services to address specific needs and achieve treatment goals. Care Coordination is a client-centered service intended to complement clinical services, such as individual and group counseling, and address areas in an individual's life that may negatively impact treatment success and overall quality of life. Care Coordination offers support services to clients to increase self-efficacy, self-advocacy, basic life skills, coping strategies, self-management of biopsychosocial needs, benefits and resources, and reintegration into the community.

Care Coordination is:

- Client-centered (i.e., focused on meeting the varied needs of clients)
- A point of contact between SUD care, mental health care, medical care, and social services
- Advocacy by acting in the client's best interests

- Helping the client navigate and obtain community resources, and integrate into the community after discharge from inpatient or residential services
- Culturally sensitive
- Flexible
- Anticipatory with the understanding that SUDs may be chronic and relapsing

Care Coordination is available to all clients who enter the SUD treatment system. This service is available throughout treatment and may be continued during RS. Care Coordination services may be provided in-person, by telephone, or by telehealth.

Overview of Care Coordination and Services

The primary goal of Care Coordination is to ensure clients in SUD treatment receive support and services necessary to be successful in meeting treatment and recovery goals. A barrier to successfully completing treatment may be a lack of communication and established referral procedures between health and social systems. Care Coordination is effective at keeping individuals in treatment and moving toward recovery by addressing other life challenges along with substance use.⁷ Care Coordination services are especially important for clients with chronic health problems, CODs, PEH, or justice involvement.

Although an important component of Care Coordination in SUD treatment is connecting clients to outside systems of care, such as physical and mental health systems, it is equally important in transitioning clients through the SUD system of care. Care coordinators need to have a working knowledge of the appropriate resources to successfully link clients to services and resources (e.g., financial, medical, or community services). Services provided through Care Coordination are tailored to facilitate and track continuity of care across all systems of care.

Provider staff need to perform three (3) core Care Coordination functions to ensure successful treatment outcomes and recovery: **Connection**, **Coordination**, and **Communication**. Although not an exhaustive list, see [Table 9: Core Functions of Care Coordination](#) for a list of the three (3) functions and the respective activities that can be performed and billed under Care Coordination.

- **Connection:** Establishing connections through referrals that link clients to housing, educational, social, prevocational, vocational, rehabilitative, or other community services. This includes providing high-quality referrals and linkages to resources and services necessary to address the problems documented on the Problem List (for non-OTP settings) or in the Treatment Plan (OTP settings). High-quality referrals and linkages require the care coordinator to play an active role in reducing access barriers and ensuring clients have “actual” access to needed services. This means going beyond providing resource lists to clients to actively establishing relationships and protocols with external providers, ensuring clients are connected to relevant agencies and services upon referral.

Note: Care coordinators assist clients with applying for and maintaining health and public benefits (e.g., Medi-Cal, Minor Consent Program, GR, and LA County-funded programs/projects); and help clients who have moved transfer their Medi-Cal benefits from the previous county of residence to LA County.

⁷ SAMHSA. (2015). Chapter 4 – Evaluation and Quality Assurance of Case Management Services. *Treatment Improvement Protocol (TIP) Series, No. 27*. <https://library.samhsa.gov/sites/default/files/sma15-4215.pdf>

- **Coordination:** Care coordinators act as a bridge between health and human service providers to ensure that information is appropriately exchanged, and clients are successfully linked to needed resources/services. Activities include helping clients set up medical appointments, ensuring SUD providers at the treating agency are aware of the client's other services, following up with clients in service transition, and notable events. For example, care coordinators follow up with clients within a few days of an ER visit, hospital discharge, or discharge from a residential facility. Care coordinators also coordinate successful transitions between SUD LOCs, including setting up an assessment appointment, transferring necessary documentation to the receiving provider agency, and providing a warm hand-off for necessary services. If clients are transitioned to a higher or lower LOC at a different provider agency, the care coordinator should use the SBAT to identify provider agencies that meet the client's needs. Care coordinators are expected to schedule appointments and track referrals until obtaining confirmation that clients have enrolled at the receiving provider agency.
- **Communication:** Communication is the primary way in which Care Coordination activities are successfully performed. It is the responsibility of care coordinators to serve as a liaison between clients and their service providers. Communication may include telephone calls, emails, letters, Progress Notes, and/or reports to the County, State, and other service providers on behalf of the client. For example, a client may need a letter sent to a judge verifying their participation in SUD treatment. At times, care coordinators also need to advocate on behalf of clients. If client service needs are unmet, care coordinators educate clients about their rights and advocate for them with their service providers.

Table 9: Core Functions of Care Coordination

The 3 Cs of Care Coordination	
1. <u>CONNECTION</u>: Referrals that link clients to housing, education, social, prevocational, vocational, rehabilitative, or other community services.	
• Establishing and Maintaining Benefits ◦ Helping clients to apply for and maintain health and public benefits (e.g., Medi-Cal, GR, Perinatal, Housing, etc.). ◦ Assisting PEH in accessing the Coordinated Entry System (CES), and if needed, assisting in completing any intake/assessment documents such as the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT). ◦ Transferring benefits from the previous county of residence to LA County for clients who have moved. • Community Resources ◦ Coordinating with other service providers to provide individualized connection, referral, and linkages to community-based and governmental services and resources, including direct referrals to local food banks and/or community churches for groceries and meals, clothing assistance, educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.	

The 3 Cs of Care Coordination**2. COORDINATION: Acting as a liaison to aid in transitions of care and arranging for health services and social services.**

- Transitioning between SUD LOCs
 - Facilitating necessary transitions in SUD LOCs (e.g., from Residential to IOP treatment, OP to RS, etc.), including initiating referrals to the next LOC, and coordinating with and forwarding necessary information to the accepting provider agency.
- Mental and Physical Health Services
 - Coordinating care with physical health providers (including managed care health plans such as L.A. Care, Health Net, and Kaiser), community health clinic providers, and mental health care providers to ensure a coordinated approach to whole-person care by monitoring and supporting care for other health conditions.
- Social Services
 - Coordinating with State and County entities (DPSS, DCFS, LAC-Probation, LA Superior Courts, Housing Providers, etc.) to ensure the social aspects of health and well-being are being coordinated with health services.

3. COMMUNICATION: Correspondence, including emails, letters, and reporting documentation, by the care coordinator to the County, State, and other service providers on behalf of the client.

- Health Providers
 - Communicating with physical health (including managed care health plans such as LA Care, Health Net and Kaiser), community health clinics providers, and mental health providers to ensure a coordinated approach to whole-person health service delivery.
 - Monitoring and following up with other agencies regarding scheduled services and/or services received by clients.
- Service Partners
 - Communicating with DPSS workers, DCFS social workers, DMH workers, LA Superior Courts, LAC-Probation Officers, Housing Providers, etc., to align objectives and activities.
- Advocacy
 - Advocating for clients with health/social service providers, County, and community partners, and others (such as officials at schools, juvenile or adult court hearings and/or meetings with corrections staff, and Student Attendance Review Boards or other school-related hearings) in the best interests of clients (e.g., respectfully advocating for necessary services to be provided in a timely manner).

Care Coordination: Considerations for Vulnerable Groups

People with special needs may require more intensive Care Coordination activities. Moreover, some County agencies (DCFS, DPSS, Law Enforcement, LA Superior Courts, etc.) may require providers to submit additional documentation and perform additional activities (e.g., attending court hearings or meeting with case workers to advocate on the client's behalf).

These groups include people living with HIV/AIDS or mental illness, PEH, PPW, youth, and justice-involved individuals. Each population will require coordinated activities to help individuals effectively navigate, access, and participate in treatment, as well as secure housing and obtain other supportive services.

People Experiencing Homelessness

A client-centered Care Coordination approach ensures that PEH participate in identifying goals and service needs, and that there is a shared accountability with the care coordinator. Care Coordination aims to empower people, draw on their strengths and capabilities, and promote an improved quality of life by facilitating timely access to the necessary supports to help them obtain and maintain housing. Care coordinators require the right skills and a thorough understanding of the community to succeed.

Therefore, it is highly recommended that care coordinators take the Direct Service Training Curricula Courses provided by the [Los Angeles Homeless Services Authority \(LAHSA\) Centralized Training Academy](#). These courses emphasize the application and adherence to EBPs of Trauma-Informed Care, Cultural Humility, Housing First, Harm Reduction, MI, and Critical Time Intervention. The courses address how care coordinators can apply these practices to their work with the following subpopulations: chronically homeless; single adults; families; youth; young adults; women; Lesbian, Gay Bisexual, Transgender, Queer (LGBTQ+, “+” represents other identities such as non-binary, asexual, pansexual, two-spirit, and more) people; people with disabilities; domestic violence/intimate partner violence (DV/IPV) survivors; human trafficking survivors; the aging and the elderly; incarceration/reentry; and veterans.

Justice-Involved

The care coordinator communicates with criminal justice staff (e.g., LAC-Probation, LASD, LA Superior Courts) to ensure that Care Coordination activities meet the referring agency's criminal justice supervision requirements. As needed, care coordinators may be asked to perform the following activities:

- Attend court hearings to report the progress of SUD treatment.
- Arrange letters, phone calls, emails, and/or direct in-person meetings with law enforcement agencies (LAC-Probation, LASD, and Parole) and courts (LA Superior Courts) about client enrollment and SUD treatment progress.
- Receive health records related to in-custody treatment for individuals being released from custody, including those released from facilities outside of LAC.

Children and Family Services

For clients participating in County-funded programs for children and family services, one of the primary focuses for providers should be the family unit (e.g., helping clients meet the requirements set forth in their family reunification plan). Therefore, Care Coordination activities help clients gain access to services and resources that take family needs into account. Care Coordination activities for this group may include linkage to parenting classes, childcare, food and clothing assistance, and family planning services.

When working with children, families, and perinatal women, the care coordinator confers with the client's DPSS worker, DCFS social worker, DMH worker, etc., at least once to ensure that the objectives and activities developed in Care Coordination are consistent and do not unintentionally overwhelm the client. For additional information about these populations and requirements, see the following sections: [Pregnant and/or Parenting Women Population](#), [Family Programs – DPSS Programs – CalWORKs](#), and [Family Programs – DCFS Programs – RSC Program](#).

Care Coordination: Service Requirements and Components

Eligibility Criteria for Care Coordination Services

Care Coordination services are available to all clients who are enrolled in any LOCs under the DMC-ODS. Reimbursement eligibility criteria for Care Coordination services match the DMC-ODS enrollment criteria.

Staffing Requirement

The care coordinator needs to be a registered/certified SUD counselor and/or license-eligible LPHA/LPHA.

Documentation

Planning and documentation are important to a structured and integrated Care Coordination model. Following the ASAM CONTINUUM™ Assessment or Assessment Tool - Youth (Paper Version) found on the SAPC website, a care coordinator needs to discuss the results and collaborate with the client to develop a plan of action that includes the client's Care Coordination needs. The plan should address the problems documented in the client's Problem List and Progress Notes in non-OTP settings, or in the Treatment Plan and Progress Notes in OTP settings. For CENS RS, see CENS Standards and Practices on SAPC's [Manual, Bulletins, and Forms](#) webpage.

The Care Coordination plan should include tracking key service components, including Care Coordination needs, Connection/Coordination/Communication activities, and advocacy efforts. Progress notes that clearly document Care Coordination activities are critical for demonstrating the rationale and details of the activities performed. Care coordinators are responsible for working with clients to implement a Care Coordination plan that addresses the problems listed on the Problem List, follow the action steps documented in the plan section of the Progress Note narrative (non-OTP settings) or the Treatment Plan (OTP settings), and monitor the client's progress.

Care Coordination activities are documented in progress notes and include a description of the client's prioritized service needs. In non-OTP settings, action steps to address the client's prioritized needs are documented in progress notes. In OTP settings, the Treatment Plan includes a problem statement, long-term goals, short-term goals in SMART format, action steps, desired outcomes, and target completion dates. When appropriate, The Progress Notes (non-OTP settings) or the Treatment Plan (OTP settings) describe barriers, ways for handling anticipated complications, or alternative plans to achieve the stated objectives. Provider staff obtain an ROI documented on SAPC-approved ROI forms whenever a Care Coordination activity requires releasing any client information, including the client's enrollment in an SUD program.

Provider agencies maintain verifiable documentation related to the delivery of care coordination services, including, but not limited to, the amount of time spent by staff for the provision of these services. Documentation is provided upon request(s) for compliance audit and/or review purposes to support billing claims. Compliance activities may include audits/reviews from federal, State, and County departments as part of funding verification, including DMC and SUBG.

Treatment Plan

Evaluating Care Coordination needs can be documented in progress notes as an assessment activity, and discussing the Care Coordination component of the Plan of Care can be documented under Care Coordination. Updating Problem Lists (non-OTP) or Treatment Plans (OTP settings) is not a Care Coordination activity and is not billed under the Treatment Planning billing code. Billing under Care Coordination requires the Care Coordinator to engage in a Care Coordination activity. A Care Coordination activity includes coordinating with a person, agency, and/or service to connect the client to a service or resource not provided by the agency that would support the client's SUD treatment and recovery goals.

Service Hour Requirements

For most LOCs, Care Coordination services can be billed separately from other services. The only exceptions are WM Levels 3.7, and 4.0, where the benefit is covered by the day rate, and there is **not** a separate billable service. Care Coordination services may be delivered face-to-face, by telephone, or through telehealth.

Care Coordination service delivery needs to be consistent with client confidentiality as outlined in [42 CFR Part 2](#); [42 CFR Part 438](#); [HIPAA](#); [CCR Title 9, Chapter 8: Certification of Alcohol and Other Drug Counselors](#); and [Title 22 CCR § 51341.1 - Drug Medi-Cal Substance Use Disorder Services](#), and an appropriate ROI needs to be obtained for care coordination that accords with these regulations.

Early Intervention Services for Youth and Young Adults (ASAM 0.5)

Early Intervention services are covered DMC services under EPSDT (ASAM 0.5) for Youth (age 17 and under) and Young Adults (age 18-20) who have been screened and determined to be at risk of developing an SUD (i.e., but who do not meet DSM criteria for an SUD) and would benefit from psychoeducation (using the *“Healthy YOUth: An Early Intervention Service Model for Addressing Substance Use Risk and Promoting Wellness Among At Risk Youth”* Curriculum) and any other services covered under the OP LOC as early intervention services and in accordance with the EPSDT benefit to correct or ameliorate a substance use condition. This includes services that sustain, support, improve, or make more tolerable an existing substance misuse or an SUD condition. The Early Intervention services benefit also includes the receipt of any DMC-reimbursable service available in OP settings. For a description of service components available in Early Intervention and OP treatment settings, see [Early Intervention and Treatment Service Components](#) section.

Early Intervention services are provided in an OP modality and must be available as needed, based on individual clinical needs, even if the member is not participating in the full array of OP treatment services.

A full assessment utilizing the ASAM criteria is not required for a DMC member to receive Early Intervention services. To establish medical necessity for Early Intervention services, providers need to screen youth (age 17 and under) and/or young adults (age 18-20) using the ASAM Screener for Youth and Young Adults. For additional requirements, see [Checklist of Required Documentation for Utilization Management](#).

While an SUD diagnosis is not required to provide Early Intervention services, claims for Early Intervention services need to include a CMS-approved ICD-10 diagnosis code. For example, these include codes for “Other specified” and “Unspecified” disorders, or “Factors influencing health status and contact with health services.”

ICD-10 codes Z55-Z65, “Persons with potential health hazards related to socioeconomic and psychosocial circumstances,” or ICD-10 code Z03.89, “Encounter for observation for other suspected diseases and conditions ruled out.” If the member meets the diagnostic criteria for an SUD, a full ASAM assessment must be performed, and the member must receive a referral to the appropriate LOC indicated by the assessment.

ASAM 0.5: Service Requirements

Treatment services at this LOC include screening, assessment/intake (if applicable), care planning, and/or physical exam, group counseling, client education, individual counseling, crisis intervention, family therapy, collateral services, medication services (including the provision of, or referral for addiction medication services for clients who use alcohol, opioids, and/or tobacco products, unless the client’s declining addiction medications is documented in Progress Notes), alcohol/drug testing, RS, discharge services, and Care Coordination. Early Intervention services are delivered as medically necessary and appropriate to ameliorate or correct a substance use condition and may be delivered in a wide variety of settings, and can be provided in-person, by telehealth, or by telephone.

Outpatient Treatment (ASAM 1.0)

ASAM 1.0 treatment services are provided in an environment that facilitates recovery, directed toward alleviating and/or preventing alcohol and drug problems. ASAM 1.0 treatment services do not include residency at a provider agency’s facility as part of the treatment and recovery process. Services are provided to clients when medically necessary. This LOC is appropriate for clients who are stable with regard to acute intoxication/withdrawal potential, biomedical, and mental health conditions.

ASAM 1.0: Service Requirements

Treatment services at this LOC include screening, assessment/intake, care planning, completing the health status questionnaire ([Health Status Questionnaire Form 5103](#)) and/or physical exam, group counseling, patient education, individual counseling, SUD crisis intervention, family therapy, medication services (including provision of or referral for addiction medication services for individuals who use alcohol, opioids, and/or tobacco products, unless the client’s declining addiction medications is documented in Progress Notes), alcohol/drug testing, RS, discharge services, and Care Coordination.

Services may be provided up to:

- Six (6) hours per week for Youth (age 17 and under)
- Nine (9) hours per week for Young Adults (age 18-20) and Adults (age 21 and over)

Services may exceed the maximum based on individual clinical needs and supported by medical necessity. Services may be provided in-person or via telehealth services for individuals who consent to receive SUD services. Some services may be provided via telephone. For additional information, see [Service Delivery Options](#) section.

Provider agencies are required to either offer addiction medications directly or have effective referral mechanisms in place to connect clients to clinically appropriate addiction medication services (or MAT).

Intensive Outpatient Treatment (ASAM 2.1)

ASAM 2.1 treatment services are appropriate for clients with minimal risk regarding acute intoxication/withdrawal potential, biomedical conditions, and mental health conditions. They are also appropriate for clients who need close monitoring and support several times a week in a clinic (non-residential and non-inpatient) setting. Services are provided to clients when medically necessary.

ASAM 2.1: Service Requirements

Treatment services at this LOC include screening assessment/intake, care planning, health status questionnaire ([Health Status Questionnaire Form 5103](#)) and/or physical exam, group counseling, patient education, individual counseling, SUD crisis intervention, family therapy, medication services (including provision of or referral for addiction medication services for clients who use alcohol, opioids, and/or tobacco products, unless the client's declining addiction medications is documented in Progress Notes), alcohol/drug testing, RS, discharge services, and Care Coordination.

Treatment services need to be provided between:

- Six (6) and 19 hours per week for Youth (age 17 and under); more than 19 hours per week may be provided when determined to be medically necessary and when a higher LOC is not clinically appropriate. Service hours can exceed the maximum of 19 hours and are submitted under DMC claims.
- Nine (9) and 19 hours per week for Young Adults (age 18-20) and Adults (age 21 and over); more than 19 hours per week may be provided when determined to be medically necessary.

If it is determined that the client no longer consistently requires at least 6-9 hours of service per week, they should be stepped down to a lower LOC (e.g., OP). Reviews are conducted to determine whether clients are served in the appropriate LOC and whether reimbursement needs to be modified (i.e., reduced to the OP rate) due to a consistently insufficient number of service hours. Services may be provided in-person or via telehealth for individuals who consent to receive SUD services. Some services may be provided via telephone. For additional information, see [Service Delivery Options](#) section.

Provider agencies are required to either offer addiction medications directly or have effective referral mechanisms in place to connect clients to clinically appropriate addiction medication services (or MAT).

Residential Services

All residential treatment services are primarily provided in-person. Telehealth and telephone services, when provided, supplement but do not replace the in-person service. For additional information, see [Service Delivery Options](#) section. These services are tailored to address the functional deficits identified in the ASAM Criteria.

All provider agencies delivering Residential Treatment services at Levels 3.1, 3.3, and 3.5, billed to DMC-ODS, must have either a DHCS LOC Certification or an [ASAM LOC Designation](#). Each client lives on the premises and is supported in their efforts to restore, maintain, and apply interpersonal and independent living skills and access community support systems.

Provider agencies are required to either offer addiction medications directly or have effective referral mechanisms in place to connect clients to clinically appropriate addiction medication services (or MAT).

As outlined in [CCR Title 9, Chapter 5 - Licensure of Residential Alcoholism or Drug Abuse Recovery or Treatment Facilities](#): Every resident needs to be tested for tuberculosis (TB) under licensed medical supervision six (6) months prior to or 30 days after admission.

The residential bundled day rate and Room and Board are not billable on the date of discharge. Unbundled residential services, such as Care Coordination, PSS, and medication services, remain billable on the client's date of discharge.

Incidental Medical Services (IMS) are services provided at a licensed residential facility by a healthcare practitioner or staff under the supervision of a healthcare practitioner to address medical issues associated with detoxification, treatment, or rehabilitation services. IMS does not include general primary medical care or medical services required to be performed in a licensed health facility as defined by [California HSC § 1200](#) or [California HSC § 1250](#).

Low-Intensity Residential Services (ASAM 3.1)

ASAM 3.1 Residential services are 24-hour non-medical, short-term rehabilitation services for clients with an SUD diagnosis. It is appropriate for clients needing time and structure to practice and integrate their recovery and coping skills in a supportive residential environment. IMS may be approved by the State to allow for addiction medications, including medication services for withdrawal, to be provided in residential settings. The facility needs to have a DHCS LOC Certification to deliver care under this designation.

ASAM 3.1: Service Requirements

Treatment services at this LOC include screening, assessment/intake, care planning, health status questionnaire ([Health Status Questionnaire Form 5103](#)) and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, safeguarding medications and medication services (including provision of or referral for addiction medication services for individuals who use alcohol, opioids, and/or tobacco products, unless the client's declining addiction medications is documented in Progress Notes), transportation, alcohol/drug testing, RS, discharge services, Care Coordination, and room and board.

Clients enrolled in full-scope Medi-Cal are exempt from paying fees for room and board and/or treatment services. Residential provider agencies may collect CalFresh benefits from clients if these benefits are applied to the preparation and serving of food for that client and the costs exceed those covered by SAPC's rates. SAPC residential provider agencies may collect General Relief payments on the residential client's behalf if that agency develops a spending plan specific to that client associated with the plan of care documented in the clinical record (including, but not limited to, any funding the client may need to advance their housing plan). The remaining balance of General Relief payments received on the residential client's behalf must be disbursed to that client upon discharge from residential treatment. CalFresh benefits collected by the agency need to be reported to SAPC in the year-end cost report. Clients must apply for CalFresh voluntarily, and

clients cannot be required to enroll in CalFresh as a prerequisite for admission into a residential SUD program.

At least **one (1) 15-minute unit** of Clinical Services is required for individual-based services (Intake and ASAM Assessment, Individual Counseling, Family Therapy, Collateral Service, Crisis Intervention, Care planning, Discharge Services, and Care Coordination) or **four (4) to six (6) 15-minute units** for group-based services (Group Counseling and Patient Education) per client per day. Treatment services need to be provided **at least 20 hours per week** and include preparation for step down into less intense levels of treatment, when appropriate. At a minimum, Clinical Services are equal to at least half of the weekly treatment hour standard (10 hours or 40 units of services). The remaining treatment hour requirements may be fulfilled by eligible Therapeutic, Support, OTP, and/or Mental and Physical Health services (**up to two (2) hours weekly for both on-site and off-site services**).

For a detailed list of approved services at Residential Treatment Programs, see [BHIN 24-001](#).

If the client receives less than 10 hours or 40 units of Clinical Services per week:

- For more than two (2) weeks for Youth (age 17 and under) and Young Adults (age 18-20); **or**
- For more than three (3) weeks for Adults (age 21 and over);

then the client needs to be moved to a lower LOC, and no further reimbursement is allowed.

When services provided are below the minimum, they must be clinically necessary (e.g., hospitalized, on pass) and documented in a Progress Note.

Provider agencies may choose to hold a client's bed if the client is anticipated to return to treatment within seven (7) calendar days. However, in these instances, residential beds that are held are only reimbursed for room and board and do not receive the full residential day rate for treatment, since services are not provided for held beds.

The facility requires 24-hour care with trained personnel, including staff on the overnight shift who are awake to address client needs.

Residential clients need to meet medical necessity requirements. For additional information, see [Table 16: Residential Authorization and Reauthorization Service Limits](#).

High-Intensity Residential Services: Population Specific (ASAM 3.3)

ASAM 3.3 Residential services are 24-hour non-medical short-term rehabilitation services for clients with an SUD diagnosis. They are appropriate for clients with primarily cognitive functional limitations who require a slower pace of treatment and are unable to fully participate in the social and therapeutic environment. These functional limitations may be either temporary or permanent and may result in problems in interpersonal relationships, emotional coping skills, or comprehension. The facility needs to have a DHCS LOC Certification to deliver care under this designation.

IMS may be approved by the State to allow for addiction medications, including medication services for withdrawal, to be provided in residential settings.

Level 3.3 services are available to Young Adults (age 18-20) and Adults (age 21 and over). ASAM Level 3.5 (High-Intensity Residential) is recommended for Youth (age 17 and under) requiring high-intensity clinical services that meet functional limitations.

ASAM 3.3: Service Requirements

Treatment services at this LOC include screening, assessment/intake, care planning, health status questionnaire ([Health Status Questionnaire Form 5103](#)) and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, safeguarding mediations and medication services (including provision of or referral for addiction medication services for individuals who use alcohol, opioids, and/or tobacco products, unless the client's declining addiction medications is documented in Progress Notes), transportation, alcohol/drug testing, RS, discharge services, Care Coordination, and room and board.

Clients enrolled in full-scope Medi-Cal are exempt from paying fees for room and board and/or treatment services. Residential provider agencies may collect CalFresh benefits from clients if these benefits are applied to the preparation and serving of food for that client and the costs exceed those covered by SAPC's rates. SAPC residential provider agencies may collect General Relief payments on the residential client's behalf if that agency develops a spending plan specific to that client associated with the plan of care documented in the clinical record (including, but not limited to, any funding the client may need to advance their housing plan). The remaining balance of General Relief payments received on the residential client's behalf must be disbursed to that client upon discharge from residential treatment. CalFresh benefits collected by the agency need to be reported to SAPC in the year-end cost report. Clients must apply for CalFresh voluntarily, and clients cannot be required to enroll in CalFresh as a prerequisite for admission into a residential SUD program.

At least **one (1) 15-minute unit** of Clinical Services is required for individual-based services (Intake and ASAM Assessment, Individual Counseling, Family Therapy, Collateral Service, Crisis Intervention, care planning, Discharge Services, and Care Coordination), or **four (4) to six (6) 15-minute units** for group-based services (Group Counseling and Patient Education) per client per day. Treatment services need to be provided **at least 24 hours per week** and include preparation for step down into less intense levels of treatment, when appropriate. At a minimum, Clinical Services must equal at least half of the weekly treatment-hour standard (12 hours or 48 units of services). The remaining treatment hour requirements may be fulfilled by eligible therapeutic support, OTP, and/or Mental and Physical Health services (**up to two (2) hours weekly for both on-site and off-site services**).

For a detailed list of approved services at Residential Treatment Programs, see [BHIN 24-001](#).

If the client receives less than 12 hours or 48 units of services per week:

- For more than two (2) weeks for Youth (age 17 and under) and Young Adults (age 18-20); **or**
- For more than three (3) weeks for Adults (age 21 and over);

then the client needs to be moved to a lower LOC, and no further reimbursement is allowed.

When services provided are below the minimum, they must be clinically necessary (e.g., hospitalized, on pass) and documented in a Progress Note.

Provider agencies may choose to hold a client's bed if the client is anticipated to return to treatment within seven (7) calendar days. However, in these instances, held residential beds are reimbursed only for room and board and do not receive the full residential day rate for treatment, since services are not provided for held beds.

The facility requires 24-hour care by trained personnel, including overnight staff who are awake to address client needs.

Residential clients must meet medical necessity requirements. For additional information, see [Table 16: Residential Authorization and Reauthorization Service Limits](#).

High-Intensity Residential Services: Non-Population Specific (ASAM 3.5)

ASAM 3.5 Residential services are 24-hour non-medical short-term rehabilitation services for clients with an SUD diagnosis. It is appropriate for clients who have specific functional limitations and need a safe and stable living environment to develop and/or demonstrate sufficient recovery skills to avoid immediate relapse or continued use of substances. The facility needs to have a DHCS LOC Certification to deliver care under this designation.

IMS may be approved by the State to allow for addiction medications, including medication services for withdrawal, to be provided in residential settings.

ASAM 3.5: Service Requirements

Treatment services at this LOC include screening, assessment/intake, care planning, health status questionnaire ([Health Status Questionnaire Form 5103](#)) and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, safeguarding medications and medication services (including provision of or referral for addiction medication services for individuals who use alcohol, opioids, and/or tobacco products, unless the client's declining addiction medications is documented in Progress Notes), transportation, alcohol/drug testing, RS, discharge services, Care Coordination, and room and board.

Clients enrolled in full-scope Medi-Cal are exempt from paying fees for room and board and/or treatment services. Residential provider agencies may collect CalFresh benefits from clients if these benefits are applied to the preparation and serving of food for that client and the costs exceed those covered by SAPC's rates. SAPC residential provider agencies may collect General Relief payments on the residential client's behalf if that agency develops a spending plan specific to that client associated with the plan of care documented in the clinical record (including, but not limited to, any funding the client may need to advance their housing plan). The remaining balance of General Relief payments received on the residential client's behalf must be disbursed to that client upon discharge from residential treatment. CalFresh benefits collected by the agency need to be reported to SAPC in the year-end cost report. Clients must apply for CalFresh voluntarily, and clients cannot be required to enroll in CalFresh as a prerequisite for admission into a residential SUD program.

At least **one (1) 15-minute unit** of Clinical Services is required for individual-based services (intake and ASAM assessment, individual counseling, family therapy, collateral service, crisis intervention, care planning, discharge services, and Care Coordination), or **four (4) to six (6) 15-minute units** for group-based services (Group Counseling and Patient Education) per client per day. Treatment services need to be provided **at least 22 hours per week** and include preparation for step down into less intense levels of treatment, when appropriate. At a minimum, Clinical Services must equal at least half of the weekly treatment-hour standard (11 hours or 44 units of services). The remaining treatment hour requirements may be fulfilled by eligible Therapeutic, Support, OTP, and/or Mental and Physical Health services (**up to two (2) hours weekly for both on-site and off-site services**).

For a detailed list of approved services at Residential Treatment Programs, see [BHIN 24-001](#).

If the client receives less than 11 hours or 44 units of services per week:

- For more than two (2) weeks for Youth (age 17 and under) and Young Adults (age 18-20); **or**
- For more than three (3) weeks for Adults (age 21 and over);

then the client needs to be moved to a lower LOC, and no further reimbursement is allowed.

When services provided are below the minimum, they must be clinically necessary (e.g., hospitalized, on pass) and documented in a Progress Note.

Provider agencies may choose to hold a client's bed if the client is anticipated to return to treatment within seven (7) calendar days. However, in these instances, held residential beds will be reimbursed only for room and board and will not receive the full residential day rate for treatment, since services are not provided for held beds.

The facility requires 24-hour care by trained personnel, including overnight staff who are awake to address client needs.

Residential clients must meet medical necessity requirements. For additional information, see [Table 16: Residential Authorization and Reauthorization Service Limits](#).

Withdrawal Management

Withdrawal Management (WM), also known as detoxification or detox, is a set of treatment interventions aimed at medical and clinical management of acute intoxication and withdrawal from alcohol and other substances. WM services provide the appropriate level of medical and clinical support to ensure client safety during the withdrawal period, which then allows the client and treatment team to work together to determine the best ongoing treatment strategy. WM services may be provided in an OP, residential, or inpatient setting. Members who receive WM in a residential setting need to be residents of that facility. Inpatient treatment services are primarily provided in-person. Telehealth and telephone services, when provided, supplement but do not replace the in-person service. For additional information, see [Service Delivery Options](#) section.

WM is an opportunity to initiate abstinence and begin substance use treatment. The primary goal is client safety to minimize the health risks associated with withdrawal. All SUD clients, particularly those with sedative, AUD, and OUDs, should be considered for WM and have access to these essential treatment services. Whether or not the client's goal includes sustained abstinence from all substances, the WM services are provided to clients with medical necessity, and clients' WM services need to be offered a referral for ongoing care.

The science of comprehensive and effective SUD treatment supports the use of medications for withdrawal and the use of medications that treat SUD during WM and in all other LOCs where clients with SUDs are treated. Research has consistently shown that the use of medications for withdrawal and addiction medication helps to improve client engagement and SUD outcomes, especially when combined with other evidence-based interventions. Providers are required to either offer addiction medications directly or have effective referral mechanisms to the most clinically appropriate addiction medication services in place. **Medications for withdrawal and addiction must be discussed as a treatment option for all clients for whom it may be appropriate and helpful.**

Required components of WM at any LOC include:

- **Intake:** The intake process should, at minimum, include a thorough evaluation, establishing the diagnosis of substance withdrawal syndrome, and formalizing an individual assessment; it may also include a physical exam and/or laboratory testing.
- **Observation:** At a minimum, a client needs to be monitored during withdrawal as frequently as deemed appropriate. This may include, but is not limited to, monitoring the client's health status.
- **Medication Services:** Medications need to be offered to all clients for whom there are medication options to help manage withdrawal and/or treat the underlying use disorder.
- **Documentation:** Documentation of medications prescribed, administered, and/or the assessment of side effects and the results of medication use is required. If medications are available but not utilized, documentation needs to be provided as to the reason medications were not used (e.g., client refusal).
- **Discharge Services:** Clients should be referred to another LOC following WM, and/or connected to appropriate community treatment, housing, or other social service resources, as needed.

Table 10: Withdrawal Management

Treatment/Service Type	ASAM LOC	Description
Ambulatory-Withdrawal Management (Outpatient) without extended on-site monitoring	1-WM	Mild withdrawal with daily or less than daily OP supervision.
Ambulatory-Withdrawal Management (Outpatient) with extended on-site monitoring	2-WM	Moderate withdrawal with daytime OP WM, support, and supervision in a non-residential setting.
Clinically Managed Residential-Withdrawal Management	3.2-WM	Moderate withdrawal that is not manageable in OP settings and needs 24-hour support, which can be managed by non-medical staff) to complete WM and increase the likelihood of continuing treatment or recovery.

Treatment/Service Type	ASAM LOC	Description
Medically Managed Inpatient- Withdrawal Management	3.7-WM	Severe withdrawal in addition to medical or psychiatric co-morbidities; needs 24-hour nursing care and physician visits as needed; unlikely to complete WM without medical monitoring.
Medically Managed Intensive Inpatient-Withdrawal Management	4-WM	Severe, unstable withdrawal with documented risk for acute medical complications requiring 24-hour nursing care and daily physician visits to modify WM regimen and manage medical instability.

WM should consist of three (3) essential features:

1. Assessment of needs
2. Stabilization
3. Facilitation of follow-up, including readiness for and entry into SUD treatment

WM: Assessment

- Substance withdrawal and the client's related needs need to be assessed during every initial SUD assessment when a client shows up for treatment. This assessment needs to be performed by appropriate personnel operating within their scope of practice and licensure and includes a determination of anticipated risks that will inform the need for WM, the intensity of services needed, and the most appropriate treatment setting.
- Best practice includes using an age-appropriate assessment tool (ASAM CONTINUUM™ Assessment or Assessment Tool - Youth (Paper Version) found on the SAPC website), which should result in a determination about whether WM services are necessary. If additional clinical assessment information is needed for Dimension 1 (withdrawal potential), additional withdrawal assessment tools such as the Clinical Institute Withdrawal Assessment (CIWA) or Clinical Opioid Withdrawal Scale (COWS) may be used.
- If the assessment indicates WM is needed, qualified SUD treatment providers need to determine the most appropriate LOC (ambulatory WM vs. residential WM vs. inpatient WM) and explain the WM options, including medication, available to the client.
- Individuals recommended for ambulatory (OP) WM (e.g., 1-WM or 2-WM) should be at lower risk for complications and have a greater likelihood of successful WM than individuals recommended for withdrawal services in residential or inpatient settings. Assessments also need to take into consideration the individual's unique situation, symptom severity, history of withdrawal episodes, and client preference.
- If the client needs an LOC not provided at the current location, SUD treatment providers have two (2) options:
 - Call the SASH to schedule an intake appointment with another agency; **or**
 - Identify and call another agency directly by using the SBAT to set up an intake appointment.
- Provider agencies need to make every effort to facilitate a warm hand-off with the receiving provider agency. The new intake appointment needs to be rescheduled within three (3) business days. If the agency does not use the County's EHR, Sage, the assessment results must be sent to the receiving provider agency electronically or by fax within 24 hours.

WM: Stabilization

Following a comprehensive assessment of WM needs, the stabilization period focuses on developing a Plan of Care to effectively manage the client's withdrawal symptoms while also considering the potential general medical and psychiatric complications that may accompany withdrawal.

- The SUD treatment team works with the client to develop a comprehensive Plan of Care that considers the biopsychosocial needs of an individual to effectively manage withdrawal symptoms, which may include the use of medications.
- Stabilization should consist of a combination of psychosocial intervention and medications, when appropriate.
- If it is determined that a client would benefit from and is interested in addiction medications, a determination needs to be made about the most appropriate medication intervention for withdrawal symptoms and initiation of medications for OUD.
- Although not all clients will be in a state of mind to engage in behavioral/talk therapy during WM, psychosocial interventions are an important component of the services that should be offered in the WM setting. MI, for example, can be skillfully used during WM to better understand clients' readiness to change and help them progress along the readiness continuum to encourage them to continue treatment after withdrawal symptoms are addressed.
- Throughout WM, qualified staff need to continually evaluate the client for changes in their condition and health status.
- The provider agency needs to assign the client a care coordinator to assist them with transitioning to an appropriate LOC.
- WM is not eligible for bed holds. In cases where a client needs to leave WM, providers should support the client with discharge, transition to another LOC as appropriate, and facilitate readmission to WM when medically necessary.

WM: Facilitation of Follow-Up

In and of itself, WM does not constitute adequate addiction treatment, and thus, clients who receive withdrawal services should be connected with ongoing SUD treatment.

- As early during the withdrawal process as is feasible and appropriate, provider agencies need to engage their clients in discussions about their readiness for change and begin preparing them for entry into ongoing SUD treatment at the next point along the continuum of SUD care. Care Coordination can and should support this LOC transition.
- This preparation needs to include engaging the client in discussion regarding comprehensive SUD treatment, the fact that WM is typically only the first component of treatment, and the Care Coordination priorities and activities outlined in [Eligibility Verification – Transitions in Care](#) section.

The duration of WM services needs to be based on individual client needs, as determined by qualified personnel within their scope of practice and licensure.

WM for Youth (age 17 and under)

WM is generally not indicated for youth (17 and under) because they typically have not consumed substances for sufficient duration, intensity, or frequency to cause significant withdrawal symptoms. However, WM should be provided to youth when clinically warranted, based on medical necessity, and consistent with EPSDT requirements for youth and young adults (under 21). Parental consent is not required for services delivered to youth aged 12 and over, but is required for services delivered to youth aged 11 and under.

Ambulatory-Withdrawal Management

Ambulatory-Withdrawal Management without extended on-site monitoring (ASAM 1-WM)

ASAM 1-WM ambulatory services are provided in OP settings for clients with mild alcohol, sedative, and/or opioid withdrawal symptoms. Clients treated in this setting should require daily or less than daily OP supervision and are generally likely to complete WM and continue treatment or recovery.

Individuals treated in this setting should be physically and psychiatrically stable enough to be managed in an OP setting. Clients should be at a lower risk for withdrawal complications and have a greater likelihood of successful WM than individuals recommended for withdrawal services in residential (ASAM 3.2-WM) or inpatient (ASAM 3.7-WM and 4-WM) settings.

ASAM 1-WM services do not require pre-authorization (prior to services being provided) but are not reimbursed beyond 14 calendar days unless medical necessity warrants extended treatment in this setting. Care should be transitioned to an appropriate LOC, as clinically indicated.

ASAM 1-WM: Staffing

ASAM 1-WM services are staffed by interdisciplinary staff who are appropriately trained and credentialed to assess the client and manage mild withdrawal. Although they need not always be present, physicians/prescribers and nurses should be readily available to assess, evaluate, and confirm that clients are stable for management in an OP setting.

ASAM 1-WM: Service Requirements

Treatment services at this LOC include screening, assessment/intake, care planning, [Health Status Questionnaire Form 5103](#), and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, ambulatory detoxification, medication services (including provision of or referral for addiction medication services for individuals who use alcohol, opioids, and/or tobacco products, unless the client's declining addiction medications is documented in Progress Notes), alcohol/drug testing, RS, discharge services, and Care Coordination.

Ambulatory-Withdrawal Management with extended on-site monitoring (ASAM 2-WM)

ASAM 2-WM ambulatory services are provided in OP settings for clients with mild-moderate alcohol, sedative, and/or opioid withdrawal symptoms. Clients treated in this setting require daily OP supervision and serial medical assessments. They are likely to complete WM and to continue treatment or recovery.

Individuals treated in this setting should be physically and psychiatrically stable enough to be managed in an OP setting. Clients should have access to psychological and psychiatric consultation when needed. Clients should be at lower risk for withdrawal complications and have a greater likelihood of successful WM than individuals recommended for WM in residential (ASAM 3.2-WM) or inpatient (ASAM 3.7-WM and 4-WM) settings.

ASAM 2-WM services do not require pre-authorization or authorization but are not reimbursed beyond 14 calendar days unless medical necessity warrants extended treatment in this setting. Care should be transitioned to a lower LOC, as clinically indicated.

ASAM 2-WM: Staffing

Care at level 2-WM is delivered by interdisciplinary staff trained and credentialed to assess the client. As with all other WM LOCs, 2-WM services are medically and clinically focused. Although they do not always need to be present, physicians/prescribers and nurses should be readily available to assess, evaluate, and confirm that clients are stable enough to be safely managed in an OP setting.

ASAM 2-WM: Service Requirements

Treatment services at this LOC include screening, assessment/intake, care planning, [Health Status Questionnaire Form 5103](#), and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, ambulatory detoxification, medication services (including provision of or referral for addiction medication services for individuals who use alcohol, opioids, and/or tobacco products, unless the client's declining addiction medications is documented in Progress Notes), alcohol/drug testing, RS, discharge services, and Care Coordination.

Residential-Withdrawal Management (ASAM 3.2-WM)

ASAM 3.2-WM services are 24-hour short-term rehabilitation services provided in residential settings for clients with moderate alcohol, sedative, and/or opioid withdrawal who need 24-hour support to successfully complete WM. IMS may be approved by the State to allow for medication treatments and IMS, including WM, to be provided in residential settings.

Clients appropriately treated in Residential-WM settings typically exhibit, have a history of exhibiting, or are at risk for exhibiting moderate withdrawal symptoms with a greater need for support than can be provided in Ambulatory-WM settings (ASAM 1-WM and 2-WM), but less need for medical supervision and support than is provided in inpatient WM settings (ASAM 3.7-WM and 4.0-WM).

ASAM 3.2-WM: Staffing

The care provided at level 3.2-WM is medically and clinically focused and is delivered by interdisciplinary staff who are appropriately trained and credentialed to assess the client and manage moderate withdrawal from opioids, alcohol, or sedatives. Withdrawal from stimulants is not an indication of WM.

Although it is not required that a physician/prescriber be on-site at all times, medical evaluation and consultation are available 24 hours a day. In addition, the facility requires 24-hour care by trained personnel, including overnight staff who are awake to address client needs. The additional training required for staff who monitor or supervise the provision of WM services includes: certification in cardiopulmonary resuscitation and first aid, training in the use of naloxone, six (6) hours of orientation for providing, monitoring, and supervising WM services, repeated orientation training within 14 days for returning staff following a 180 continuous day break in employment, and eight (8) hours of training annually that covers the needs of residents who receive WM services.

Training documentation needs to be maintained in personnel records. Personnel training needs to be implemented and maintained by the licensee pursuant to [Title 9 CCR § 10564\(k\)](#). It is recommended that a licensed physician/prescriber with specific training in addiction be available for consultation as medically necessary (for example, a physician/prescriber prescribes medications, and an on-site nurse can coordinate providing the prescribed medications to clients without the physician/prescriber needing to be on-site). Individuals in 3.2-WM should receive both medications and psychosocial therapies. Necessary services need to be coordinated or referred to other LOCs as needed, either through direct affiliation or an external referral process.

Note: To participate in 3.2-WM, providers are required to arrange for medications to be available on-site. Providers can coordinate medication services with off-site physicians or other licensed prescribing clinicians to arrange medications that are medically necessary to treat withdrawal. ASAM 3.2-WM services do not require pre-authorization but are not reimbursed beyond 14 calendar days unless medical necessity warrants extended treatment in this setting. Care should be transitioned to a lower LOC, as clinically indicated.

ASAM 3.2-WM: Service Requirements

Treatment services at this LOC include screening, assessment/intake, care planning, [Health Status Questionnaire Form 5103](#), and/or physical exam, group counseling patient education, individual counseling, crisis intervention, family therapy, safeguarding medications, and medication services (including provision of or referral for addiction medication services for individuals who use alcohol, opioids, and/or tobacco products, unless the client's declining addiction medications is documented in Progress Notes), transportation, alcohol/drug testing, RS, discharge services, Care Coordination, and room and board (which cannot include financial participation by the client in the form of payment/transfer of Federal, State, or local benefits such as CalFresh).

Inpatient-Withdrawal Management – Medically Monitored (ASAM 3.7-WM)

ASAM 3.7-WM services are short-term, medically monitored settings for clients with severe alcohol, sedative, and/or opioid withdrawal or stimulant intoxication that offer 24-hour nursing care and physician visits, as necessary. Clients treated in this setting have severe problems in Dimensions 1, 2, or 3 that require inpatient-level care with medical oversight and are unlikely to complete WM without medical monitoring. Treatment in Inpatient-WM settings should be reserved for those who cannot be successfully managed at a lower LOC. Withdrawal from stimulants, cannabis, dissociatives, and/or hallucinogens alone does not require an inpatient level of medical intervention. In some instances, acute stimulant intoxication and/or withdrawal from multiple substances, including alcohol, opioids, and/or sedatives, may be considered for inpatient admission.

ASAM 3.7-WM: Admission Criteria

Criteria for admission to 3.7-WM include one (1) or more of the following within 14 days of the client's most recent use of opioids, alcohol, sedatives, or stimulants:

1. The diagnosis of delirium tremens (DTs), also known as alcohol withdrawal delirium (AWD), also includes any combination of the following clinical manifestations resulting from cessation or reduced intake of alcohol and/or sedatives:
 - a. Hallucinations
 - b. Disorientation
 - c. Tachycardia
 - d. Hypertension
 - e. Fever
 - f. Agitation
 - g. Diaphoresis
2. A severe score on a validated withdrawal scale, including the Clinical Institute Withdrawal Assessment Scale for Alcohol, revised (CIWA-Ar), Prediction of Alcohol Withdrawal Severity Scale (PAWSS), Clinical Assessment of Narcotic Assessment (CINA), and COWS.
3. A moderate score on a validated withdrawal scale, including the CIWA-Ar, PAWSS, CINA, COWS, and one (1) or more of the following high-risk factors:
 - a. A current serum ethanol level over 0.10mg%
 - b. Serum chloride under 96mEq/L (if known)
 - c. Use of multiple substances
 - d. History of AWD
 - e. Inability to receive necessary medical assessment, monitoring, and treatment at a lower LOC
 - f. Medical co-morbidities that make detoxification in a lower LOC unsafe
 - g. History of failed OP treatment
 - h. Psychiatric co-morbidities
 - i. Pregnancy
 - j. History of seizure disorder or withdrawal seizures
4. Complications of alcohol, sedative, and/or opioid withdrawal that cannot be adequately managed in the OP setting due to:
 - a. Presenting with persistent vomiting and diarrhea from withdrawal
 - b. Dehydration and electrolyte imbalance that make managing withdrawal in a lower LOC unsafe

5. Stimulant intoxication complications that impair client stability or significantly reduce the client's ability to safely participate in treatment at a lower LOC.
6. Recent history of severe withdrawal symptoms.

Note: Substances with a higher risk of causing illness and death (e.g., alcohol, opioids, sedatives) are often more appropriate for inpatient WM than substances with lower risk that may be able to be managed at a lower LOC. Level 3.7-WM and 4-WM are both inpatient LOCs for WM and offer similar services, with the key difference being in the level and availability of medical staffing in these settings. Level 4-WM requires greater availability of medical staffing and 24-hour direct observation and nursing care compared to Level 3.7-WM. For additional information, see the respective Staffing sections in Level 3.7-WM and 4-WM.

ASAM 3.7-WM services do not require pre-authorization but are not reimbursed beyond 14 calendar days unless medical necessity warrants extended treatment in this setting. Care should be transitioned to a lower LOC, as clinically indicated.

Transitions to and from this LOC are critical and need to be managed carefully, with the plan to transition to an appropriate lower level of SUD care, when clinically indicated.

ASAM 3.7-WM: Staffing

All 3.7-WM programs are staffed by physicians/prescribers who are available by phone 24 hours per day. A physician/prescriber needs to assess the client within 24 hours of admission (or earlier if needed) and is available on-site daily. The facility requires 24-hour care by trained personnel, including overnight staff who are awake to address client needs. An RN or other licensed nurse is available to perform a nursing assessment upon admission and is responsible for oversight of the client's progress and medication administration on an hourly basis (if needed). The level of nursing care is consistent with the severity of the client's needs.

ASAM 3.7-WM: Service Requirements

Treatment services at this LOC include screening, assessment/intake care planning, [Health Status Questionnaire Form 5103](#), and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, safeguarding medications and medication services (including provision of or referral for addiction medication services for individuals who use alcohol, opioids, and/or tobacco products, unless the client's declining addiction medications is documented in Progress Notes), transportation, alcohol/drug testing, RS, discharge services, Care Coordination, and room and board (which cannot include financial participation by the client in the form of payment/transfer of Federal, State, or local benefits such as CalFresh). These services are intended to be individualized to treat functional deficits identified in the ASAM criteria.

Inpatient-Withdrawal Management – Medically Managed (ASAM 4-WM)

ASAM 4-WM services are short-term medically managed settings for clients with severe and unstable alcohol, sedative, and/or opioid withdrawal or stimulant intoxication that offer 24-hour nursing care and daily physician visits. Clients treated in this setting are unlikely to complete WM without medical management and have severe problems in Dimensions 1, 2, or 3 that require inpatient-level care with medical oversight. Treatment in inpatient WM settings should be reserved for those who cannot be successfully managed at a lower level of WM care. Withdrawal from stimulants, cannabis, dissociatives, and/or hallucinogens alone does not require an inpatient level of medical intervention. In some instances, acute stimulant intoxication and/or withdrawal from multiple substances, including alcohol, opioids, and/or sedatives, may be considered for inpatient admission.

ASAM 4-WM: Admission Criteria

Criteria for admission to 4-WM includes one (1) or more of the following within 14 days of the client's most recent use of opioids, alcohol, sedatives or stimulants:

1. The diagnosis of DT that also includes any combination of the following clinical manifestations resulting from cessation or reduced intake of alcohol and/or sedatives:
 - a. Hallucinations
 - b. Disorientation
 - c. Tachycardia
 - d. Hypertension
 - e. Fever
 - f. Agitation
 - g. Diaphoresis
2. A severe score on any one (1) of the following scales: CIWA-Ar, PAWSS, CINA, and COWS.
3. A moderate score on any one (1) of the following withdrawal scales CIWA-Ar, PAWSS, CINA, COWS, and one (1) or more of the following high-risk factors:
 - a. A current serum ethanol level over 0.10mg%
 - b. Serum chloride under 96mEq/L (if known)
 - c. Use of multiple substances
 - d. History of AWD
 - e. Inability to receive necessary medical assessment, monitoring, and treatment at a lower LOC
 - f. Medical co-morbidities that make detoxification in a lower LOC unsafe
 - g. History of failed OP treatment
 - h. Psychiatric co-morbidities
4. Pregnancy
5. History of seizure disorder or withdrawal seizures
6. Complications of withdrawal that cannot be adequately managed in the OP setting due to:
 - a. Presenting with persistent vomiting and diarrhea from withdrawal
 - b. Dehydration and electrolyte imbalance that make detoxification in a lower LOC unsafe
7. Complications from stimulant intoxication that result in medical or psychiatric conditions that impair the client's stability or drastically reduce the client's ability to safely participate in treatment at a lower LOC.

Note: Substances with a higher risk of causing illness and death (e.g., alcohol, opioids, sedatives) are often more appropriate for inpatient WM than substances with lower risk that may be able to be managed at a lower LOC.

Level 3.7-WM and 4-WM are both inpatient LOCs for WM and offer similar services. The key differences are in the level and availability of medical staffing in these settings. Level 4-WM requires greater availability of medical staffing and 24-hour direct observation and nursing care compared to Level 3.7-WM. For additional information, see the respective Staffing sections in Level 3.7-WM and 4-WM.

ASAM 4-WM services do not require pre-authorization but are not reimbursed beyond 14 calendar days unless medical necessity warrants extended treatment in this setting. Care should be transitioned to a lower LOC, as clinically indicated.

Transitions to and from this LOC are critical and need to be managed carefully, with the plan to transition to an appropriate lower level of SUD care, when clinically indicated.

ASAM 4-WM: Staffing

All 4-WM programs are staffed by physicians/prescribers who are available 24 hours per day. A physician or prescriber is required to assess the client within 24 hours of admission (or sooner if necessary) and provide daily follow-up visits. The facility requires 24-hour direct observation and nursing care.

ASAM 4-WM: Service Requirements

Treatment services at this LOC include screening, assessment/intake care planning, [Health Status Questionnaire Form 5103](#), and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, safeguarding medications and medication services (including provision of or referral for addiction medication services for individuals who use alcohol, opioids, and/or tobacco products, unless the client's declining addiction medications is documented in Progress Notes), transportation, alcohol/drug testing, RS, discharge services, Care Coordination, and room and board (which cannot include the client's financial participation in the form of payment/transfer of Federal, State, or local benefits, such as CalFresh). These services are tailored to address the functional deficits identified in the ASAM criteria.

Opioid Treatment Programs

OTPs are treatment settings that dispense medications for OUD, including methadone, buprenorphine, naltrexone, and dispense naloxone for opioid overdose prevention and disulfiram for AUD. If the OTP is unable to directly administer or dispense medically necessary medications covered under DMC-ODS, they need to prescribe the medication to a pharmacy or refer the member to a provider who can dispense it.

OTPs are the only setting that can legally provide methadone treatment for addiction. OTP services are provided in DHCS-licensed facilities pursuant to the [California CCR Title 9, Chapter 4, Division 4](#), and [42 CFR Part 2](#). OTPs offer a range of services, including medical, prenatal, and psychosocial support.

An OTP is classified as an ASAM LOC. Medical necessity for OTP services must be established, including a DSM-5 diagnosis of an OUD, any other applicable SUD, and an appropriate LOC designation based on an ASAM assessment.

Practitioners, including counselors and non-medical LPHAs, play an important role in identifying who may benefit from addiction medications and treatment at an OTP. For example, SUD service practitioners should explain the potential benefits of addiction medications alongside other services and refer clients to appropriate medical professionals for further assessment. SUD providers from across disciplines need to work together to ensure familiarity with and access to addiction medications in OTP and non-OTP SUD treatment settings.

OTP: Service Requirements

Treatment services at this LOC include screening, assessment/intake, care planning, [Health Status Questionnaire Form 5103](#), and/or physical exam, group and individual counseling, patient education, crisis intervention, family therapy, medication services (including ordering methadone, naltrexone, buprenorphine, and naloxone to be dispensed from the OTP or prescribed, as allowed by federal and state regulations, through a community pharmacy to meet the client's needs), alcohol/drug testing, syphilis testing, HIV testing, Hepatitis C testing, TB testing, RS, discharge services, medical psychotherapy, and care coordination.

Clients served in OTP settings need to receive between 50 and 200 minutes of counseling services per calendar month. OTPs may be reimbursed for additional counseling when the medical necessity for additional counseling is justified through documentation in the client record and completed within 14 days of that month's counseling sessions. Counseling services provided in OTP can be delivered in person, via telehealth, or by telephone.

The medical screening evaluation for medication services must be conducted in person or via telehealth. If the designated medical practitioners (physician, advanced practice RN, nurse practitioner, or physician assistant) determine that an adequate evaluation can be performed by telephone, the medical diagnostic evaluation for opioid use disorder and treatment with buprenorphine may be conducted by telephone if the client does not have access to audiovisual technology.

OTPs need to comply with all Federal and State licensing requirements. If they cannot comply, they need to assist the client in choosing another addiction medication provider, ensure continuity of care, and facilitate a warm hand-off to ensure engagement. OTPs are regulated under [CCR Title 9](#).

OTP: Documentation

All OTP providers must complete an initial ASAM CONTINUUM™ Assessment for all clients. Reimbursement for cases in which ASAM assessments were not completed within the required timeframes will be subject to recoupment.

Consistent with [CCR Title 9](#) requirements, OTP provider agencies need to re-verify DMC eligibility and perform justification every 12 months from the treatment admission date for clients who need ongoing OTP care. An annual ASAM assessment is not required. A narrative justification of the ongoing need for OTP services is sufficient to re-establish medical necessity.

Recovery Services

Recovery Services (RS) are support services designed to help individuals remain engaged in care, support their recovery, and reduce the likelihood of relapse.⁸ They emphasize a client's central role in managing their health and recovery, promoting effective self-management and coping strategies, and using interval and community resources to support ongoing self-management. Clients may receive services based on a self-assessment or provider assessment of relapse risk, which should be listed on the Problem List. Clients do not need to be in remission to access RS.

RS can be provided prior to admission, concurrently with admission to any other LOC, and following discharge from another LOC; and may be delivered as a standalone service or concurrently with other DMC-ODS services and LOCs as clinically appropriate. For clients admitted to RS concurrently or immediately following SUD treatment at a higher LOC where medical necessity had been established for that higher LOC, no additional screening is required. If there is a lapse between treatment discharge and receipt of RS, or RS are discontinued, completion of ASAM CO-Triage® Tool for Adults (age 21 and over) or ASAM Screener for Youth (age 17 and under) and Young Adults (age 18-20) needs to occur to determine if RS is appropriate for the client.

RS are available for Youth (age 17 and under), Young Adults (age 18-20), and Adults (age 21 and over) clients prior to enrollment in another LOC, who are currently participating in or discharging from any LOC, and immediately upon discharge from another LOC or upon release from incarceration based on pre-incarceration SUD history (and regardless of receipt of in-custody treatment services). Clients may receive RS based on either self-assessment or a provider's assessment of relapse risk. Clients enrolled in RS as a standalone service are required to have a new CalOMS/LACPRS admission and Financial Eligibility form completed in Sage. Continued participation is based on the client's continued financial eligibility for DMC-ODS services. For CENS RS, see CENS Standards and Practices available on the SAPC website under the "Manuals & Guides" section on SAPC's [Manual, Bulletins, and Forms](#) webpage.

RS may be conducted in-person in a contracted DMC-certified treatment facility, through FBS, and/or by telephone, or by telehealth; and can be delivered by either an experienced registered or certified SUD counselor, LPHA, or license-eligible LPHA, and will be offered when they are deemed medically necessary by an LPHA or license-eligible LPHA (e.g., during a treatment episode or after completion of a treatment episode).

How to Ensure Client Engagement in Recovery Services

- Ensure that clients connect with others in recovery to establish a supportive network.
- Emphasize the client's central role in managing their health.
- Emphasize the importance of effective self-management and coping strategies for managing stress and overcoming setbacks.
- Facilitate access to internal and community resources to provide ongoing self-management support to clients.
- Facilitate autonomy by linking clients to necessary resources (e.g., vocation, education, housing, transportation) to ensure needs are met, enabling them to navigate the health and social service system independently in the future.

⁸ SAMHSA. (2024, March 26). Recovery and Recovery Support. www.samhsa.gov/find-help/recovery.

Participation is voluntary for the client. Therefore, provider agencies should make every effort to educate and engage clients, facilitate their acceptance, and ultimately honor their choices and preferences.

RS are billed via PAuth. Each agency is configured in Sage with a PAuth for the FY, allowing services to be billed without a member authorization for the client. DHCS requires that RS be billed with the U6 LOC modifier and an additional LOC modifier indicating the LOC the site is certified to deliver.

RS: Prior to Admission to SUD Treatment

The RS benefit allows for pre-admission contact with clients prior to formal enrollment in treatment. Clients enrolled in RS as a standalone treatment are required to complete a new CalOMS/LACPRS admission and Financial Eligibility form in Sage.

RS: During SUD Treatment

Given the value of RS, the provider agency should explain the benefits at the beginning, during, and at the end of treatment; and should introduce the client to any designated counselor/clinicians and ensure that a warm hand-off is completed. This is particularly important when the RS provider agency is different from the treatment provider agency. Clients can be enrolled in RS and another LOC at the same time.

RS: Following SUD Treatment

Following discharge from treatment, an assigned counselor/clinician needs to contact the client within two (2) business days from their last treatment service to ensure the client is receiving necessary support. Counselors are required to demonstrate efforts to engage a client in this benefit prior to terminating follow-up efforts. If the client does not consent to services, at least three (3) documented attempts to engage the client on three (3) separate days are required. If the counselor has neither heard from nor contacted the client for 60 calendar days after the last attempted contact, the client should be discharged from RS, and the provider staff documents all follow-up contacts in the client's EHR.

For the first 60 calendar days following a client's discharge from treatment, the counselor/clinician contacts and engages the client at a frequency according to clinical need if the client consented to participate. Clients who reconnect with RS more than six (6) months since their last DMC-ODS clinical service need to be screened to determine if it continues to be an appropriate service.

RS: Service Requirements

Services at this LOC include assessment, care planning, recovery monitoring, relapse prevention, group counseling, individual counseling, family therapy, Care Coordination, and discharge services.

Individuals can continue to receive RS as long as they continue to meet financial eligibility requirements for DMC-ODS services. An LPHA at the provider site needs to document the justification in a progress note for ongoing services at least every six (6) months. Individuals may receive services while enrolled in other DMC-ODS services and LOCs, as clinically appropriate.

Note: CalOMS/LACPRS discharge needs to be completed when a client is discharged from the program on the day of discharge. The discharge date should correspond to the date of the client's last face-to-face or telehealth treatment session or addiction medication service. They need to document the actual date of discharge as the "Discharge Process Date" in the relevant CalOMS Discharge forms.

RS: Counseling

The goal of individual or group counseling is to allow the client to gain/develop personal autonomy (managing stress, free time, and activities of daily living):

- Personal care (grooming, managing finances), health, and wellness (exercise options, nutrition)
- Social skills, coping skills, and learning adaptive behaviors (coping with cravings or triggers that could result in relapse)
- Individualized Recovery Plan

Counseling services may be provided one-on-one or in group settings. Groups should consist of 2-12 individuals, and these services need to be delivered in person or via telehealth. Clients enrolled in RS, OP (ASAM 1.0), and IOP (ASAM 2.1) can participate in the same group counseling, if clinically appropriate. Clients enrolled in RS are not eligible to participate in the same group counseling and patient education sessions as those in residential treatment services.

RS: Recovery Monitoring

This service provides clients with dedicated guidance and recovery management to help them learn practical strategies to prevent relapse and address real-world triggers for drug or alcohol misuse. Recovery Monitoring targets SUD behavior and associated symptoms of use/relapse (stress, mood, and self-efficacy). This service can be delivered in person, via telehealth, or by telephone.

RS: Care Coordination

Individual service coordination, providing linkages with other services, including:

- Support for education and job/life skills, employment services, job training, and legal and educational services.
- Parenting support for childcare, parent education, child development support services, and family/marriage education.
- Linkages to benefits, mental and physical health, self-help and support groups, spiritual and faith-based support, and peer-delivered support services and groups.
- Ancillary services, such as housing assistance and transportation. Providers should identify service gaps and link the client to ancillary supports to address them.

Note: Care Coordination can be delivered in person, via telehealth, or by telephone.

RS: Relapse Prevention

Relapse prevention focuses on identifying a client's current stage of recovery and establishing a recovery plan to identify and manage the relapse warning signs and cope with the potential for relapse.

For definitions, see respective sections on [Care Coordination](#), [Group Counseling](#), and [Individual Counseling](#).

RS: Required Documentation

Counselors/clinicians need to document each client encounter, capturing relevant recovery details such as a summary of status and progress, pertinent changes, relapse potential, etc.

RS provided in the community, via telehealth, or by telephone requires equivalent quality and comprehensiveness of documentation to that of in-person services provided within a certified facility.

Recovery Bridge Housing

Housing and residing in a safe and stable living environment are often critical to achieving and maintaining recovery from SUDs. Research shows that SUD treatment outcomes are better for PEH, particularly those who experience chronic homelessness, when they are stably housed. People with SUDs need access to safe, stable, and supportive living environments to help them initiate and sustain their recovery and reduce the risk of relapse. RBH is a type of recovery-oriented, peer-supported housing that provides a safe IH environment for individuals who are homeless, according to the United States Department of Housing and Urban Development (HUD) and are considered unstably housed. Clients in RBH need to also be concurrently enrolled in treatment, such as OP, IOP, OTP, RS, or Outpatient (aka Ambulatory) Withdrawal Management (OP-WM) settings.

The goal of RBH is to provide safe IH that is supportive of recovery for clients who are receiving OP/IOP/OTP/RS/OP-WM treatment for their SUD. RBH is available for Young Adults (age 18-20) and Adults (age 21 and over), including PPW clients, who are:

- In need of a stable, safe living environment to best support their recovery from SUD; **and**
- Concurrently enrolled in OP/IOP/OTP/RS/OP-WM treatment settings

PPW clients include pregnant women, women with dependent children, or women working toward reunification. Women with dependent children may be accompanied by up to five (5) dependent children (age 0-17) in RBH. RBH providers authorized by the County to provide PPW services need to ensure that all services being provided to the parent and child(ren) are in accordance with [DHCS's Substance Use Disorder Perinatal Practice Guidelines \(November 2025\)](#). For additional information on PPW eligibility, see [PPW: Target Populations](#) section

Through the RBH for Dads program, RBH is also available for men with dependent children at select SAPC-contracted sites across the County. Like PPW clients, RBH for Dads clients may be accompanied by up to five (5) dependent children (age 0-17) in RBH. Clients in RBH for Dads may have primary or joint custody, visitation, or be working towards reunification with their children.

RBH providers authorized by the County to serve PPW clients and/or RBH for Dads clients may bill SAPC for the RBH bed day rate for accompanying children for each night the child(ren) resides with their parent in the RBH facility. For parents whose children do not reside with them full-time, RBH providers may also bill SAPC for the RBH bed day rate for accompanying children for ten (10) days per month when the child(ren) are not actively residing in the RBH facility.

Clients discharged from treatment in OP/IOP/OTP/RS/OP-WM settings are no longer eligible for the RBH benefit. As such, provider agencies may not bill for RBH services after a client has been discharged from treatment. RBH provider agencies may hold beds for up to seven (7) days for clients who need to leave the IH facility for reasons such as hospitalization, a therapeutic pass (violation of post-release supervision), or a lapse in treatment or Discharge Against Medical Advice (AMA). Beds held for this timeframe and for the reasons listed are billable through the provider's RBH contract.

Certain populations, such as PEH, are particularly at risk for relapse without access to housing and should be prioritized for this benefit. Other vulnerable populations will be prioritized for RBH, see [Table 11: RBH Requirements](#) (Number 3).

The RBH Requirements are based on the characteristics defined by HUD and on DHCS recommendations on best practices. RBH aligns with the spirit of the ASAM Criteria® in the sense that clients should be appropriately placed in the least restrictive treatment environment necessary to meet their clinical needs. While RBH is not officially an ASAM LOC, it serves as a bridge between the more intensive and restrictive residential treatment setting and OP/IOP/OTP/OP-WM treatment settings. Clients cannot be required to accept treatment with addiction medications as a condition for admission to RBH.

Table 11: Recovery Bridge Housing Requirements

Recovery Bridge Housing Requirements	
1	RBH beds are available to any eligible member, especially those in one of the prioritized groups for this benefit. RBH providers: • Cannot restrict access to this benefit only to their treatment clients; • Are required to accept referrals to available RBH beds from other network provider agencies; • Are required to accept referrals to available RBH beds from external entities; and • Need to refer their clients to other available RBH beds if they have met their capacity.
2	SAPC-contracted beds can only be dedicated to SAPC members. Providers utilizing SAPC-contracted beds for non-SAPC members are out of compliance with SAPC contract requirements.
3	SUD provider agencies need to prioritize the following high-risk populations for RBH according to the following ranking: • CARE Court program individuals • PPW • History of IV drug use

Recovery Bridge Housing Requirements

	• Clients with high utilization of treatment services (as defined by high utilizer criteria for high-tier care management⁹) • People experiencing chronic homelessness (according to HUD definition¹⁰) • People who are justice-involved without alternative options for RBH • Young Adults (age 18-20) • People living with HIV/AIDS • PEH stepping down from residential treatment into RBH, also known as “residential step down” • LGBTQ+ populations *Populations not on the prioritized list will be considered for RBH only if there is enough capacity to accommodate those on the prioritized list first. Note: Undocumented homeless adult members who meet the prioritization criteria listed above and are receiving concurrent SUD treatment through Medi-Cal or other programs listed under the Covered Members and Eligible Individuals section are eligible for placement in RBH.
4	Eligible clients should be medically and psychiatrically stable enough to benefit from RBH.
5	Program participation is self-initiated, and the member chooses recovery-oriented housing. Clients who receive the RBH benefit are expected to be abstinent from drugs and alcohol. However, abstinence is not defined as including abstinence from addiction medications. Clients placed in RBH need to be allowed to continue receiving addiction medications when clinically indicated and cannot be excluded from admission. RBH provider agencies need to have policies and procedures to ensure a client-centered process for RBH clients receiving addiction medications.
6	Program policies and operations are consistent with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) and ensure individual rights of privacy, dignity, respect, and safety.
7	Program emphasizes the personal recovery goals of clients and long-term housing stability to minimize the likelihood of homelessness.
8	Program design establishes minimal barriers to entry.
9	Programs are to meet or exceed National Alliance for Recovery Residences (NARR) standards of care, including ensuring that there is 50+ sq. ft. of bed per sleeping room (NARR standard Core Principle E.14.d) and that there is a minimum of one (1) sink, toilet, and shower per six (6) residents (NARR standard Core Principle E.14.e).
10	Holistic services and peer-based supports are available to all clients.
11	A relapse or lapse should not be an automatic cause for eviction from housing or termination from the program. Provider staff need to work with the clients to refer them to a higher LOC or a more appropriate housing type if the client is no longer interested in stopping substance use or engaging in treatment.
12	Incorporate low-barrier policies as follows: • Whenever possible, separate beds (or housing) for clients who lapse so they can sober up while still maintaining housing placement, but not being disruptive to other residents • Establishing a "buddy support system" after a client lapses to support individuals during this transition phase to maintain their recovery and recovery-oriented housing

⁹ **High tier care management inclusion criteria:** All individuals diagnosed with SUD who meet any of the following criteria: **(a)** 3+ emergency department (ED) visits related to SUD within the past 12 months; **(b)** 3+ inpatient hospital admissions within the past 12 months for physical and/or mental health conditions and co-occurring SUD; **(c)** Homeless with SUD (as defined by HUD homelessness definition); **(d)** 3+ residential SUD treatment admissions within the past 12 months; **(e)** 5+ incarcerations with SUD in 12 months.

¹⁰ Clients in RBH meet the HUD chronic homelessness definition. For clients who are chronically homeless upon entering RBH, they maintain their chronic homeless status even by staying in RBH for 90 days or longer.

Recovery Bridge Housing Requirements

	- When a resident lapses, increase participation in self-help meetings, as applicable - In instances where clients need to be discharged, provide a warm hand-off to an appropriate LOC or other service, with an open-door policy for them to return when ready - Streamlining the intake process for RBH - Implement contingency plans for intoxication and overdose that are clear to clients and staff, including having overdose medications readily available for use - Host, at a minimum, monthly house meetings to ensure staff and clients are trained in administering overdose medications. - Allowing staff within an RBH setting to be part of the process of shaping low-barrier policies - Encourage social activities and team-building opportunities
13	Involuntary discharge from housing only occurs under two (2) conditions: - A client's behavior substantially disrupts or impacts the welfare of the recovery community. - The client is no longer able to benefit from RBH due to becoming medically or psychiatrically unstable. Clients may apply to reenter the program if they express a renewed commitment to living in a recovery-oriented housing setting.
14	Clients who determine they are no longer interested in living in recovery-oriented housing, or who are discharged from the program, are assisted in accessing other housing and service options.
15	Throughout program participation, programs assist clients in transitioning to permanent housing, ensuring a smooth transition once they are ready to leave RBH.

RBH: Considerations

- RBH is voluntary. Clients must actively choose to be placed in recovery-oriented housing before being considered for RBH.
- RBH is appropriate for members who have minimal risk regarding acute intoxication/withdrawal potential biomedical and mental health conditions.
- Activities in RBH may include peer support, group and house meetings, self-help, and other recovery-focused services. Life skills training such as budgeting, paying bills, shopping, cooking, managing a household, and developing social skills is essential to support self-sufficiency and independent living.
- RBH clients cannot receive in-person SUD treatment services or Care Coordination at RBH sites.
- RBH provider agencies may conduct alcohol/drug testing or urinalysis, or coordinate with the treatment provider to request testing. Client consent must be obtained before releasing test results to the RBH provider. A positive test result should not automatically lead to removal from the program. Instead, the RBH provider should work with the client to refer them to a more appropriate LOC or housing option.
- Individuals appropriate for RBH may be stepping down from residential or may be entering the SUD treatment system directly into OP/IOP/OTP/RS/OP-WM LOCs.
- RBH clients need to be screened for TB or provide evidence of being screened (e.g., for those stepping down from residential treatment) within six (6) months prior to or 30 days after admission into RBH.
- Whenever possible and as preferred by the client, they should be placed in an RBH site that is located within 30 minutes or 15 miles of their treatment provider site.
- RBH sites should be in geographic areas that will not hinder recovery and should not be near alcohol outlets and/or high drug trafficking areas.

Note: Youth (age 17 and under) who require recovery-oriented housing may be eligible for placement in a group home that provides treatment and ancillary services in sites licensed by DPSS.

RBH: Authorization Process

If RBH is deemed appropriate, SUD treatment provider agencies need to refer the client to the appropriate RBH provider within one (1) business day of determination. The SUD treatment provider agency and RBH provider need to coordinate very closely to ensure the client's safe and timely arrival at the RBH facility.

- The RBH provider agency needs to submit a Sage authorization request and supporting documentation to ensure the client meets RBH eligibility criteria and receives reimbursement for RBH from SAPC.
- The RBH provider needs to collaborate with the treatment provider to submit the needed documentation, ensuring the client's concurrent enrollment in OP/IOP/OTP/OP-WM treatment.
- When the SUD provider and RBH provider are different agencies, there must be clear communication, policies, and procedures in place to confirm bed availability and coordinate care. These policies should outline the referral and admission process, the coordination responsibilities, and the procedures for resolving any disagreements between providers.
- If a bed is not available within 24 hours of the determination of RBH need, then the SUD treatment provider agency needs to make efforts to connect the client to appropriate IH.¹¹

SAPC-UM staff will review the Sage authorization request form and supporting documentation (e.g., justification for RBH, Financial Eligibility, and concurrent treatment in an OP LOC), and render a decision on authorization, which is required for a provider agency to receive reimbursement for RBH services. SAPC reimburses up to seven (7) days of RBH services while the client enrolls in OP treatment. Referring treatment provider agencies need to document the need for RBH in the client's Problem List (non-OTP settings) or Treatment Plan (OTP settings), and Housing Support Plan (HSP) (OTP setting). Both RBH and treatment provider agencies should refer to the most recent version of the [Checklist of Required Documentation for Utilization Management](#) and [Eligibility Verification and Member Authorizations](#) on [SAPC's Clinical Forms and Documents - Treatment Services Related webpage](#).

RBH: Duration

Services for Young Adults (age 18-20) and Adults (age 21 and over), including PPW clients, may be authorized in 90-day increments. The initial 90 days need not be continuous and may be used over a 12-month period starting from the date of the initial RBH admission.

A provider agency may request a maximum of three (3) reauthorizations that extend the time RBH clients continue to reside in RBH for longer than 90 days if they meet medical necessity and as long as the client continues to meet the RBH eligibility criteria specified above, including concurrent enrollment in OP/IOP/OTP/RS/OP-WM. Reauthorizations past the initial 90 days will be granted if the provider agency offers documentation showing active progress or steps taken to secure housing (e.g., actively working with a Housing Navigator, CES, Housing Authority, etc.).

¹¹ SAPC. (2024, January). Recovery-Oriented Housing Assessment and Intervention Workflow. <http://publichealth.lacounty.gov/sapc/docs/providers/trainings/Recovery-Oriented-Housing-Assessment-Intervention-Workflow.pdf>.

If a client utilizes the first authorization and the additional three (3) reauthorizations, RBH clients can receive a maximum of 360 days in a 12-month period. Once a client has resided in RBH for a total of 360 calendar days within the past 12 months or has met the 12-month period since the first day of RBH admission (e.g., June 1st – May 31st), whichever occurs first, the benefit period ends and cannot restart until 30 days after the most recent discharge date. SAPC-UM reviews the authorization requests and issues a response to the RBH provider agency in accordance with established UM response timelines.

RBH: Discharge Procedure

SUD treatment provider agencies should initiate discharge planning for PEH's housing needs upon admission to treatment. Housing Navigators need to work with clients to create or update an existing HSP to ensure a smooth transition to stable housing upon RBH discharge. Once RBH clients finish their stay or no longer receive the benefit, the RBH provider agency needs to fill out the Recovery Bridge Housing Discharge Form in Sage on the same day of discharge.

Note: The day rate for RBH is not billable on the date of discharge.

RBH: Eligible Provider Agencies

RBH provider agencies are currently limited to SAPC-contracted provider agencies with experience delivering RBH to clients receiving treatment in OP/IOP/OTP/RS/OP-WM settings. Also, RBH provider agencies need to be members of a Recovery Residence organization, such as Sober Living Network (SLN), or California Consortium of Addiction Programs and Professionals (CCAPP), that adheres to NARR standards and best practices. RBH provider agencies need to enter into a separate housing agreement with each client placed in RBH. It is best practice for RBH provider agencies to maintain a naloxone kit for on-site overdose prevention and to ensure that RBH House Managers, other designated staff, and clients receive training in administering naloxone.

RBH: Hours of Operation

RBH must operate 24 hours per day, seven (7) days a week, and accept intakes during regular weekday business hours (9:00 a.m. to 5:00 p.m., at a minimum).

RBH: Staffing

RBH provider agencies need to ensure that on-site house managers oversee the facility's day-to-day operations. This includes ensuring adherence to policies and procedures, rules, and requirements, the facility's quality, and clients' health and safety. RBH house managers need to receive appropriate on-site orientation and training prior to performing assigned duties, have appropriate experience and necessary training at the time of hiring, and should be familiar with SUD client record confidentiality regulations under [42 CFR Part 2](#). Further, housing managers should be trained in and practice, at a minimum, trauma-informed, cultural humility, and implicit bias awareness.

RBH staff submit reports requested by the County and/or County partners, including required information and supporting documentation (e.g., daily client sign-in/out logs). RBH staff are responsible for completing

authorization applications and other required documentation in Sage and coordinating with the treatment provider agency if the client receives treatment elsewhere. Coordination examples include verifying with the treatment provider agency that the client is still concurrently receiving OP/IOP/OTP/RS/OP-WM treatment, informing the treatment provider agency if the client leaves or has been discharged from RBH, reminding the treatment provider agency to conduct housing activities and/or refer the client to interim or permanent housing resources, and sharing requested information with the treatment provider agency to accurately complete the client's CalOMS/LACPRS records. The RBH staff needs to document coordination efforts with the treatment provider agencies.

Recovery Housing

RH is a low-barrier recovery-oriented IH provided for Young Adults (age 18-20) and Adults (age 21 and over), including PPW clients and Dads who have SUDs and minimal risk of acute biomedical and mental health issues that would prevent them from being safely housed. Certain populations, such as PEH, are particularly at risk for relapse without access to housing and should be prioritized for this benefit. Clients in RH need to be interested in living in recovery-oriented housing and be interested in following RH requirements. However, while it is encouraged, concurrent enrollment in treatment is not a condition of residing in RH.

RH: Program Eligibility

- In need of a stable, safe, and recovery-oriented living environment to best support their substance use recovery.
- Engaged in SUD treatment and/or RBH in the last 90 days at a SAPC provider agency.
- Able to conduct activities of daily living independently.

Participation is voluntary, and the client needs to choose recovery-oriented housing. Those placed in RH are allowed to continue receiving addiction medications when clinically indicated and cannot be excluded from admission. RH provider agencies need to have policies and procedures to ensure a client-centered process for receiving addiction medications.

Additionally, the RH provider agencies need to ensure that clients remain continuously engaged in SAPC Housing Navigation (HN) or other HN services, unless they have already established a housing plan for discharge from RH.

RH: Program Length

Young Adults (age 18-20) and Adults (age 21 and over), including PPW clients, may be authorized and reimbursed for a cumulative total of up to 12 months within the last two (2) years (does not need to be consecutive) if they meet the eligibility criteria specified above. SAPC wants to avoid planned transitions out of RH to unsheltered homelessness. SAPC will consider one (1) extension up to three (3) months beyond the 12-month allowance on a case-by-case basis. If a provider would like to request an extension, they need to submit a written request to SAPC explaining the circumstances, and SAPC will make a final determination.

RH: Referral Process

Referrals for RH are made directly to SAPC. The referral can be made by:

- Any SUD treatment provider agency within the SAPC network;
- A service provider (e.g., DMH, IH Provider);
- The individual themselves (self-referral); **or**
- One (1) of the SAPC entryways: SASH or CENS.

RH: Admission/Referral Procedure

1. Referring party completes the [Recovery Housing Intake Form \(SAPC IN 25-04, Attachment I\)](#) up to 30 days but no later than three (3) days prior to the intended intake date.
2. Submit Recovery Housing Referral Form via a secure email to DPH-SAPC_HSU@ph.lacounty.gov.
3. SAPC will review the referral and respond to the referring party with a disposition within one (1) business day.
4. If beds are available, SAPC staff will coordinate with the referring party and the RH provider agency to place the individual in the available bed. Only individuals approved by SAPC will be placed in the beds.
5. If there are no current available beds, the individual will be added to a waitlist.

RH: Discharge Procedure

Complete and securely submit the [Recovery Housing Discharge Form \(SAPC IN 25-04, Attachment II\)](#) via email to SAPC-SOC at DPH-SAPC_HSU@ph.lacounty.gov within one (1) business day of client discharge.

Relapse is not treated as an automatic cause for eviction from housing or termination from the program.

Discharge from housing only occurs under the following conditions:

- Client is no longer interested in residing in RH and voluntarily leaves on their own accord.
- Client's behavior substantially disrupts or impacts the welfare of the recovery community.
- Client is no longer able to benefit from RH due to becoming medically or psychiatrically unstable.

In all cases, the provider agency needs to work with the client to support a transition to a more appropriate treatment or housing setting. Clients who choose to leave recovery-oriented housing or are discharged from the program need assistance accessing other housing and service options. Clients may reapply to the program if they express a renewed commitment to recovery-oriented housing and have not exceeded the 12-month program limit within the past two (2) years.

RH providers authorized by the County to provide RH services must ensure that all services provided are in accordance with [SAPC IN 25-04](#). For additional information regarding RH, see [SAPC IN 25-04](#) and the [Recovery Housing Billing Procedure \(SAPC IN 25-04, Attachment IV\)](#).

Housing Navigation

HN is an integral part of the process of helping people identify housing options, resources, and services. Housing navigators help individuals prepare for, find, move into, and retain affordable, permanent housing opportunities. Providing HN services to clients residing in RBH and RH will ensure that clients can actively work towards securing a permanent housing plan, thus mitigating the risk of homelessness and relapse with SUD.

HN: Program Eligibility

- PEH and are enrolled in SAPC-contracted RBH or RH.
- Individuals enrolled in RBH or RH need to enroll in HN services.
- Clients have the option to opt out of these services if:
 - Have already established a permanent housing plan when they complete RBH and/or RH; **or**
 - Are already engaged in HN services through another agency/provider.

HN: Program Length

Clients have access to HN services during their enrollment in RBH or RH, and for up to 30 days after leaving RBH/RH.

HN: Referral Process

Housing Navigators are limited to providing services to individuals seeking or enrolled in SAPC-contracted RBH or RH. Housing navigators receive referrals from, and collaborate with, the RBH/RH agencies within their respective SPA locations for individuals who would benefit from HN services. RBH/RH agencies are required to connect individuals in either housing setting to HN services using the [Housing Navigation Referral form \(SAPC IN 25-16, Attachment I\)](#), unless the individuals are connected to another HN service, as reported by the client. Provider agencies are expected to document when a client declines participation in the client file.

HN: Documentation

The Housing Navigator:

- Develops and/or updates an existing HSP for each client and documents progress on the plan.
- Completes the [Homeless Management Information System \(HMIS\) Intake and Referral Form](#).
- Maintains a file documenting all occurrences and services provided as part of HN services.
- Submits billing with all the required documentation as directed by SAPC.

HN: Participant Assistance Funds

As funds are available, HN includes distributing Participant Assistance Funds (PAF) of up to \$1,500 to each enrolled PEH to remove barriers and mitigate stress that may contribute to behavioral health conditions while assisting in meeting their immediate housing needs (e.g., assistance obtaining identification and related vital documents, transportation, food, and hygiene products). Funds may also be used to support individuals in completing housing applications or for costs associated with credit reports, security deposits, utility hookups, and moderate furnishings.

HN provider agencies are tasked with distributing PAF as part of HN services and should follow the steps below to document the distribution and submit an invoice for reimbursement, as directed. Detailed information can be found in the [SAPC's Participant Assistance Funds Standards and Practices \(SAPC IN 25-16, Attachment III\)](#).

HN: Length for Use of Funds

Clients will receive PAF while enrolled in HN services. Clients are eligible for HN while enrolled in RBH or RH and for up to 30 days after leaving the program.

HN: Documentation for Funds

Records of all PAF distributed should be documented and logged in accordance with the County's accounting manual and SAPC's [Participant Assistance Funds Standards and Practices](#), and should include:

- Name and contact information of clients who received them;
- Date the funds were received;
- What the funds were used for; **and**
- Agency staff and client signature that funds were received.

HN providers authorized by the County to provide HN services and the associated PAF need to ensure that all services being provided are in accordance with [SAPC IN 25-16](#). For additional information regarding HN, see [SAPC IN 25-16](#).

Transitional Rent

Transitional Rent (TR) is a CalAIM Community Supports service providing up to six (6) months of rental assistance for eligible clients who are Medi-Cal members experiencing or at risk of homelessness with a SUD, serious mental illness, and/or chronic health conditions. TR is designed to support health, safety, and recovery during a housing transition and will supplement existing RBH funding to enhance the overall continuum of care. For SAPC clients, TR will support PEH's stay in RBH for up to six (6) months.

SAPC-contracted RBH and OP/IOP/OTP/RS/OP-WM providers will play a key role in supporting TR, including preparing required documentation (e.g., HSP, Universal Consent, Consent for TR services), care coordination, and adherence to SAPC and DMC program requirements.

Peer Support Services

Peer Support Services (PSS) are a Medi-Cal reimbursable benefit under DMC-ODS. PSS are delivered by Certified Medi-Cal Peer Support Specialists (CMPSS), referred to throughout this manual as Certified Peers, who are recognized by DHCS as a distinct provider type. In alignment with [Senate Bill \(SB\) 803](#), DHCS established statewide standards for the certification of peer support specialists and designated the California Mental Health Services Authority (CalMHSA) as the sole certifying entity. CalMHSA is responsible for implementing certification requirements, including eligibility, training, and examination, for individuals seeking to become Certified Peers.

Scope of Practice for Certified Peers

PSS are culturally responsive individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, and the development of natural supports. Services are grounded in lived experience and delivered through structured activities such as coaching, skill-building, and linkage to community resources. These services aim to prevent relapse, empower individuals through strength-based coaching, provide support linkages to community resources, and educate members and their families about their conditions and recovery.

PSS may be provided to the individual or a significant support person in a clinical or non-clinical treatment setting, as a standalone service, with or without the member present. They may be delivered in person, via telehealth, by telephone, or at approved Established FBS locations.

For PSS to be reimbursable, they need to be provided by a Certified Peer. Per DHCS, Certified Peers' scope of practice is limited to the services outlined in the section below and based on a Plan of Care approved by an LPHA or a Certified Peer Supervisor. The Plan of Care needs to be submitted in accordance with the guidelines outlined in [Sage for Certified Peers – Documentation for PSS](#) section. In residential treatment settings, PSS would count toward weekly therapeutic hours. For additional information, see [SAPC's Manuals, Bulletins, and Forms – Bulletins Tab webpage](#) for the most current version of the Provider Staffing Guidelines.

In accordance with [BHIN 25-010](#), Certified Peers can utilize the following two (2) codes to provide Medi-Cal reimbursable PSS:

- **H0025 Behavioral Health Prevention Education Services:**
 - **Educational Skill Building Groups:** Providing a supportive environment in which members and their families learn coping mechanisms and problem-solving skills to help members achieve desired outcomes. These groups promote skill-building for members in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services

Note: Educational Skill-Building groups are available in all LOCs and are offered in person, via telehealth, or by telephone contact with a Certified Peer, and must be outlined in the member's Individualized Plan of Care. A separate progress note documenting the client's education session is written for each group member and documented in the EHR or Sage. Group sign-in sheets need to include printed names (first and last name) and signatures of all group members and group facilitators.

- **H0038 Self-Help/Peer Services:**

- **Engagement:** Activities and coaching led by a Certified Peer to encourage and support clients to participate in behavioral health treatment. Engagement may include supporting clients in their transitions between LOCs and developing their own recovery goals and processes.
- **Therapeutic Activity:** A structured non-clinical activity provided by a Certified Peer to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the client's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the client; promotion of self-advocacy; resource navigation; distribution of naloxone or other overdose prevention supplies in accordance with established distribution policies; and collaboration with the client and others providing care or support to the client, family members, or significant support persons.

Note: Individual Self-Help/Peer Service sessions are designed to support direct communication and dialogue between the Certified Peer and the client to focus on supporting the client in behavioral health treatment and/or the PSS components outlined in the client's Individualized Plan of Care. Individual Self-Help/Peer Service sessions are available in all LOCs and are offered in person, via telehealth, or by telephone with a Certified Peer.

Sage for Certified Peers

Certified Peer User Enrollment

For Primary Sage Users, SAPC developed three (3) different access levels for Certified Peers to document and/or bill reimbursable services, as indicated below.

- **(3) PCNXCertPeerSupSpec:** For Certified Peers who provide non-clinical, recovery-oriented, culturally appropriate services that promote engagement, socialization, self-sufficiency, self-advocacy, natural supports, and are trauma-aware.
- **(7) PCNXCertPeerFinClin:** For Certified Peers who provide the same recovery-oriented services as a PCNXCertPeerSupSpec and submit billing claims for treatment services eligible for reimbursement from the County.
- **(14) PCNXPeerSupportSupervisor:** For Certified Peers who serve as a supervisor for other Certified Peers, which necessitates a higher level of system access. Specifically, this user role is for supervising staff to conduct non-clinical treatment services, including Educational Skill Building, Engagement Services, Therapeutic Activity, problem list/treatment plans, and the documentation of those services.
- ***Note: SUD Counselors or LPHAs who supervise Certified Peers do not need to be assigned to this user role to fulfill their supervisory responsibilities***

Documentation for PSS

PSS are based on an approved, individualized Plan of Care to be reimbursable. The Plan of Care needs to be documented on the Progress Note form using the “Peer Support Services – Plan of Care” Service Type in Sage, for Primary Sage users or within a SAPC-approved EHR Progress Note format for Secondary Sage Users, and approved/signed by a Behavioral Health Professional or a Certified Peer Support Specialist Supervisor as referenced in SAPC’s [Peer Support Services Guide \(January 2024\)](#). Certified Peers can develop a Plan of Care, but it needs to be reviewed and signed by an LPHA **or** a Certified Peer Supervisor.

The Plan of Care is documented:

- Using Plan of Care service type option on the Progress Note form in Sage for a primary Sage user; **or**
- Within a SAPC-approved EHR Progress Note form for a secondary Sage user.

The Plan of Care is approved/signed by an LPHA **or** a Certified Peer Supervisor within the time frames listed below:

- **For clients in residential treatment settings:**
 - **Within seven (7) calendar days** of first service or first intake appointment in residential settings for Young Adults (age 18-20) and Adults (age 21 and over); **or**
 - **Within 14 calendar days** of first service or first intake appointment in residential settings for Youth (age 17 and under).
- **For clients in non-residential treatment settings (e.g., OP, IOP, RS):**
 - **Within 30 calendar days** of first service or first intake appointment for Adults (age 21 and over); **or**
 - **Within 60 calendar days** of first service or first intake appointment for Youth (age 17 and under) and Young Adults (age 18-20), and all Adults (age 21 and over) who are documented as a PEH¹². For additional information, see [Initial Engagement Authorizations](#) section.

The Plan of Care is reviewed and updated when clinically appropriate to reflect significant changes in the client’s treatment and signed by an LPHA **or** a Certified Peer Supervisor:

- No later than every 90 calendar days after the initial Plan of Care approval in OP settings, **or**
- No later than every 30 calendar days after the initial Plan of Care approval in residential settings.

Plan of Care Guidelines for PSS

Provider agencies can adapt the guidelines below in accordance with their current documentation formatting. In addition, PSS needs to be documented in a Progress Note within three (3) business days. For documentation examples, see SAPC’s [Peer Support Services Guide \(January 2024\)](#).

¹² Documentation of homelessness status must be indicated in a Progress Note.

These guidelines are intended to be used within a Progress Note with “Peer Support Services – Plan of Care” Service Type. Below are the minimum requirements of what to include in a Plan of Care.

- Indicate if this is a new Plan of Care, an updated plan, or a review of an existing Plan of Care;
- Long-term goals;
- Short-term goals (in SMART format);
- Indicate that the client participated in and agreed with the Plan of Care; **and**
- Signatures: Certified Peer and license-eligible LPHA/LPHA **or** Certified Peer Supervisor.

Complaints, Appeals, and Actions for PSS

DHCS conducts a review of the Medi-Cal Peer Support Specialist Certification Program upon receipt of a complaint regarding the violation of an applicable law or guidance. Complaints may only be submitted by those who have applied for Medi-Cal Peer Support Specialist Certification, their designated representative, a staff member from the Medi-Cal Peer Support Specialist Certification Program, or a county staff member.

Complaints regarding Medi-Cal Peer Support Specialist Certification Programs may be submitted to DHCS at peers@dhcs.ca.gov or submitted by mail to:

Department of Health Care Services
Behavioral Health MS 2710
P.O. Box 997413
Sacramento, CA 95899-7413.

CalMHSA investigates all complaints made against Certified Peers and approved training entities. CalMHSA will also review:

- Appeals related to denials of application for certification
- Suspension or revocation of a certification
- Denials for certification renewal
- Denials for training provider applications

CalMHSA completes the investigation of a complaint within 90 days upon receipt of a complaint. Information on how to file a complaint is available on the CalMHSA Certification Registry. The registry posts updates on complaints regarding a Certified Peer within 72 hours of a change in certification status.

For additional information regarding CalMHSA’s complaints, appeals, and actions, see [CalMHSA Medi-Cal Peer Support Specialist Certification – Guidelines, Standards & Procedure Manual](#).

In addition to CalMHSA’s process, complaints regarding agencies delivering PSS or a Certified Peer can be submitted directly to SAPC at SAPCMonitoring@ph.lacounty.gov.

Recovery Incentives-Contingency Management

The Recovery Incentives Contingency Management (RI-CM) program covers contingency management (CM) services for DMC-ODS members. CM is an evidence-based intervention for individuals with stimulant use disorder (StimUD), including use of substances such as methamphetamine and cocaine.

RI-CM is an OP treatment program in which eligible participants can receive incentives (e.g., gift cards) for regular negative urine drug tests (UDTs). CM has been shown to improve treatment engagement and long-term outcomes, including reduced substance use and increased abstinence, when compared to standard SUD treatment alone. Provider Agencies are encouraged to offer CM services to eligible clients.

RI-CM participant program eligibility:

- Be eligible for Medi-Cal
- Reside in LA County
- Complete a screening indicating moderate to severe StimUD
- Agree to regular UDT
- No age restriction

Eligible participants engage in a structured OP program for 24 weeks. This includes regular UDTs and ongoing participation in treatment and recovery supports. Clients receiving SUD treatment from a DMC-ODS provider that does not offer RI-CM services can receive RI-CM services from another provider within the SAPC provider network. For the most current list of participating RI-CM providers, see [SAPC's List of Agencies Providing Contingency Management Services](#).

RI-CM providers must ensure services are delivered according to SAPC and DHCS requirements, including:

- Adherence to participant eligibility criteria; **and**
- Compliance with incentive limits and program protocols.

Note: In accordance with [BHIN 24-031](#), *Certified Peers are eligible providers that can deliver and bill for RI-CM services when CM certification requirements are met before submitting claims for CM services.*

For more information on requirements, refer to:

- [SAPC IN 23-06](#): local implementation guidance specific to LA County
- [BHIN 24-031](#): statewide DHCS policies for RI-CM services

For all RI-CM-related inquiries, email SAPC-SOC at SAPC-SOC@ph.lacounty.gov. For additional information on the RI-CM program, see [SAPC's Contingency Management webpage](#).

Clinician Consultation Services

Clinician Consultation Services are available to SAPC network LPHAs. Clinician Consultation Services consist of DMC-ODS LPHAs consulting with LPHAs, such as addiction medicine physicians, addiction psychiatrists, licensed clinicians, or clinical pharmacists. It is designed to support DMC-ODS licensed clinicians with complex cases and may address medication selection, dosing, side-effect management, adherence, drug-drug interactions, or LOC considerations. It includes consultations between clinicians designed to assist DMC clinicians seeking expert advice on treatment needs for specific DMC-ODS clients. DMC-ODS counties may contract with one (1) or more physicians, clinicians, or pharmacists specializing in addiction to provide consultation services. These consultations can occur in person, via telehealth, by telephone, or by asynchronous (not in real-time) telecommunication systems such as email.

Clinician Consultation Services available to physicians within the specialty SUD system in LA County are provided by the University of California, San Francisco (UCSF) Substance Use Warmline.

Note: *Clinician Consultation is not a direct service provided to DMC-ODS clients.*

Licensed Clinician Consultation Process

Licensed clinicians within the specialty SUD system who seek consultation are responsible for initiating the consultation with specialists outside of their agency for expert clinical consultation. One (1) option for expert clinician consultation is through the **UCSF Substance Use Warmline** at **(855) 300-3595**. For additional information, see www.nccc.ucsf.edu/clinical-resources/substance-use-resources/.

Eligible Clients

Clinician Consultation requests are intended for **licensed clinicians only** and need to not be initiated by non-licensed clinicians or clients.

Service Hours

These services are available Monday through Friday (excluding holidays) between 6:00 a.m. and 5:00 p.m. Pacific Time. Voicemail is available 24 hours per day. Every effort is made to respond to consultation requests in a timely manner.

All consultation requests need to include a clear explanation of the reason for the consultation and any relevant history and clinical details that help inform and provide context for the concern/question. Additional details related to consultation topics include:

- The content of the consultative advice offered through Clinician Consultation Services is limited to addiction expertise, and these consultations may involve, but are not limited to, the management of complex cases and questions involving addiction medications.
- Consultation requests that are non-clinical in nature, administrative, or more appropriate for County staff are not appropriate for this line. For example, if a clinician has a question regarding DMC eligibility, service availability, or questions regarding policies/procedures related to SUD treatment, these questions should be directed to the applicable SAPC Division. The UCSF Substance Use Warmline

provides general addiction expertise and cannot answer non-clinical or administrative questions specific to LA County.

- For the protection of clients and providers, Clinician Consultation Services are strictly limited to routine consultation requests. Emergency and urgent consultation needs should be directed to more appropriate resources (e.g., ED, PES). If the Consultant Specialist determines whether a consultation request is emergent or urgent, or that the consultation request is otherwise inappropriate (e.g., client's condition is not consistent with services provided by the consult service), the Referring Clinician will be notified of this determination and will be provided an explanation for this decision.
- The Consultant Specialist from UCSF will utilize the information provided by the Referring Clinician to provide recommendations focused on the question/concern. The question posed by the Referring Clinician may be asked of other addiction specialists within the UCSF Substance Use Warmline to elicit alternative clinical options and ideas.
- In conjunction with the consultant's expert opinion, the Referring Clinician will then utilize their own professional judgment and other considerations (e.g., client preferences, family concerns, other health conditions, and psychosocial factors) to provide comprehensive and client-centered treatment.

Documentation

Documentation expectations for services provided as a result of Clinician Consultation Services are the same as those for other client care scenarios. A Progress Note must be completed within three (3) business days by an LPHA or MD, practicing within the scope of their practice. Progress Notes need to include:

- Client's name;
- Purpose of the service;
- Date of consultation;
- Start and end times of each service; and
- Identify if services were provided in-person, via telehealth, or by telephone.

If the Referring Clinician utilizes the Clinician Consultation Service, the Referring Clinician is also responsible for thoroughly documenting the client encounter and the Clinician Consultation Service's role in informing that encounter. All documentation should use clear and comprehensible language to non-physician LPHA and SUD counselors.

Billing

Clinician Consultation Services are provided free of charge for the specialty SUD system. The time clinicians spend seeking consultation from the Clinician Consultation Service is not billable.

All Federal, State, and local confidentiality requirements involving [HIPAA](#) and [42 CFR Part 2](#) need to be followed during the Clinician Consultation process.

Treatment Service Components

This section provides an overview of the treatment services available to clients in the SAPC SUD network. Each service is described in detail in the subsections below:

- [Alcohol and Drug Testing](#)
- [Client Education](#)
- [Culturally and Linguistically Appropriate Services](#) (CLAS)
- [Discharge Planning](#)
- [Group Counseling](#)
- [Individual Counseling](#)
- [Medications FDA-Approved to Reverse Opioid Overdose](#)
- [Medications for Addiction Treatment](#)
- [Medication Services and Safeguarding Medications](#)
- [SUD Crisis Intervention](#)
- [Transportation Services](#)

For additional services, see the following sections: [Allowable Screening Tools](#) for Screening, [Table 2: Eligibility Requirements for Specialty SUD Services in LA County](#) for Assessment, [Care Coordination](#), and [Recovery Services](#).

For additional information on how these services are billed and any service minimums or maximums, see [SAPC's Manuals, Bulletins, and Forms – Bulletins Tab webpage](#) for the most current version of the SAPC IN for the Rates Matrix.

Alcohol and Drug Testing

Alcohol and drug testing involves examining biological specimens (e.g., urine, blood, hair) to detect the presence of specific substances and to determine prior substance use. While there is not a widely agreed-upon standard for drug testing in SUD treatment, it is often a useful tool to monitor engagement and provide an objective measure of treatment effectiveness and progress to inform treatment decisions. The frequency of alcohol and drug testing should be based on the client's progress in treatment, and the frequency of testing should be higher during the initial phases of treatment when continued alcohol and/or drug use has been identified to be more common. In general, alcohol and drug testing should not exceed more than twice (2x) a week. OTP requires monthly testing at a minimum.

Drug testing is best when administered randomly rather than scheduled, and the method of testing (e.g., urine, saliva) should ideally vary as well. When body fluid testing is performed, practitioners should balance the need to protect against the falsification and/or contamination of any urine sample with the need to respect client privacy. Reasonable steps should

Drug Testing as a Therapeutic Tool

Drug testing should be viewed and used as a therapeutic tool. A punitive approach to drug testing generally does not facilitate a productive relationship with clients and should be avoided. Consequences to drug testing should also be communicated in a therapeutic manner. Use of accurate language such as negative or positive to report the results of drug testing is encouraged.

be taken to ensure specimens are not switched, substituted, or adulterated before analysis. Direct observation specimen collection is not routinely necessary unless clinically indicated, such as when there is a discrepancy between a client's clinical examination and prior toxicology results.

Decisions about appropriate responses to positive drug tests and relapses should consider:

- Chronic nature of addiction.
- Relapse is a part of the condition for which people are seeking SUD treatment.
- Medications or other factors may, at times, lead to false or appropriately positive drug test results.

Alcohol and Drug Testing is allowable at all LOCs. Testing is not allowable for RBH. While it is not a reimbursable service for all practitioner types, a Progress Note must be written for each test, and the service must be reported in the EHR or Sage.

Client Education

Client Education sessions aim to teach clients and encourage discussion on research-based educational topics such as SUDs, SUD treatment, including addiction medications, recovery, and associated health consequences. The goal of these sessions is to minimize the harm of SUDs, lower the risk of overdose, and reduce the severity of substance use. This does not include recreational activities, skill-building sessions (e.g., employment, education, tutoring), or time viewing videos/DVDs (although discussion time is generally allowable). Client Education sessions need to include EBPs that incorporate youth or adult learning styles and support information retention.

A SAPC-approved early intervention curriculum entitled *“Healthy YOUTH: An Early Intervention Service Model for Addressing Substance Use Risk and Promoting Wellness Among At Risk Youth”* is available for Youth (age 17 and under) and Young Adults (age 18-20) enrolled in Early Intervention services. All youth and young adult provider agencies must complete the required Early Intervention Curriculum training before delivering early intervention client education sessions.

To ensure that clients are aware of upcoming Group Counseling and Client Education sessions, a monthly calendar needs to be posted in client-accessible areas, including the topic, location, date, time, and facilitator's name.

Client Education sessions are available at all LOCs and are defined as in-person, by telephone, or by telehealth contact between up to two (2) practitioners within their scope of practice, and

- 2-12 clients at the same time in non-residential settings, **or**
- 2-30 clients at the same time in residential settings.

Client Education sessions may include family members and legal guardians. Services are reported in 15-minute increments, with sessions ranging from 60 to 90 minutes in length. A separate Progress Note documenting the Client Education session needs to be written for each client and documented in the provider's EHR or Sage. Group sign-in sheets need to include signatures and printed names of clients and group facilitators, date, start/end times, location, and group topic.

The frequency of Client Education sessions, in combination with other Treatment Services, needs to be based on medical necessity and individualized client needs rather than a prescribed program required for all clients.

Culturally and Linguistically Appropriate Services

CLAS promotes respect and understanding of how culture and language shape individual experiences and interactions. This includes race, ethnicity, faith, gender identity, sexual orientation, housing status, education, ability, and class. The National CLAS Standards were created to support the delivery of equitable and high-quality care, including for individuals receiving SUD services. Research shows that when services lack cultural relevance, diversity, and inclusivity, it can negatively affect outcomes such as access, engagement, help-seeking behaviors, treatment participation, goal setting, and family involvement.

SAPC's requirements for ensuring equitable services are outlined in [SAPC IN 24-02](#). These requirements reflect a commitment to providing services that respect each person's culture, language, identity, developmental stage, and any physical, psychiatric, sensory, or cognitive disabilities. Providers need to ensure that their policies, practices, and daily operations support culturally, linguistically, and population-appropriate care.

Services for Persons with Disabilities

Providers need to comply with all aspects of the [Americans with Disabilities Act of 1990 \(ADA\)](#). This includes providing access to assistive technologies (e.g., TTY, magnification, audio, etc.) and policies that allow the use of service animals.

As outlined in [BHIN 24-007](#) and [SAPC IN 24-02](#), providers need to have clear policies to accommodate the communication needs of all qualified individuals. They should be prepared to offer information in alternative formats, such as Braille, audio recordings, large print, and accessible electronic formats, including data CDs. Other auxiliary aids and services also need to be provided when appropriate.

SAPC offers resources to help providers implement accessibility, including "[Creating Accessibility: An ADA Toolkit for Service Providers](#)", available on the [SAPC Learning and Network Connection \(SAPC-LNC\) platform](#) website. Providers can also refer to the [DHCS Alternative Format website](#) to identify member preferences for accessible materials.

TGI-Inclusive Services

In accordance with [BHIN 25-019](#) and [SAPC IN 24-02](#), SAPC and its contracted provider agencies need to comply with requirements under [SB 923](#) to provide trans-inclusive care to individuals who identify as Transgender, Gender Diverse, or Intersex (TGI) consistent with the standards of care for individuals who identify as TGI, honors the individual's personal bodily autonomy, does not make assumptions about an individual's gender, accepts gender fluidity and nontraditional gender presentation, and creates spaces of inclusivity and belonging, treating everyone with compassion, understanding, and respect.

Under [SB 923](#) and [BHIN 25-019](#), SAPC is required to ensure that staff who have direct contact with clients are trained on a specific set of training curriculum requirements, as well as to track, monitor, and report complaints for failure to provide TGI-inclusive care and submit them to DHCS. The TGI Training has been published on the [SAPC-LNC platform](#). Providers may access the training, complete the course, and download completion certificates directly from SAPC-LNC. The course is a recording of a live virtual training and includes closed captioning for accessibility.

Language Assistance Services

SAPC and its contracted provider agencies must comply with Federal, State, and contract requirements for ensuring access to language assistance services, including oral interpretation, sign language, written translation, etc., at no cost for clients who are monolingual, non-English speakers, or LEP, including posting of notifications about the availability of such services.

When a client requests services in a non-English language, providers should (as outlined in [SAPC IN 24-02](#)):

- Input clients' self-reported preferred language for treatment services into the Sage and the relevant data fields in CalOMS.
- Offer language assistance services for treatment in their preferred language.
- Use the Care Coordination benefit to refer the client for treatment in their preferred language, when requested by the client.
- If a client refuses interpreter services, document in the client's chart that free interpreter services were offered and declined.
- Where applicable, providers should use the language assistance add-on when using a third-party interpreter during DMC-ODS eligible services; see [SAPC IN 24-02](#) (or most recent version) of the <https://www.dhcs.ca.gov/services/MH/Documents/DMC-ODS-Billing-Manual-SFY2025-26.pdf>
- Do not use family members, friends, etc., as interpreters unless specifically requested by the member. In such cases, the family member, friend, or other individual cannot be used in the normal course of providing contracted services, and the client should sign an ROI form to ensure they are fully informed of the information that may be disclosed. A minor child **may not be used as an interpreter** except when an emergency involves an imminent threat to the safety or welfare of the individual or the public and a qualified interpreter is unavailable.

In very limited circumstances, SAPC may assist with interpretation services. To initiate a request, complete and submit the required forms found on SAPC's Cultural Responsiveness and Language Assistance (CRLA) webpage.

Language assistance requests will be evaluated for approval. Provider agencies should not rely upon SAPC to comply with language assistance services requirements. For any questions related to language assistance services, email eas@ph.lacounty.gov.

Discharge Planning

Discharge planning is the process of preparing the client for referral to another LOC, post-treatment return, or reentry into the community, and/or linking the individual to essential community treatment, housing, and human services. The discharge planning process should be initiated at the onset of treatment services to ensure sufficient time to plan for the client's transition to subsequent treatment, RS, or the next step in their recovery journey. It also helps to convey that recovery is an ongoing life process, not a unit of service. Transition to RS needs to be included in this process. Discharge planning should include a description of the client's triggers, a plan to avoid relapse for each trigger, and an overall support plan.

Discharge planning sessions are available at all LOCs and are conducted in person, via telehealth, or by telephone between one (1) practitioner and one (1) client. Services are reported in 15-minute increments, with sessions ranging from 15 to 60 minutes. A Progress Note needs to be written for each session and documented in the EHR or Sage.

The Discharge and Transfer Form is required to be completed by both Primary and Secondary Sage Users directly in Sage-PCNX. This form, when combined with the Provider Site Admission Form, will accurately track each client admission and enable census tracking within Sage. The Discharge and Transfer form needs to be completed on the day of the last in-person treatment/telehealth session, or on the day medication is dispensed or administered (OTP), for all LOCs, unless the client's discharge is unplanned. For unplanned discharges, the form needs to be completed within 30 calendar days of the last date services were provided. For RBH, the Recovery Bridge Discharge form must be completed for each client in Sage at the time of discharge from RBH.

Group Counseling

Group Counseling sessions are designed to support discussion among clients, with guidance from the facilitator to support understanding and encourage participation in psychosocial issues related to substance use. This does not include recreational activities, skill-building sessions (e.g., employment, education, tutoring), or time spent viewing videos/DVDs (although discussion time is generally allowable). Group Counseling sessions need to incorporate techniques such as MI and CBT. To ensure clients are aware of upcoming Group Counseling and Client Education sessions, a monthly calendar must be posted in client-accessible areas, including the session topic, location, date, time, and facilitator.

Group Counseling sessions are available at all LOCs and are defined as in-person or telehealth contact between up to two (2) practitioners within their scope of practice and 2-12 clients at the same time. This includes family members and non-Medi-Cal clients. Only services to eligible clients (Medi-Cal clients or individuals participating in programs listed under the [Covered Members and Eligible Individuals](#) section receiving treatment) can be claimed to SAPC.

Services are reported in 15-minute increments with sessions ranging from 60 to 90 minutes in length. A separate Progress Note needs to be written for each client and documented in the EHR or Sage. Group sign-in sheets need to include the signatures and printed full names (first and last name) of all clients (including clients not reimbursed by SAPC and family members) and group facilitators, as well as the date, start/end times, location, and group topic.

The frequency of Group Counseling sessions, in combination with other Treatment Services, needs to be based on medical necessity and individualized client needs rather than a prescribed program required for all clients.

Note: Youth (age 17 and under) and Young Adults (age 18-20) are only allowed to participate in the same Group Counseling sessions in school-based settings.

Individual Counseling

Individual Counseling sessions are designed to support direct communication and dialogue between staff and clients and focus on psychosocial issues related to substance use, outlined in the client's individualized Problem List (non-OTP settings) or Treatment Plan (OTP settings). They need to incorporate techniques such as MI and CBT.

Individual Counseling sessions are available at all LOCs and are defined as in-person, via telehealth, or by telephone contact between one (1) DHCS-approved practitioner type and one (1) client. Services are reported in 15-minute increments with sessions ranging from 15 to 60 minutes. Individual Counseling sessions of less than eight (8) minutes cannot be billed as they are less than the minimum requirement. If Individual Counseling sessions exceed 60 minutes, the Progress Note for that encounter must justify the additional time. If the counseling session is split into different services (e.g., Care Coordination, Crisis Intervention, etc.), a Progress Note must be written for each session and documented in the EHR or Sage.

The frequency of Individual Counseling sessions, in combination with other Treatment Services, needs to be based on medical necessity and individualized client needs, rather than a prescribed program required for all clients.

Medications FDA-Approved to Reverse Opioid Overdose

Naloxone is a critical tool in responding to the opioid crisis. Naloxone is a life-saving medication used to reverse an opioid overdose, including heroin, fentanyl, and prescription opioid medication overdoses. Naloxone works by blocking the opioid receptor sites, reversing the toxic effects of the overdose. Naloxone is administered when a client is showing signs of opioid overdose and can be quickly administered by intranasal spray, intramuscularly, subcutaneously, or by IV injection. Naloxone is safe and easy to use, works almost immediately, and has no abuse potential. Naloxone is available to all Medi-Cal members with a prescription and may also be furnished by community pharmacists to individuals without a prescription.

Provider agencies need to establish protocols for both prescribing FDA-approved medications to reverse an opioid overdose, such as naloxone, and to distribute FDA-approved medications to reverse an opioid overdose obtained outside of pharmacy-dispensing and OTP-dispensing sources, such as the DHCS's Naloxone Distribution Project (NDP) for California, to all clients within the SAPC treatment network. NDP can be accessed via the [NDP online application form](#).

Provider agencies must:

- Maintain, at all times, at least two (2) unexpired doses of naloxone or any other FDA-approved opioid antagonist medication for the treatment of an opioid overdose on their premises.
- Have at least one (1) staff member on the premises at all times who knows the specific location of the naloxone or other FDA-approved opioid antagonist medication **and** has been trained in its administration. Training includes a review of educational resources provided by SAPC to respond effectively to an opioid-associated overdose emergency.
- Staff are required to certify that they have reviewed and undergone training in opioid overdose prevention and treatment. Document proof of completion of the training in the staff member's individual personnel file.

Naloxone should be readily available and not stored in locked cabinets or offices. Providers should develop written policies and procedures for labeled naloxone, whether prescribed or received through community distribution, to be kept on the person or at the bedside while in DHCS-licensed treatment facilities, similar to how a person may keep an inhaler on their person to treat asthma. Provider Agencies can arrange for naloxone to be prescribed and provided to each client through Medi-Cal. For example, practitioners whose scope of practice includes prescribing medication can prescribe naloxone to each client under their care and arrange for staff to routinely fill these naloxone prescriptions at a pharmacy on behalf of the members. Additionally, providers can coordinate the delivery of the naloxone from a pharmacy to the client's location.

Medical Directors and prescribing clinicians are also able to establish a Standardized Protocol that authorizes designated staff working in a DMC-ODS provider agency (using a standardized procedure and standing order specific to prescribing medications FDA-approved to reverse opioid overdose) to issue prescriptions on behalf of the Medical Directors or prescribing clinicians to a local pharmacy for medications FDA-approved to reverse opioid overdose. The pharmacy bills these prescriptions for medications FDA-approved to reverse opioid overdose through Medi-Cal. The staff may bring this dispensed medication back to the DMC-ODS provider site, or the pharmacy may arrange delivery to furnish these medications directly to clients. This method enables DMC-ODS providers to facilitate better on-site access to medications FDA-approved to reverse opioid overdose reimbursement through Medi-Cal. DMC-ODS providers may also refer clients to pharmacies that will dispense FDA-approved medications to reverse opioid overdose directly to the client.

Bystanders are often present when an overdose is occurring, and everyone can act to prevent overdose deaths. Anyone can carry naloxone and administer it to someone experiencing an overdose and potentially save that person's life. During an overdose, a person's breathing can dangerously slow down or stop, causing brain damage or death. It is important to recognize the signs and administer naloxone quickly, even before emergency workers arrive.

Clients who return to substance use should be encouraged not to use alone, carry naloxone, and let others around them know they have it in case they experience an overdose, since naloxone cannot be used on oneself during an overdose. California has a "Good Samaritan" law in place to protect those who are overdosing and anyone assisting them in an emergency from arrest, charges, or a combination of these. California's Good Samaritan law may be found at [California HSC § 1799.102](#). Additionally, [California HSC § 11376.5](#) provides limited protections from criminal arrest and prosecution for people who seek medical assistance at the scene of a suspected drug-related overdose. California's naloxone access laws may be found at [California CIV § 1714.22](#), [California BPC § 4052.01](#), and [California BPC § 4119.9](#).

Medications for Addiction Treatment

MAT, also known as addiction medication, service components include Assessment, Care Coordination, Individual Counseling, Group Counseling, Family Therapy, Medication Services, Client Education, RS, SUD Crisis Intervention, and WM services. MAT may be provided in clinical or non-clinical settings and can be delivered as a standalone service or as part of all LOCs. For a list of FDA-approved addiction medications that SAPC requires providers to offer clients, see [Table 12: Required Medications for Addiction](#).

Table 12: Required Medications for Addiction

Opioid Use Disorder (OUD)	Alcohol Use Disorder (AUD)	Tobacco Use Disorder (TUD) ¹³
Methadone <i>(oral methadone for the indication of OUD is only available via OTPs)</i>	Naltrexone Oral and long-acting injectable formulations are effective for AUD	Varenicline Oral formulation
Buprenorphine Sublingual or injectable extended-release buprenorphine formulations for the indication of OUD	Disulfiram Oral formulation	Bupropion Oral formulation
Naltrexone Long-acting injectable formulation is preferred to oral for OUD	Acamprosate Oral formulation	Nicotine Replacement Therapy Transdermal patch, transmucosal gum/lozenge, inhaler, nasal spray formulations
Medications FDA-Approved to Reverse Opioid Overdose¹⁴ Injectable or Intranasal Formulations that Reverse Opioid Overdose		

Medi-Cal covers the use of medications that can be used outside of their FDA-approved indications (off-label) to treat SUD, including off-label medications effective at treating methamphetamine, cocaine, and cannabis use disorders through the Medication Services benefit. Treatment providers should make clinically effective off-label medications that treat SUD available to clients in their care. Provider agencies should refer to the latest [SAPC IN 24-01](#) (along with corresponding attachments, specifically [Required Addiction Medications \[Attachment B\]](#)) and the [SAPC Training](#) webpage for additional information and resources on clinically effective medications that can be used outside of their FDA-labeled indications to treat SUD.

¹³ TUD cannot be a primary diagnosis for DMC-ODS services, but SAPC programs should treat TUD as a component of other DMC-ODS services as long as a non-tobacco SUD is the primary diagnosis for DMC-ODS services. Given the high co-occurrence of TUD and other SUDs, tobacco use can be a topic for client education groups, included as part of risk reduction groups and individual counseling services, and as part of a client's overall treatment for the primary SUD.

¹⁴ Medications FDA-Approved to Reverse Opioid Overdose should be prescribed to clients who received treatment within the SAPC network. Naloxone does not require a prescription to be distributed, and should be distributed to clients, their family members, and the community when it is impractical to prescribe Medications FDA-Approved to Reverse Opioid Overdose to people (such as those who are not enrolled as clients).

Addiction Medications as a Core Component of SUD Treatment

Just as medications are commonly accepted for the treatment of other chronic conditions, the evidence shows that addiction medications can help decrease alcohol- and opioid-related cravings and ease withdrawal symptoms. While interventions such as counseling are critical for recovery, the use of medications for the treatment of addiction is also important and necessary in many cases. **Addiction Medications are a best practice and a core component of SUD treatment** for individuals for whom it is clinically appropriate because it facilitates recovery and improves outcomes.

MAT Services for Youth (age 17 and under)

Research and clinical experience have not identified any age-specific safety concerns for addiction medications, and all treatment options should be considered for clients of all ages. Providers treating Youth (age 17 and under) with addiction medications should obtain parental/guardian consent when required to provide medication services. A minor 16 years of age or older may consent to OUD treatment that uses buprenorphine outside of an OTP setting, whether or not the minor also has the consent of their parent or guardian.¹⁵

MAT Services Requirements

Provider agencies are required to create and, as necessary, update active policies and procedures related to the provision of addiction medications, either directly to their clients or through linkage with other providers (e.g., FQHCs, primary care providers [PCPs]) that offer addiction medication services. SAPC encourages formal arrangements, such as a Memorandum of Understanding (MOU), between agencies to optimize referral relationships and processes. [California HSC § 11831](#), [California HSC § 11834.28](#), and [BHIN 23-054](#) require active policies and procedures for the provision of addiction medications, either directly to clients or through linkage with external agencies that offer them.

Provider agency practitioners must provide clients and any adult collateral contacts (including but not limited to adult family members) with information about addiction medications at intake, during treatment, and at discharge in accordance with the client's Plan of Care. The information provided needs to be specific to each type of addiction medication that is clinically effective for treating that client's specific SUD(s) to support informed client consent. Clients who are not actively being treated with addiction medications should continue to be offered addiction medications, as clinically appropriate, in accordance with the client's Plan of Care.

Provider agencies need to provide clients with information, using SAPC-approved materials, about addiction medications that clearly explain their benefits and the risks of not accepting them; see [Client Information About Addiction Medications \(SAPC IN 24-01, Attachment A\)](#). Provider agencies need to document specifically which addiction medication information was provided to clients, the client's response upon receiving this information, and all medication services offered to the client, including a description of the client's clinical history and prior use of addiction medications when applicable.

¹⁵ [California FAM § 6929.1](#), amended by [AB 816](#), effective January 1, 2024.

Every client admitted to a provider agency's care needs to have access to all required addiction medications, either directly or through referral to external partners. For a list of required addiction medications, see [Required Addiction Medications \(SAPC IN 24-01, Attachment B\)](#).

Direct Provision of MAT Services to Clients On-Site

Each provider agency needs to have available to its staff and keep an updated list of addiction medications available directly via practitioners providing on-site services, including when these medications are prescribed through fee-for-service (FFS) Medi-Cal and picked up at an off-site pharmacy. Each client with a documented SUD meets the criteria to receive a medical evaluation, which needs to include the client being offered all addiction medications clinically appropriate to treat the client's particular SUD(s). Each provider agency needs to ensure that initial and follow-up addiction medication service appointments are arranged in accordance with the client's individualized Plan of Care. Provider agencies that offer on-site medication services need to maintain sufficient medical LPHA staffing operating within the scope of practice of their license (licensed prescribing clinician) to meet client demand for addiction medication services, which may include employing or contracting with prescribing clinicians and arranging coordination of telehealth medication services, if applicable.

Documentation of Medication Services Provided to Clients On-Site

Medication services billed to SAPC require documentation of the eligible (non-tobacco) SUD diagnosis. The documentation must also specifically describe the medication services provided and how they relate to the treatment of each applicable SUD. Provider agencies need to offer TUD treatment, including medications appropriate for the client when TUD is present with a non-tobacco SUD. For TUD treatment services offered on-site with treatment of non-tobacco SUD(s), the applicable (non-tobacco) SUD(s) should be listed as the primary diagnosis on the claim. Other conditions treated by the licensed prescribing clinician, such as psychiatric or general medical care, can also be addressed during the same visit, provided that the eligible (non-tobacco) SUD was documented as the primary focus of the visit. Medication services associated with documentation that lacks both a mention of an eligible (non-tobacco) SUD diagnosis and a documented treatment focus on the SUD are not billable to SAPC and may be subject to disallowance.

Referral for Addiction Medication Services through External Partners

Each provider agency that does not directly offer each required addiction medication via practitioners operating on-site must coordinate care, as clinically appropriate, to ensure client access to each remaining addiction medication through one (1) or more external partners. Provider agencies need to:

- Maintain a list of referral locations that include (at minimum) the name, address, phone number, website (when available), and distance to the external partner.
- Ensure that at least one (1) external partner offers each remaining required addiction medication is identified.
- Maintain procedures for client transportation to/from these external partners.

Client Eligibility for Addiction Medication Services

Provider agencies must obtain a history of the client's substance use during intake and provide the client with information about addiction medications, as clinically appropriate, in accordance with SAPC-approved materials addressing addiction medications. For additional information, see [SAPC IN 24-01](#).

For clients who indicate a history of substance use (outlined in [SAPC IN 24-01](#)), each provider agency needs to perform a diagnostic assessment confirmed by an LPHA within the first 24 hours of the initial date of service to determine whether the client meets the current version of the DSM criteria for one or more substance-related and addictive disorders.

All clients who meet the current version of the DSM criteria for one or more substance-related and addictive disorders (outlined in [SAPC IN 24-01](#)) should be offered an evaluation by a licensed prescribing clinician within the first 48 hours of the initial date of service. The licensed prescribing clinician needs to determine which addiction medications, if any, are appropriate for the client and needs to either prescribe the addiction medication(s) directly and/or initiate a referral for addiction medication services to one (1) or more external partners as described above. The addiction medications need to be provided to the client in alignment with the provider agency's approved policies and procedures.

Administration, Storage, and Disposal of Addiction Medications

Each provider agency needs to create and keep updated a policy that describes the appropriate administration, storage, and/or disposal of each addiction medication (outlined in [SAPC IN 24-01](#)), as is aligned with the agency's LOC and in accordance with which addiction medications are available on-site and/or through referral to external partners. This policy needs to describe the medication self-administration requirements, the documentation requirements for self-administered medication, the medication storage requirements (including location, accessibility, inventory, handling, and documentation), and the medication disposal procedures (including how often medications are disposed of, the methods of destruction, and documentation). This policy needs to be aligned with the most current version of the SAPC Bulletin addressing addiction medications, see [SAPC IN 24-01](#).

Staff Training Requirements for Addiction Medications

Each provider agency must ensure that all staff who interact with clients receive SAPC-approved training (outlined in [SAPC IN 24-01](#)) on the benefits and risks of addiction medications and on the agency's addiction medication policy. This training must occur within 90 days of hire and not less frequently than annually thereafter. Provider agencies need to document their staff's training in each staff member's personnel file.

Procedures for Client Use of Addiction Medications

Each provider agency's Medical Director or their licensed prescribing clinician designee, with appropriate input from the client, determines when a current medication treatment, including treatment with controlled medications, is clinically beneficial. When the client is being treated with clinically beneficial medication(s), the provider agency needs to, at a minimum, do all of the following:

- Ensure access to the facility is not denied because a client is being treated with addiction medication(s).
- Assure the client that the full range of medically necessary treatment services are available and not contingent upon the client changing their addiction medication(s).
- Support the client's continued receipt of addiction medication(s).
- Confirm that a client will not be compelled to taper, discontinue, decrease the dosage, or abstain from addiction medications as a condition of entering or remaining in treatment.
- Assure the client that they will not be denied access to addiction medications if they do not participate in all services offered by a facility.
- Assure the client that they will not be denied access to addiction medication services if they use non-prescribed intoxicants.

Clients diagnosed with OUD need to receive information about the medications available for OUD, including through provider agencies and external partners (outlined in [SAPC IN 24-01](#)). Medications for OUD are available through both OTP and non-OTP sites of care.

Procedures for Care Coordination for OTP Services

Provider agencies without on-site OTP services need to arrange referrals within 24 hours for clients requesting addiction medication evaluations through an OTP. Medications dispensed from OTPs need to be stored in accordance with [the Administration, Storage, and Disposal of Addiction Medications \(SAPC IN 24-01, Attachment D\)](#) for applicable LOCs. Provider agency sites without on-site OTP services need to create and maintain a plan to submit requests to the treating OTP for exceptions to take-home limits when additional take-home doses are clinically appropriate, in accordance with the client's individualized Plan of Care.

Provider agencies need to coordinate the continuation of clinically beneficial OTP-dispensed addiction medications(s) at intake, throughout admission, and at discharge. This needs to include coordinating OTP services arranged prior to discharge to ensure that sufficient medication is available until the next scheduled follow-up appointment.

Procedures for Treatment with Buprenorphine

Licensed prescribing clinicians registered with the DEA may treat clients with buprenorphine at provider agency sites of care. Residential facilities with practitioners who offer on-site addiction medication services, including buprenorphine treatment, should be certified to provide IMS; see [Incidental Medical Services \(SAPC IN 24-01, Attachment G\)](#). Clients with OUD need to be informed about the scientific evidence base, effectiveness, associated risks and benefits, and clinical considerations for treatment with buprenorphine; see [Client Information About Addiction Medications \(SAPC IN 24-01, Attachment A\)](#). All clients with OUD being treated in sites without buprenorphine medication services available on-site should be offered a referral and

care coordination for addiction medication services through external partners, where treatment with buprenorphine is available. Provider agencies need to coordinate continuing clinically beneficial treatment with buprenorphine on intake, throughout the admission, and at discharge. This needs to include arranging follow-up appointments scheduled prior to discharge, with coordination of access to addiction medication services arranged to ensure that sufficient buprenorphine is available until the next scheduled follow-up appointment.

Note: Provider agencies need to provide a copy of their current addiction medication policy to their assigned SAPC CPA and the assigned DHCS licensing analyst.

Medication Services and Safeguarding Medications

Medication Services include the prescription, administration, or supervised self-administration (in residential settings) of medications related to SUD treatment services or other necessary medications that are not already reimbursed as medications dosed through an OTP. Medication Services may also include assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services and/or order laboratory testing within their scope of practice or licensure. SAPC does not cover the drug product costs for addiction medications outside of the pharmacy or OTP/NTP benefit. SAPC reimburses for addiction medication services, even when provided by DMC-ODS providers in non-clinical settings and as standalone services. These are billed under Addiction Medication Services (or MAT).

All MAT must be prescribed in accordance with generally accepted standards of medical practice and best practice guidelines for the condition being treated.

Safeguarding medications in accordance with regulations is required in residential and WM settings and may be performed by qualified staff (e.g., LVNs or Medical Assistants [MAs]).

Medication Services are available at all LOCs and are defined as in-person, telephone, or telehealth contact between clients and medical staff (e.g., physicians, NPs, or PAs) regarding the use of FDA-approved medications or other medications clinically effective in treating SUDs. Medication Services are reported in 15-minute increments, with sessions ranging from 15 to 30 minutes in length. A separate Progress Note needs to document the encounter with each client.

Note: Medication Services provided in residential settings require IMS approval from the State for the specified residential site.

SUD Crisis Intervention

For DMC-ODS, [DHCS's DMC-ODS Billing Manual \(Version 3, July 2025\)](#) defines a crisis as an “actual relapse or an unforeseen event or circumstance, which presents to the member an imminent threat of relapse.” SUD Crisis Intervention Services include direct communication and dialogue between the staff and the client. These are unscheduled sessions, and need to be available to the client as needed during the agency’s normal operating hours or according to after-hours crisis procedures.

These sessions are short-term, immediate encounters limited to alleviating and/or stabilizing the client's immediate situation, provided in the least intensive LOC medically necessary to treat the condition.

Note: Crisis Intervention sessions need to incorporate techniques such as MI and CBT.

Though the crisis definition does not include a threat to physical and/or emotional health, such as suicidal and/or homicidal ideation, practitioners should attend to these concerns immediately. These encounters should be documented as individual counseling or family therapy services, depending on who was present, as they fall outside DHCS's crisis definition under the DMC-ODS treatment standards.

A component of this service includes linkages to ensure ongoing care following the crisis. Crises that are not responsive to intervention need to be escalated to urgent care (e.g., urgent care clinic) or emergent care (e.g., medical or psychiatric ER). Crisis situations should not be confused with emergencies, which require immediate intervention, such as calling 911.

Crisis Intervention sessions are available at all LOCs and are defined as in-person contact between one (1) practitioner and one (1) client. Services may, however, involve a team of care professionals. Services are reported in 15-minute increments. A Progress Note needs to be written for each session and documented in the EHR or Sage. Crisis intervention sessions conducted via phone or telehealth must be documented as individual counseling or family therapy, as appropriate, because the State did not include telephone or telehealth as available delivery options for SUD crisis intervention services. Family Therapy is a form of psychotherapy that involves both clients and their family members and uses specific techniques and EBPs (e.g., family systems theory, structural therapy, etc.) to improve the psychosocial impact of substance use and the dynamics of a social/family unit. Sessions also need to incorporate techniques such as MI and CBT.

Family Therapy sessions are available at all LOCs and are defined as in-person, by telephone, or by telehealth contact between one (1) therapist-level LPHA, one (1) client, and their family member(s). Services are billed in 15-minute increments, with sessions ranging from 15 to 60 minutes. A Progress Note needs to be written for each session and documented in the EHR or Sage.

The frequency of Family Therapy sessions, in combination with other Treatment Services, needs to be based on medical necessity and individualized client needs rather than on a prescribed program required for all clients.

Transportation Services

Providers need to make every effort to provide transportation or arrange transportation to and from medically necessary, non-emergent treatment. The client's Medi-Cal MCP (LA Care, Health Net, or Kaiser) may cover transportation services. Transportation services may require pre-authorization from the health plan, and the client's care coordinator is responsible for arranging services in advance. The time spent coordinating transportation services is billable under Care Coordination, but not the transportation services.

In accordance with [BHIN 22-031](#) and [All Plan Letter \(APL\) 22-008](#), transportation services are available for members receiving behavioral health services as outlined at these links and below. For additional information, see [APL 22-008 FAQs](#).

There are two (2) types of transportation in the Medi-Cal program:

1. Non-medical transportation (NMT) for members who do not need medical assistance during transit.
2. Non-emergency medical transportation (NEMT) for when the member's medical and physical condition is such that transport by ordinary public or private means is medically contraindicated.

The client's Medi-Cal MCP may cover NMT and NEMT services for the following situations:

- Transportation to medical, dental, or behavioral health appointments for all Medi-Cal services (available to clients receiving OP, inpatient, or residential services).
- Transportation for transfer from general acute care hospitals or EDs to psychiatric facilities, including psychiatric hospitals, skilled nursing facilities, and mental health rehabilitation centers.
- Transportation after discharge.

Clients in need of NEMT will require the treating physician to submit an approved physician certification statement form from the client's MCP authorizing the NEMT. For additional information about Medi-Cal covered transportation services, see [DHCS's Transportation Webpage](#).

For additional information on how these services are billed, see [SAPC's Manuals, Bulletins, and Forms – Bulletins Tab webpage](#) for the most current version of the SAPC IN for the Rates Matrix.

For each Provider Agency with a DMC Perinatal Contract and site certification with SAPC, non-emergency transportation is billable under Perinatal Transportation (up to 100 miles per month, per member family unit) for OP LOCs. For additional information, see [Pregnant and/or Parenting Women Population](#) section.

Also, select costs can be added to the budget, which includes but is not limited to transporting the client to and from medical appointments, mileage for staff vehicle (a log for odometer readings before and after trip need to be properly maintained), or provider vehicle costs (e.g., gas, maintenance, depreciation). Bus and metro tokens can also be included in the budget, provided a log of total purchases and distribution to each client is maintained and available to auditors upon request. Rideshare services (e.g., taxi, Uber, Lyft) cannot be included in the budget.

Transportation costs need to be reported under the "Transportation" line item under the "Services and Supplies" category and be clearly tracked and managed. Since transportation costs are included in the day rate for residential treatment, transportation is not billable as a separate service in residential treatment. However, for Non-Emergency Transportation services to count towards the Residential weekly treatment hour standard, providers need to document how transportation contributes to client care and recovery in a Progress Note. Start and end times per trip need to be captured in the note.

Service Delivery Options

Field-Based Services

FBS is a method of delivering SUD treatment services to clients outside of DMC-certified facilities and delivered in community settings where clients live, work, learn, and receive other services. FBS aims to improve access to treatment services, enhance client motivation and engagement, and reach underserved populations.

FBS: Allowable Services

The DMC-ODS benefit allows for the provision of FBS as a method of service delivery for OP-type services as classified by ASAM. Based on the ASAM Criteria, the following service components are allowable: Screening, Assessment/Intake, Individual Counseling, Group Counseling, Care Coordination, Problem List/Treatment Planning, Discharge Planning, SUD Crisis Intervention, Client Education, Family Therapy, MAT, and PSS. Claims submissions can only include the time actively providing treatment and exclude travel time, breaks, wait time, casual conversations unrelated to the intervention and/or treatment plan, and any other activities inconsistent with the allowable service components.

All SAPC provider agencies are allowed to offer FBS without an application, except when launching an **Established FBS Location**.

FBS: Established FBS Location Application

An Established FBS Location is a community site where a provider agency serves multiple clients on a regular schedule and with an ongoing presence. A provider agency may engage, admit, and provide treatment to clients at an Established FBS Location. When a SAPC provider agency consistently offers SUD services at a community location, they are required to apply for the location to be an *Established FBS Location* by submitting a complete application package with the subject line “Field-Based Services Application” to SAPC-SOC at SAPC-SOC@ph.lacounty.gov.

For additional information, review the [FBS Application Instructions \(SAPC IN 26-01, Attachment II\)](#) and [FBS New Application Form \(SAPC IN 26-01, Attachment III\)](#).

FBS: Documentation

FBS must be documented as outlined in [SAPC IN 26-01](#). Claims may be subject to recoupment if documentation is missing, incomplete, or incorrect. A progress note must be written for each session and documented in Sage or another approved EHR. Additionally:

- Primary Sage Users must:
 - Select “Field-Based Services” for Method of Service Delivery;
 - Enter the appropriate Place of Service Code within the Location field; **and**
 - Document the location where services were provided (e.g., name of approved FBS location and/or address) within the Field-Based Service Location field.

- Secondary Sage Users must document services with a progress note in their EHR which includes the following information:
 - Notation that services were delivered via FBS;
 - Sage-PCNX Client ID/PATID;
 - Date of Service;
 - Service Type (specifies the actual allowable service that was delivered);
 - Service Duration (the total number of minutes providing direct patient care);
 - Appropriate Place of Service Code; **and**
 - Name of the FBS location and/or address where the services were delivered (e.g., Client's Home in Echo Park, Riverdale High School, etc.).

A claim for FBS requires the use of the appropriate Place of Service Code entered into the Location field of the Fast Service Detail within Sage. The Place of Service Codes must correspond to their respective locations when billing for FBS. Secondary Sage users must enter the appropriate Place of Service Code in the SV105 line; see [Companion Guide HIPAA 837P \(v2.8, June 2024\)](#). The Place of Service Code and services provided for a claim must match the progress note. Claims may only be submitted for allowable service components for FBS.

For additional information on FBS, please refer to [SAPC IN 26-01](#).

Mobile Opioid Treatment Programs

A Mobile Opioid Treatment Program (MOTP), also known as a Mobile Narcotic Treatment Program (MNTP), is a mobile component of a primary OTP operating from a motor vehicle under the primary OTP's DEA registration and DHCS license. MOTPs provide OTP treatment at DHCS-approved locations in LA County remote from the primary OTP's registered location. MOTPs are authorized by DHCS to operate under the existing OTP certification, provided that applicable Federal, State, tribal, and local requirements have been met. Pursuant to [21 CFR §1300.01](#), MOTPs operate as a coincident activity of an existing OTP and, therefore, do not need to obtain a separate DEA registration for the mobile component. A MOTP needs to operate under the license of only one (1) OTP with which it is affiliated and associated. MOTPs must obtain all necessary approvals from DHCS, DEA, and SAMHSA prior to operation. This includes DHCS's route approval and the schedule for when and where MOTP services will be delivered. MOTPs require SAPC's approval, as site additions are processed through the contract amendment process outlined in [Table 28: Contract Amendment Process](#). For additional information, see [Updating Service Provider's Contract](#) section.

As with OTPs, MOTPs provide treatment for addiction, including buprenorphine, methadone, and naltrexone. In addition to dispensing medications for OUD treatment, a MOTP may provide additional services when approved by DHCS/SAPC: collecting samples for drug testing or analysis ([9 CCR §10315](#)), dispensing take-home medications ([9 CCR, Division 4, Chapter 4, Subchapter 5 Article 4](#)), admission into treatment ([9 CCR §10270](#)), medical evaluation ([9 CCR §10270](#)), and/or counseling. MOTPs function as the same ASAM LOC as standard OTPs, and medical necessity for OTP services needs to be established, including a DSM-5 diagnosis of an SUD and an appropriate LOC designation based on an ASAM assessment. The OTP is responsible for ensuring that its MOTP clients have access to any treatment services not provided by a MOTP.

MOTP staff members transporting controlled substances in a MOTP need to retain control over all controlled substances when transferring them between the OTP and the MOTP. MOTPs may not share or transfer controlled substances from one mobile component to another mobile component while deployed away from the registered location. The MOTP may only obtain controlled substances from the OTP under which it is licensed and needs to return to the primary licensed location to restock or transfer controlled substances.

MOTP: Service Requirements

An MOTP must be on a vehicle that operates with a minimum of four (4) wheels and follows a predefined, pre-approved route. MOTPs are required to operate a minimum of five (5) days a week, and methadone needs to be available seven (7) days a week at the home OTP under which the MOTP operates. This can be fulfilled with take-home meds or courtesy dosing. A MOTP may have different hours than the home OTP site. The home OTP is responsible for ensuring that MOTP clients have access to medically necessary OTP treatment services not provided by the MOTP. The MOTP is required to have a written schedule detailing the days and hours of operation for dispensing medications. For additional information, see [BHIN 24-005](#).

Telehealth and Telephone

In accordance with [BHIN 23-018](#), if a service is provided through telehealth (synchronous audio or video) or telephone, the provider staff need to inform the client prior to initiating applicable health care services (e.g., SUD) and obtain verbal or written consent for the use of telehealth as an acceptable mode of delivering health care services. Providers are required to share additional information regarding:

- Right to in-person services;
- Voluntary consent for the use of telehealth can be withdrawn at any time without affecting their ability to access covered Medi-Cal or other SUD services in the future;
- Availability of Medi-Cal coverage for transportation services to in-person services when other available resources have been reasonably exhausted;
- Potential limitations or risks related to receiving services through telehealth compared to an in-person visit, if applicable; **and**
- Availability of translation services.

Note: Telehealth and telephone services are meant to supplement, not replace, in-person services. Providers must also offer in-person services or have a documented process to link clients to in-person care within a reasonable time if the services are unavailable from the provider.

The provider staff needs to document the provision of this information and the client's verbal or written acknowledgment that the information was received in the client's record.

Note: Consent requirements may be found in [California BPC § 2290.5\(b\)](#) and [California WIC § 14132.725\(d\)](#).

Telehealth

Telehealth is a way to deliver healthcare services remotely. Telehealth allows SUD services to be delivered between a DHCS-allowable practitioner type and a client via audio and video communication, even when they are not in the same location. Telehealth services will be available to all populations and allow eligible DMC services to be provided where physical access is a barrier for clients. The types of settings clients can receive telehealth services in include, but are not limited to, hospitals, medical offices, community clinics, and the client's home. Licensed providers and non-licensed staff may provide services via telehealth as long as the service is within their scope of practice.

Available Telehealth Services

Telehealth services are available to all individuals who meet the eligibility requirements for SUD services and consent to receive these services remotely. Each of the services offered in the following LOCs are permitted to be conducted via telehealth:

- OP services (ASAM 1.0 & 0.5 LOC)
- IOP services (ASAM 2.1)
- Ambulatory-Withdrawal Management (ASAM 1-WM & ASAM 2-WM)
- RS

Within all LOCs, the following are allowed to be provided via Telehealth:

- Care Coordination
- Determination of Medical Necessity
- Individual Counseling
- Group Counseling¹⁶
- Initial Clinical Assessment
- Medication Services (MAT)
- Positive Youth Development
- Care Planning
- Relapse Prevention
- Recovery Monitoring
- SUD Crisis Intervention

In-person appointments need to occur whenever client signatures are required. This would include signing initial consents, Treatment Plans, and Treatment Plan Updates in OTP settings. Client signatures are not required on Problem Lists documented in non-OTP settings. If the client is unable to sign, the reason needs to be clearly documented in the client's chart.

As noted in the Crisis Intervention, DHCS does not allow for SUD crisis intervention services to be delivered via telephone or telehealth and will not accept the telehealth place of service code or modifiers when claiming. Providers should follow the instructions in the Crisis Intervention section above.

¹⁶ **Group counseling sessions** may be conducted via telehealth if the provider obtains consent from all the clients and takes the necessary security precautions in compliance with [HIPAA](#) and [42 CFR Part 2](#).

Agency Requirements and Responsibilities for Telehealth

Each registered or certified SUD counselor/LPHA delivering Telehealth DMC-covered services needs to meet the requirements of [California BPC § 2290.5 \[a\]\(3\)](#), or equivalent requirements under California law. For example, SUD counselors are certified as outlined in the [CCR Title 9, Chapter 8: Certification of Alcohol and Other Drug Counselors](#).

Provider agencies that elect to provide Telehealth services are required to ensure the staff delivering these services have the necessary knowledge, skills, and training to deliver high-quality Telehealth services. Provider agencies need to establish Telehealth policies and procedures that outline how agency staff will comply with SAPC requirements to deliver telehealth services. Agencies that provide Telehealth services need to ensure proper technical specifications, system maintenance, security, confidentiality, support, and functioning of associated technologies in accordance with applicable Federal, State, and local policies and regulations.

Services provided via Telehealth are subject to the same privacy and security laws and regulations as in-person services, and providers need to ensure compliance with [HIPAA](#), the California Medical Information Act, and, if applicable, [42 CFR Part 2](#) or [California WIC § 5328](#).

Telehealth Platforms

SAPC does not impose requirements on which live video platforms may be used to provide telehealth services, provided they are [42 CFR Part 2](#)- and HIPAA-compliant (rules for telehealth technology in Parts [160](#) and [164](#)) and conform to [DHCS](#) expectations and regulations. Telehealth platforms need to meet security safeguards to ensure PHI confidentiality. Additional information about Telehealth platforms is available through the California Telehealth Resource Center (CTRC) at www.caltcr.org.

For additional claiming requirements or clarification, see [SAPC's Manuals, Bulletins, and Forms – Bulletins Tab webpage](#) for the most current version of the SAPC IN for the Rates Matrix; and see [Companion Guide HIPAA 837P \(v2.8, June 2024\)](#).

Telephone

SAPC reimburses for eligible telephone services. Telephone services need to be documented in the client's file. Eligible telephone services include:

- Screening
- Individual Counseling
- MAT
- Care Coordination
- RS

SECTION 3: CLIENT SERVICE STANDARDS: SPECIAL POPULATIONS

Special Programs Defined

Special programs are designed to support individuals who may face greater barriers to accessing or staying engaged in treatment due to current life circumstances or co-occurring medical and psychosocial conditions. These programs provide tailored approaches to care for people whose needs may not be fully met by standard treatment services. To participate in these programs, individuals must meet medical necessity criteria under DMC-ODS, and any additional eligibility requirements set by the referring entity. Providers delivering services through special programs are encouraged to use EBPs that help individuals explore how substance use may relate to their involvement with the referral source.

The SBAT allows individuals, county partners, and other referral entities (e.g., SASH, CENS) to search for contracted SUD treatment provider agencies based on special categories, including those that serve the PPW, families with children, COD, justice-involved, PEH, LGBTQ+, veteran, youth, young adult, adult, and older adult populations.

Pregnant and/or Parenting Women Population

Substance use while pregnant can result in significant maternal, fetal, and neonatal morbidity. Pregnant people who use substances often experience stigma, which may lead them to delay or avoid seeking SUD treatment and prenatal care, increasing the risk of health harms.¹⁷ Research shows that targeted interventions during pregnancy and throughout the postpartum period improve prenatal care attendance, birth outcomes, and overall healthcare costs for both parent and child. Services need to consider this population's unique needs throughout treatment and recovery.

Motivational therapies are essential to engaging and supporting individuals in their recovery journey. While many treatment approaches overlap with those used for the general population, effective services for the PPW population include elements tailored to pregnancy and parenting, such as bonding with the expected child, reproductive health planning, and care coordination for physical, mental, and material needs. The initial assessment, Problem List (non-OTP settings) or Treatment Plan (OTP settings), and reassessments of progress need to consider the varied needs related to the health and well-being of both the perinatal (pregnant or postpartum) person and fetus/infant.

Federal guidelines prioritize access to SUD treatment in this order: people who are pregnant and inject substances, people who are pregnant and use substances, people who inject substances, and then all others¹⁸ The appropriate setting and LOC for this population need to be consistent with the ASAM criteria, and consider accommodations for the physical stresses of pregnancy and the postpartum period (e.g., climbing stairs, performing chores, bed rest when medically required, postpartum recovery, etc.) and the need for safety and support during this period. Depending on clinical need, LOC determinations must be based on individualized, multidimensional ASAM assessments and may result in placement recommendations for the residential or OP setting.

¹⁷ Weber, A., Miskle, B., Lynch, A., Arndt, S., & Acion, L. (2021). Substance use in pregnancy: Identifying stigma and improving care. *Substance Abuse and Rehabilitation*, 12, 105–121. <https://doi.org/10.2147/SAR.S319180>

¹⁸ DHCS. (2025, November). Substance Use Disorder Perinatal Practice Guidelines.

<https://www.dhcs.ca.gov/services/MH/Documents/Perinatal-Practice-Guidelines-2025.pdf>.

Staff working with this population need to be trained in procedures related to prenatal care, labor and delivery, and in responding therapeutically to the range of outcomes that may occur during pregnancy. Services need to be delivered in a respectful, inclusive, and supportive environment.

The use of addiction medications during pregnancy needs to be approached with individualized care and informed discussions about potential risks and benefits. Although some risks exist, inadequate treatment also poses significant dangers. For individuals with OUD, medications such as methadone and buprenorphine are considered the standard of care. Providers need to obtain informed consent and discuss expectations, including the possibility of Neonatal Abstinence Syndrome.

Detoxification should be carefully considered due to the risk of relapse. Breast/chestfeeding while taking these medications should be evaluated on a case-by-case basis; neither methadone nor buprenorphine is a contraindication to breastfeeding.

Support needs to continue after delivery, as individuals in the postpartum period face an increased risk of returning to substance use. Postpartum services should include, but are not limited to:

- Support for parenting a newborn
- Education on breast/chestfeeding
- Integration with other children and family members
- Care Coordination for legal, physical, and mental health needs
- Access to equipment, clothing, and material support
- Coping with the physical and psychosocial changes of the postpartum period
- Reproductive health planning
- Encouragement of the continued pursuit of recovery goals

Perinatal services need to align with the most current version of [DHCS's Substance Use Disorder Perinatal Practice Guidelines \(November 2025\)](#), developed in accordance with DMC and the Substance Use Prevention, Treatment, and Substance Use Block Grant (SUBG or SUPTRS BG; *formerly known as Substance Abuse Prevention and Treatment Block Grant or SABG*) Perinatal Set-Aside from SAMHSA. The SUBG requires specified funds to be used for perinatal clients and is governed by [45 CFR § 96, Subpart L](#); DMC funds are governed by [CCR Title 22](#).

PPW: Referral Process

PPW who self-identify or are identified by a county department (e.g., DCFS) as needing SUD treatment services are referred to the appropriate LOC by the CENS, SASH, or SUD provider agency. Referrals need to direct clients to designated PPW providers to ensure they receive the full range of services available to them. Only providers approved by DHCS to deliver PPW services are eligible to bill for those benefits.

PPW: Target Populations

Per [DHCS's Substance Use Disorder Perinatal Practice Guidelines \(November 2025\)](#), individuals eligible for PPW services include:

- Pregnant women
- Women with dependent children
- Women attempting to regain custody of their children
- Postpartum women and their children
- Women with infants who have been exposed to substances

PPW: Treatment Requirements and Care Coordination

Per [DHCS's Substance Use Disorder Perinatal Practice Guidelines \(November 2025\)](#), provider agencies are required to provide or arrange for case management to ensure that PPW clients and their children have access to the following services:

- **Primary Medical Care**, including referrals for prenatal care.
Note: Childcare services need to be provided while PPW clients receive primary or prenatal care.
- **Primary Pediatric Care**, including immunization, for the children of PPW clients receiving treatment services.
- **Gender-Specific Treatment** and other therapeutic interventions which may address issues of relationships, sexual and physical abuse (including domestic violence and intimate partner violence), and parenting.
Note: Childcare services need to be provided while PPW clients receive gender-specific treatment services.
- **Therapeutic Interventions for Children** in the custody of PPW receiving SUD treatment services, which should address the child's developmental needs; sexual, physical, and psychological abuse; neglect; and other needs.
- **Care Coordination**, including arranging, coordinating, and monitoring services such as primary medical care, prenatal care, and gender-specific treatment.
- **Child Care Coordination** for children aged 0-17, including arranging, coordinating, and monitoring services such as primary pediatric care and therapeutic interventions.
- **Mother/Child Habilitative Services, including parenting skills**, education and training in child development, and coordinating ancillary services. Services related to parenting skills include providing training, counseling, modeling, skill-building, and problem-solving in specific instances of parent-child interactions.
- **Perinatal Client Education** to reduce the harmful effects of SUD on the mother and fetus, or the mother and infant.
- **Perinatal Transportation**, including providing or arranging transportation for PPW clients and their child(ren) aged 0-17. This benefit may only be used to ensure access to primary medical care, primary pediatric care, gender-specific treatment, therapeutic services for children, and any other medically necessary treatment for PPW clients.
Note: Transportation reimbursement is not available to residential providers, as this benefit is built into the residential rate.

- **Childcare** while PPW clients are receiving SUD treatment, primary medical care, prenatal care, and gender-specific services. Childcare needs to meet applicable standards of State and local law for licensed and/or licensed-exempt childcare, as defined in [CCR Title 22, Division 12, Chapter 1](#). SAPC will reimburse for the following types of childcare for children aged 0-17 years:
 - **Cooperative (Co-op) Childcare:** Licensed-exempt cooperative childcare is delivered while PPW clients receive SUD treatment services. Co-op childcare is when one (1) client, under the supervision of an experienced staff member, watches the children of her fellow group members while they participate in treatment. The client/caregiver watching the children should rotate so that each woman can participate in treatment. The staff-to-caregiver-to-child ratio is:
 - One (1) staff and one (1) client/caregiver to 12 children.
 - **Licensed-Like Childcare:** Licensed-exempt licensed-like childcare is delivered while PPW clients receive SUD treatment services. Licensed-like childcare is provided by provider agency staff and includes therapeutic and developmentally appropriate services. Staff-to-child ratios are:
 - Infants (0 to 18 months): one (1) staff to three (3) children
 - Toddlers (18 to 36 months): one (1) staff to four (4) children
 - Preschool Age (36 to 60 months [or five (5) years]): one (1) staff to eight (8) children
 - School Age (5 to 17 years): one (1) staff to 14 children

PPW: Expanded Services for Children

In accordance with [DHCS's Substance Use Disorder Perinatal Practice Guidelines \(November 2025\)](#), SAPC expanded SUD treatment services for PPW clients to include their dependent children (aged 0-17), who can receive the following support services while their mother is enrolled in treatment:

- **Residential** room and board for up to five (5) children per parent, accompanying parent in residential treatment services. Contingent on participation in residential treatment services by PPW client.
- **RBH** bed for up to five (5) children per parent, accompanying parent in RBH. Contingent on participation in RBH by PPW client. For additional information on RBH eligibility and benefits, see [Recovery Bridge Housing](#) section.
- **Child Care Coordination** (as noted above), including arranging, coordinating, and monitoring services such as primary medical care, primary pediatric care, gender-specific treatment, and therapeutic interventions for children.
- **Transportation** (as noted above) to ensure access to the following services: primary medical care, primary pediatric care, gender-specific treatment, and therapeutic services for children.
Note: Transportation reimbursement is not available to residential providers, as this benefit is built into the residential rate.

For additional information on expanded services for PPW clients, see [SAPC Bulletin 18-11](#).

DMC Perinatal Eligibility

- The LPHA determines whether SUD services are medically necessary and documents approval of the diagnosis, performed by the therapist, PA, or NP, by signing and dating the Problem List (non-OTP settings) or the Treatment Plan (OTP settings).
- Medical documentation to substantiate pregnancy and the last day of pregnancy (if applicable) needs to be in the client's record.
- PPW agencies need to complete the Women's Health History form in Sage for all clients who are pregnant or within 365 days postpartum. The form must be completed at intake and submitted within 30 calendar days of admission or reauthorization, in accordance with the guidance in the [Timeliness of Authorization Submissions](#). The Women's Health History form needs to be completed for each pregnancy and updated if the client's pregnancy ends during treatment. Required fields include the assessment date, the pregnancy start date, and the pregnancy end date (if applicable). Eligibility is based on pregnancy and ends on the last day of the month in which the 365th day of the postpartum period occurs.¹⁹

PPW: Discharge Planning

Providers should start discharge planning soon after the PPW client begins treatment services. This planning should include transition to RS, encouragement of the continued pursuit of recovery goals, and reunification planning (if applicable).

For additional information regarding services that are required to be provided to the PPW population, see [DHCS's Substance Use Disorder Perinatal Practice Guidelines \(November 2025\)](#).

Women and Children's Residential Treatment Services

WCRTS is a program and funding source that supports residential services not covered under DMC for PPW clients receiving services in these settings. Covered non-DMC costs include:

- Room and board in residential treatment; **and**
- Full cost of treatment services for women ineligible for or unenrolled in Medi-Cal who are receiving services in a PPW residential program.

In accordance with [California HSC § 11757.65](#), providers funded by and participating in the WCRTS program need to pursue four (4) primary goals and achieve four (4) outcomes for PPW in residential SUD treatment settings.

¹⁹ [22 CCR § 51303 - General Provisions](#); [22 CCR § 5026 - Answer to Petition](#).

The **four (4) primary goals** of the WCRTS Program include:

- Demonstrate that alcohol and other drug (AOD) treatment services delivered in a residential setting and coupled with primary health, mental health, and social services for women and children can improve overall treatment outcomes for women, children, and the family unit.
- Demonstrate the effectiveness of 6- or 12-month stays in a comprehensive residential treatment program.
- Develop effective, comprehensive service delivery models for women and their children that can be replicated in similar communities.
- Provide services to promote safe and healthy pregnancies and perinatal outcomes.

The **four (4) outcomes** intended to be achieved through the WCRTS program include:

- Preserving family unity
- Promoting healthy pregnancies
- Enabling children to thrive
- Reducing or eliminating the distress caused by the symptoms of SUD for women and their families

Additional Perinatal Services

In addition to providing the expected services, provider agencies providing PPW services need to incorporate the following into PPW treatment services:

- Activities to promote bonding with the expected child.
- Care Coordination to address the material and physical/mental health needs that come with pregnancy.
- Support for newborn parenting, education about breast/chestfeeding, and integration with other children and family members.
- Care Coordination for practical needs such as legal assistance, equipment, and clothing; coping with the physical and psychosocial changes of the postpartum period; family planning and encouragement of the continued pursuit of recovery goals.
- Reproductive health counseling services to provide referrals and support individuals to make informed choices around HIV/STI testing, pregnancy prevention, family planning, sexual health, pregnancy support, pregnancy options counseling, postpartum care, etc.
- Outreach activities to engage pregnant and parenting people in need of services and encourage them to access treatment.
- Activities to promote awareness among women who inject drugs about the relationship between injection drug use and communicable diseases, such as HIV, Hepatitis B, Hepatitis C, and TB, and offer referrals to appropriate service providers for appropriate screenings.

Perinatal programs need to notify SAPC and DHCS within seven (7) days once their program reaches 90% capacity. Providers need to submit this notification by sending a notice to SAPCMonitoring@ph.lacounty.gov and DHCSperinatal@dhcs.ca.gov. In accordance with DHCS's Substance Use Disorder Perinatal Practice Guidelines (November 2025), providers must report this information in the DATAR system each month by the 10th of the following month.

Sexual and Reproductive Health Services

DHS SRH Education Classes

SAPC partners with DHS to implement sexual and reproductive health (SRH) education classes at participating PPW provider sites. DHS Health Educators provide classes in English and Spanish on a range of SRH topics, including STIs and HIV prevention, contraception, healthy pregnancy, and women's health throughout the life course. DHS Health Educators also offer referrals to health clinics/hospitals to address clients' SRH needs, including DHS MAMA's Neighborhood, which provides prenatal, postpartum, and other comprehensive healthcare services for pregnant people. The goal of this SAPC's collaboration with DHS is to better identify and support the SRH needs of clients receiving treatment at PPW provider sites, improve access to reproductive healthcare through direct linkages, expand clients' SRH knowledge, improve pregnancy and birth outcomes, manage chronic diseases and STIs, and improve recovery management and outcomes.

CENS and DHS MAMA's Neighborhood Project

The CENS and DHS MAMA's Neighborhood Project utilizes dedicated CENS counselors to identify pregnant and parenting individuals, conduct screenings, and provide referrals to treatment, pregnancy-related services, and other reproductive health services. With the pregnant or parenting person's consent, CENS counselors screen and offer referrals to SUD treatment based on the person's location, needed services, and LOC. CENS counselors are also trained to refer pregnant individuals to DHS MAMA's Neighborhood and/or other healthcare providers for prenatal care, pregnancy options counseling, or other pregnancy-related services. DHS MAMA's Neighborhood hospital and clinic staff who encounter pregnant or postpartum patients who disclose substance use are trained to refer to CENS counselors for screening and referral to SUD services.

SRH Specialist Project

The purpose of the SRH Specialist Project is to integrate SRH services for clients in SUD treatment settings to improve their individual and family health outcomes. SRH Specialists have specialized training to address the SRH needs of any client of reproductive age in treatment at a participating PPW site, whether pregnant, postpartum, parenting, or otherwise. They support clients in their decisions about when, or if, they would like to have children and otherwise integrate clients' SRH care needs into their SUD treatment goals. For PPW agencies interested in participating in the SRH Specialist Project, email SAPC-SOC at SAPC-SOC@ph.lacounty.gov.

SRH Specialists work to ensure SRH programming is developed and available to clients in treatment at PPW programs by implementing four (4) main categories of services:

- Outreach and Engagement
- SRH Education Services
- Client Screening, Appointment Scheduling, Reminders, and Follow-Up
- Service Navigation, Referral, and Linkages

Note: SRH Specialists are required to complete the *Pregnancy/Parenthood, Attitudes, Timing, and How Important (PATH)* training and use the *Reproductive Health* form in *Sage* to screen PPW clients at their sites.

Pregnancy/Parenthood, Attitudes, Timing, and How Important Training

The PATH training is a pregnancy intentionality training that offers PPW treatment providers guidance on conducting conversations about clients' reproductive health. This specialized training focuses on using standardized, client-centered questions about reproductive goals (appropriate for clients across all demographics) and on reviewing the Reproductive Health form as a tool for documenting SRH conversations. SAPC requires all SRH Specialists to complete the PATH training and encourages all PPW sites to have at least one (1) staff member trained.

Reproductive Health Form

SRH Specialists and other PPW treatment provider staff who have completed the PATH training will use the standardized RH form to screen clients for reproductive health needs and identify and refer to appropriate services. The Reproductive Health form should be offered within the first 30 days of treatment, and a rescreening should be completed whenever new SRH needs occur. SRH Specialists and other PATH-trained PPW provider staff will:

- Access the Reproductive Health form in Sage to screen clients during intake or later in treatment to identify any reproductive health needs the individual may have based on their reproductive preferences.
- Follow the prompts on the Reproductive Health form to connect the individual with the most appropriate service. This could include their primary care provider, local clinic, or the nearest DHS clinic or hospital.

For individuals who are currently pregnant, planning to become pregnant, seeking to prevent pregnancy, or working toward preferred birth spacing, providers need to support appointment scheduling and make referrals for relevant services based on the individual's reproductive goals. These may include contraception, pre- or inter-conception care, prenatal and postpartum care, pregnancy options counseling, and related services. SRH Specialists are required to complete the Reproductive Health form for all PPW clients they serve. Other PPW provider staff members who wish to complete the Reproductive Health form must first attend the PATH training.

Family Programs

DPSS - CalWORKs

CalWORKs: Referral Process

CalWORKs Welfare to Work (WtW) clients are screened for SUDs by their Greater Avenues for Independence (GAIN) Services Worker (GSW) during their GAIN Orientation and Appraisal. Clients who screen positive or self-identify a need for services will be referred for a clinical assessment in one (1) of two (2) ways:

- Referral to the CENS Area Office nearest to the individual, where the CENS will:
 - Schedule the screening appointment within three (3) business days after receiving the [GN 6006A, CalWORKs Clinical Assessment Provider Referral](#);
 - Screen the individual using the ASAM CO-Triage® Tool for Adults (age 21 and over);
 - Secure an intake appointment with an SUD provider agency selected from the SBAT within three (3) business days of screening; **and**

- Forward a copy of the [GN 6006A](#) to the selected treatment provider agency.
- Referral directly to a contracted provider agency. Clients can present directly at a provider agency of their choosing (based on location or other preferences).

Provider agencies may also admit existing clients who identify as having CalWORKs without a formal GSW referral. This is called a “Reverse Referral.” When this occurs, the provider agency needs to initiate notice to DPSS via the [CalWORKs Treatment/Services Verification \(PA 1923\)](#) form, which states that the client is in treatment and requests that their case be expedited to GAIN. The [PA 1923](#) needs to be faxed (818-671-4093) or emailed via encrypted email to DPSS’s Centralized Unit (DPSS-CU) for processing within 10 business days of completion of the [PA 1923](#).

CalWORKs: Intake

Once the provider agency receives the referral, either directly from the GSW or the CENS, they are to:

- Schedule the clinical assessment appointment within three (3) business days of receiving either the [GN 6006A](#) or [GN 6006B, CalWORKs Specialized Supportive Services Provider Referral](#);
- Conduct the full ASAM CONTINUUM™ Assessment or [Assessment Tool - Youth \(Paper Version\)](#);
- Complete page two (2), section B, of the [GN 6006B](#); and
- Submit the [GN 6006B](#) to the GSW within five (5) business days of clinical assessment to report the date services began (or failure to appear for services), expected duration of hours per week, and, if less than 32-35 hours per week, whether the number of hours is considered full-time by the provider agency.

If the provider agency receives a [GN 6006A](#) from CENS, it should be filed in the client’s records, as CENS has already sent a copy to the DPSS GSW.

Note: Clients should be admitted to treatment based on the appropriate LOC and their preferences. If a transfer to another provider agency is necessary, a copy of the [GN 6006B](#) must be sent via fax or encrypted email to the GSW to notify them of the new treatment location. A copy must also be sent to the new treatment provider agency.

CalWORKs: Status Reports

Contracted SUD provider agencies are required to communicate the status of the client’s progress and treatment/services to DPSS using the appropriate forms and in the manner noted below:

- Complete [GN 6008, Service Provider Progress Report](#), every 90 days, or as required, to indicate whether the client is complying with program requirements and maintaining satisfactory progress, has successfully completed treatment, or has dropped out of treatment.
- Complete [CW 61, Authorization to Release Medical Information](#). This form is used to evaluate a client’s ability to participate in a work/training program. The clinician completing the form will determine how long the person should be exempt from work requirements. At the end of that timeframe, the GSW will contact the client to determine whether they can participate in a work-related activity.
- Complete [GN 6007B, Enrollment Termination Notice](#), within three (3) business days of termination to report if the client has successfully completed treatment services or treatment services were terminated, and the reason for termination.

- Complete [GN 6007A, Notification of Change from Specialized Supportive Services Provider](#), within five (5) business days of a service change and include changes in LOC, start date, treatment hours, and other service information.
- Provider agencies need to retain copies of all documentation and communications with DPSS in the client's chart, including: completed DPSS forms, confirmation of faxing, and any letters/correspondence to and from DPSS regarding the client. This includes any written notice of eligibility/acceptance by the Centralized PA 1923 unit for reverse referrals. Provider agencies need to obtain and keep on file a Provider Notification Letter for clients entering treatment through the reverse referral process.

CalWORKs: Asian Pacific Islander Targeted Outreach Program

The purpose of targeted outreach to the Asian Pacific Islander (API) population is to provide SUD information and education for CalWORKs clients in API communities who may have an SUD and/or co-occurring mental health issue. The outreach seeks to identify individuals with SUD needs and connect them with culturally and linguistically appropriate staff and treatment services. The program serves CalWORKs clients in API communities across LA County, including those who are experiencing homelessness.

The program also provides intensive, family-centered pre-treatment outreach, education, and supportive services to affected API families in LA County. This is both to encourage clients with SUDs and family members to enter treatment and to ensure that a supportive family network is in place to support those individuals who choose to enter treatment.

The duties of the API Outreach Worker include, but are not limited to:

- Assist clients in self-exploration of the consequences of SUDs.
- Educate on how self-help (i.e., Alcoholics Anonymous, Al-Anon, and Narcotics Anonymous) complements SUD treatment and the unique role of each in the recovery process.
- Connect clients with culturally and linguistically appropriate treatment agencies.

CalWORKs: Adult At-Risk Program for Prevention and Early Intervention

The CalWORKs Adult-at-Risk Program is designed to provide individuals receiving CalWORKs benefits with an opportunity to learn about SUD through interactive educational sessions. This initiative provides educational courses about the effects of substances and their impact on an individual's life. These courses are designed for individuals whose screening results indicate they might be at risk of developing an SUD based on reports of experimental or early-phase substance use. The sessions are designed to provide SUD prevention education and support adults in maintaining a healthy, SUD-free lifestyle.

Adult-At-Risk: Target Population

The target population is any CalWORKs client whom DPSS's GSW has referred to the CENS due to suspected substance use and:

- Whose ASAM CO-Triage results do not meet the criteria for SUD treatment services,
- Who engage in SUD high-risk behaviors or do not meet medical necessity for SUD treatment but may benefit from an intervention based on high-risk behaviors.

Adult-At-Risk: Referral Process

DPSS refers the CalWORKs recipient deemed at-risk for SUD to the CENS Area Office for screening. The designated CalWORKs CENS counselor screens using the ASAM CO-Triage® Tool for Adults (age 21 and over). If the screening result indicates the client does not meet the criteria for SUD treatment services but may benefit from an intervention based on high-risk behaviors, CENS offers a referral to the Adult-At-Risk Program.

Participation in the program is voluntary. The dedicated CalWORKs CENS counselor provides a referral and arranges an appointment for enrollment and services with the CENS At-Risk counselor. The client enrolls and completes the program, or may decline to enroll. If the client consents, the CalWORKs At-Risk counselor informs the DPSS worker via email.

CalWORKs: LACOE GAIN Focus 360

A partnership between DPSS and the Los Angeles County Office of Education (LACOE), GAIN Focus 360 (formerly known as Job Club) is an employment preparation program for CalWORKs GAIN clients. Services include job readiness and career planning as well as assisting clients in overcoming employment barriers, such as SUD and mental health, through goal setting, building self-esteem, and providing job search activities and job fair opportunities that enable clients to obtain gainful employment.

CENS Area Office – CalWORKs Dedicated CENS Responsibilities

The CENS Area Office has dedicated CENS counselors who schedule and deliver SUD 101 presentations using the specified PowerPoint presentation created by SAPC. The presentation schedule is sent to the CENS Area Office on a quarterly basis. Upon receipt:

- CENS staff/managers complete and return the schedule to their SAPC liaison within five (5) business days.
- SAPC liaison forwards the completed schedule back to LACOE and DPSS.
- CENS counselors conduct presentations at the scheduled time they selected and document the number of CalWORKs recipients who participated.

DCFS Programs

Substance Use Disorder Trauma-Informed Parent Support

The Substance Use Disorder Trauma-Informed Parent Support (SUD-TIPS) program provides access to SUD screening and referrals to treatment for parents/guardians with open DCFS referrals and cases. Designated CENS counselors work with the DCFS Regional Offices aligned to their SPA to receive SUD-TIPS referrals. DCFS social workers may send referrals via encrypted email, and/or parents/guardians with DCFS involvement may self-refer by walking into the CENS Area Office.

The designated SUD-TIPS CENS counselors apply MI techniques to provide:

- Outreach to, and engagement with, the target population
- On-site or virtual evidence-based SUD screenings for parents with substance use challenges using the ASAM CO-Triage® Tool for Adults (age 21 and over)

- Medi-Cal eligibility assessment and enrollment
- Referral to SUD treatment services
- Client education
- Referrals to early intervention SUD or mental health services, as appropriate
- Linkages and warm hand-off to the appropriate community SUD treatment resources

SUD-TIPS: Referral Process

Any DCFS staff member may refer a parent/guardian with an open DCFS case to the SUD-TIPS program. Steps in the referral process are as follows:

- DCFS staff members complete sections A and B of the SUD-TIPS referral form and send it via encrypted email to their aligned CENS Area Office.
- Upon receipt, CENS staff will contact the DCFS Children's Social Worker (CSW) for any missing information or questions regarding contacting the parent.
- The CENS staff will contact the parent to schedule the screening appointment within 48 hours of receipt of the referral.
- If the parent does not show up for the screening appointment, the CENS staff will attempt to contact the parent to reschedule a total of three (3) attempts. After two (2) attempts, the CENS staff will update the DCFS staff by email or phone.
- If the parent declines to be screened, does not show up for a scheduled screening appointment, or is not reached for an appointment after a third attempt, the CENS staff will note the Screening as either "not completed," "no show," "declined," or "unable to reach" by completing Section D of the SUD-TIPS referral form. CENS will then forward the referral form via encrypted email to the referring DCFS staff.
- If the parent completes the screening, CENS staff will refer screened clients to the appropriate SAPC DMC contracted treatment providers based on the client's proximity, type, and level of service(s) needed.
- CENS staff will request the client's consent to release information to share their care planning and progress information with DCFS, the treatment provider agency, and the CENS provider agency. Such releases must comply with all confidentiality laws, including [42 CFR Part 2](#) and [HIPAA](#).
- By the 10th of each month, CENS staff will submit copies of the prior month's referral forms by sending an encrypted email to SAPC-SOC's Youth and Family Services Section at SAPC_FamilyServices@ph.lacounty.gov.

Recovery Support Court

RSC: Referral Process

Parents who are 18 years of age or older and have active cases with both DCFS and the Juvenile Dependency Court may qualify for treatment services through the RSC program (formerly known as Family Dependency Drug Court [FDDC]). While the program is designed to support family reunification, participation is voluntary. Parents who enroll receive court supervision throughout the course of their treatment. Candidates for the RSC program are identified by the nearest DCFS office, dependency attorneys for parents and children, County Counsel, or judicial officers. Referrals to the program must be initiated by the assigned DCFS CSW; treatment providers do not initiate them.

Once eligibility is confirmed by DCFS, the following steps are taken:

- DCFS CSW or Program Manager contacts the contracted SUD provider agency nearest to the parent to complete the initial screening/assessment and schedule an intake appointment.
- DCFS CSW completes section A of the [RSC referral form](#) and sends it via encrypted email to the contracted SUD provider agency.
- The SUD provider agency will schedule an ASAM assessment appointment within three (3) business days of receipt of the RSC referral form.
- The provider agency will make its best efforts to complete the ASAM CONTINUUM™ Assessment within five (5) business days of appointment.
- With the client's signed consent, the provider agency will notify the DCFS CSW by completing sections B and C of the RSC referral form and returning it via encrypted email to the DCFS CSW within five (5) business days of the intake appointment.
- The provider agency will notify the DCFS CSW of any appointments a parent misses within 48 hours of the missed appointment date.
- The provider agency will follow up with DCFS clients who fail to keep their initial assessment appointment and reschedule a missed appointment once.

RSC: Treatment Requirements

Treatment services are provided based on medical necessity and may include a combination of various modalities as specified in the [Early Intervention and Treatment Service Components](#) section.

Provider agencies are advised that family counseling sessions should be an integral part of the care planning and services for these clients.

RSC: Client Progress Reports

Contracted RSC provider agencies serving RSC clients are required to:

- Submit an initial [Client Progress Report](#) via encrypted email to the DCFS CSW within five (5) business days of the treatment admission.
- Submit a [Client Progress Report](#) via encrypted email to the DCFS CSW five (5) business days prior to each of the client's scheduled court appearances. Client Progress Reports must reflect client progress since the last Court hearing and pertain only to SUD treatment services.

Note: Recommendations and/or comments on visitation rights are not permitted.

RSC: Treatment Completion/Reunification/Discharge

- Contracted provider agencies need to work closely with the DCFS CSW on family reunifications. Discharge planning should begin shortly after the client enters treatment and should focus on aftercare preparation.
- Within five (5) working days of program completion, the provider agency must submit a complete client progress report via encrypted email and notify DCFS of the client's discharge.

- When clients are terminated from treatment due to non-compliance or leave AMA, the provider agency needs to submit a client progress report or termination report to the CSW via encrypted email within five (5) business days of program termination.
- Graduation celebrations are conducted to acknowledge the completion of the RSC program and may take place at a date designated by the provider agency and/or Court. Graduation from treatment marks the end of the SUD treatment episode.

Co-Occurring Disorder Population

In this document, CODs are defined as when an individual has a combination of any SUD and any mental health condition, though individuals with COD can have physical health conditions as well. The significant co-morbidity of SUDs and mental illness (typically reported as 40-80%, depending on study characteristics and population) and the growing body of research associating poorer outcomes with a lack of targeted treatment efforts have highlighted the importance of addressing the unique needs of this population.

Integrated treatment coordinates substance use and mental health interventions to treat the whole person more effectively. As such, integrated care broadly refers to ensuring that COD treatment interventions are combined within a primary treatment relationship or service setting.

According to SAMHSA's Treatment Improvement Protocol (TIP) series titled "[TIP 42: Substance Use Treatment for Persons With Co-Occurring Disorders](#)," consensus panel members recommend the following guiding principles in the treatment of clients with CODs:

- **Employ a recovery approach:** The recovery perspective essentially acknowledges that recovery is a long-term process of internal change that requires continuity of care over time and recognizes that these internal changes proceed through various stages and that treatment approaches need to be specific to the goals and challenges of each stage of the COD recovery process.
- **Adopt a multi-problem viewpoint:** Treatment comprehensively addresses the immediate and long-term needs of the multidimensional problems typically presented by clients with COD (e.g., housing, work, health care, supportive network).
- **Develop a phased approach to treatment:** Treatment phases generally include engagement, stabilization, treatment, and continuing care, which align with and parallel the various stages of recovery. Treatment through these phases enables providers to develop and implement effective, stage-appropriate interventions.
- **Address specific real-life problems early in treatment:** Given that CODs often arise in the context of social and personal problems, addressing such problems is often an important first step toward achieving client engagement in continuing treatment.
- **Plan for the client's cognitive and functional impairments:** Clients with a COD often display cognitive and functional impairments that affect their ability to comprehend information or complete tasks. As a result, services need to be tailored to and compatible with the needs and functional level of COD clients.
- **Use support systems to maintain and extend treatment effectiveness:** Given that many clients with COD have strained support systems and the central importance of supportive people and environments in the recovery process, ensuring that clients are aware of available support systems and motivated to use them effectively is a vital element of effective treatment of the COD population.

Optimal Treatment of COD Population

Research generally supports addressing through integrated care, rather than treating SUDs and mental health conditions separately. When staff are trained and skilled in managing CODs, integrated care should be provided in-house. If a provider cannot offer the necessary services, clients with CODs should be referred to appropriate external providers who can deliver the required care.

Developing a therapeutic alliance with clients who have CODs relies heavily on the counselor or clinician's comfort level in working with this population. Some SUD counselors or mental health clinicians might find clients with significant mental health conditions or SUDs intimidating. It's crucial for professionals to recognize these feelings and employ strategies to prevent them from impacting client care. Often, these challenges can be addressed through further experience, training, supervision, and consultation.

While SUD counselors are not expected to diagnose mental health disorders, they should be familiar with relevant terminology and criteria to identify potential mental health concerns that may require referral. Training that enhances understanding of mental health disorders and guidance on accessing appropriate medical or mental health support are essential.

Importantly, agencies should not be screening out clients with COD based on a mental health diagnosis or prior psychiatric hospitalization history. Simply because a client has a prior diagnosis of schizophrenia or bipolar disorder does not mean they are inappropriate for the SUD system, as people can be stable and have a mental health diagnosis or may have also been incorrectly diagnosed previously as a result of symptoms resulting from their SUD. Similarly, a prior psychiatric hospitalization history indicates prior acute psychiatric needs but does not necessarily mean that someone has acute psychiatric needs presently. The key determination for appropriateness of admission to SUD treatment for COD populations should be if an individual is psychiatrically stable enough to benefit from SUD treatment in his/her present state and not be based on a prior history of specific diagnoses or prior psychiatric hospitalization history.

Appropriate staffing is another key element in effectively addressing the needs of the COD population. An organizational commitment to professional development, skills acquisition, values clarification, and competency attainment is necessary to successfully implement integrated care programs and maintain a motivated and effective staff. Ideally, enhanced staffing for clients with a COD at SUD treatment sites would include mental health professionals, and vice versa at mental health treatment sites. Alternatively, establishing appropriate referral relationships, processes, and protocols can help ensure comprehensive and necessary care for individuals with a COD.

Psychosocial interventions that have been demonstrated to be effective for the COD population include motivational enhancement, CM, relapse prevention, and cognitive-behavioral techniques. These strategies need to be tailored to the client's unique stage of recovery and can be helpful even for clients whose mental disorder is severe. For clients with functional and cognitive deficits in areas such as understanding instructions, repetition, and skill-building strategies can aid progress. Additionally, 12-Step and other dual-recovery mutual self-help groups may be valuable in supporting individuals with COD, and counselors and clinicians often play an important role in facilitating participation in such groups.

The use of appropriate psychotropic medications and addiction medications is an essential component of the treatment of individuals with CODs. Oftentimes, the appropriate use of medications can help clients with a COD stabilize and control their symptoms so that they can better focus on their recovery for either their SUD or mental health condition. Research has clearly demonstrated that medications used in conjunction with psychosocial interventions for both SUDs and mental illness are preferable and lead to better outcomes than either intervention alone. An important component of the treatment of clients with CODs is thus ensuring a recovery environment that is supportive of the various and individualized paths to recovery that many clients with CODs take. This includes ensuring that staff are prepared to facilitate the client's treatment with medications for SUDs and mental health conditions when necessary and appropriate by counselors and clinicians practicing within their scope of practice.

In summary, treating clients with COD requires a comprehensive and flexible approach and coordination with other systems of care.

Justice-Involved Population

SUD often results in direct or indirect interactions with law enforcement and the criminal justice system. As a result, most people in carceral settings have an active SUD and are at risk of negative outcomes such as overdose and recidivism. SUD treatment can help break this cycle by supporting alternatives to incarceration, a safer pathway to community reentry, and ultimately by treating the SUD and its root causes.

Optimal Treatment of the Justice-Involved Population

Effective clinical strategies for working with justice-involved clients should include interventions that address criminal thinking and develop basic problem-solving skills. Providers need to utilize EBPs tailored to managing SUDs, mental health issues, and criminogenic needs. For example, approaches like MI and CBT target both substance use and antisocial behaviors that contribute to criminal recidivism. Additionally, trauma-informed care and CM therapies play a crucial role.

As with other populations, the treatment of justice-involved clients should be viewed as a dynamic, longitudinal process aligned with the chronic disease model of addiction. Consequently, effective treatment should persist even after the legal issues of justice-involved clients are resolved.

Adult Justice-Involved Population

While justice-involved clients may have similar clinical needs to other clients in SUD treatment, they often require that treatment providers communicate with justice partners, such as court and probation professionals, to support the client's legal obligations and keep them in the community and recovery.

Adult justice-involved programming involves the following:

- Court-Based Diversion Programs,
- Jail-Release/Community-Reentry Programs, **and**
- Community-Supervision Programs through probation or parole.

A qualified counselor or clinician should determine the appropriate LOC and interventions and should not be determined by justice partners. SUD treatment must be individualized and based on medical necessity. For clients who are incarcerated, SUD screening should be based on the client's substance use status 30 days prior to incarceration.

Justice System Entryway Programs

Court-Based Diversion Programs

Courts have an important opportunity to recognize alleged criminal activity stemming from underlying problems, such as SUD, and to offer treatment as an alternative to incarceration or further legal action. Court-based diversion is often the earliest opportunity to refer justice-impacted clients to treatment and can prevent the consequences of being charged or extended jail time. Court-based diversion is often conditional on the client being enrolled in and engaged in treatment, and judges expect regular updates to ensure they are aware that the client is continuing to receive care. For this reason, timely communication with court partners is critical to support clients in continuing treatment and avoiding legal consequences. Expected communication includes the following:

- Being responsive to requests for progress reports, **and**
- Notifying court partners if the client leaves AMA or is at risk of administrative discharge.

Jail-Release/Community-Reentry Programs

People re-entering the community after incarceration have significant physical and behavioral health needs and are at high risk of injury and death, especially immediately after release.^{20 21 22} California has developed local and statewide initiatives for justice-involved individuals with behavioral health issues to support their transition from custody to the community and promote health outcomes. These steps include mandating the Medi-Cal application process while in custody and, under [AB 133](#) in 2021, implementing a process requiring CF to facilitate referrals to counties' DMC, DMC-ODC, SMHS, and/or Medi-Cal MCPs for incarcerated members who received behavioral health services and want to continue treatment upon release to the community.

As of October 1, 2024, under the CalAIM Justice-Involved Initiative, DHCS required SAPC and all California county behavioral health agencies to launch a behavioral health link process to accommodate the post-release requests from CFs. These post-release linkages include referrals and appointments to SUD and/or mental health services to ensure continuity of behavioral health or other health services received while in custody. For additional information on SAPC's CalAIM post-release linkage process, see [SAPC IN 25-05](#).

²⁰ Binswanger, I. A., Stern, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., & Koepsell, T. D. (2007). Release from prison: A high risk of death for former inmates. *New England Journal of Medicine*, 356(2), 157-165. doi:10.1056/NEJMsa064115.

²¹ Ranapurwala, S. I., Figgatt, M. C., Remch, M., Brown, C., Brinkley-Rubinstein, L., Rosen, D. L., Cox, M. E., & Proescholdbell, S. K. (2022). Opioid overdose deaths among formerly incarcerated persons and the general population: North Carolina, 2000-2018. *American Journal of Public Health* 112(2) 300-303. doi:10.2105/AJPH.2021.306621.

²² Hartung, D. M., McCracken, C. M., Nguyen, T., Kempany, K., & Waddell, E. K. (2023). Fatal and non-fatal opioid overdose risk following release from prison: A retrospective cohort study using linked administrative data. *Journal of Substance Use and Addiction Treatment* 10;147:208971. doi:10.1016/j.josat.2023.208971.

Community-Supervision Programs – Probation & Parole

Justice-involved individuals on community-supervision (i.e., clients on probation and parole) remain in the community, allowing them to maintain their relationships and employment instead of being incarcerated. However, people under community supervision need to satisfy any number of conditions, including SUD treatment, to maintain good standing and avoid legal consequences and possible incarceration. **For this reason, timely communication with LAC-Probation partners is critical to supporting clients remaining in the community and to avoiding legal consequences.** Expected communication includes the following:

- Being responsive to requests for progress reports,
- Notifying LAC-Probation partners if the client leaves AMA or is at risk of administrative discharge, **and**
- Discharge date and final report.

The community supervision model in California today is the result of several pieces of legislation enacted over the past two (2) decades. In 2000, Proposition 36 (now known as [California PEN § 1210](#)) mandated that certain non-violent drug offenders be sentenced to probation and receive SUD treatment rather than be incarcerated. In 2011, [AB 109](#) redirected certain Non-violent, Non-serious, and Non-sexual (N3) offenses away from state prisons and towards county jails or community supervision. In 2014, Proposition 47 further reclassified certain non-violent offenses from felonies to misdemeanors. In 2016, Proposition 57 created new parole considerations for non-violent offenses. In 2024, Proposition 36 (not to be confused with the 2000 proposition) repealed some of Proposition 47's reduced sentencing measures and classified certain drug offenses as "treatment-mandated felonies." Taken all together, many offenders who would previously be incarcerated now serve their sentence in the community and often in partnership with SUD treatment providers. **Importantly, clients of PEN 1210, Proposition 36 (2024), Proposition 47, and Proposition 57 can receive SUD treatment services funded by AB 109.** SUD treatment providers should identify "AB 109" as a secondary guarantor in Sage to cover expenses not covered by Medi-Cal.

Communication with Justice Partners

Justice-involved clients – whether referred from LA Superior Courts, LAC-Probation, or other justice partners – rely on treatment providers communicating with justice partners when necessary to stay in good standing and remain in treatment. While the specifics of what needs to be communicated and when it needs to be shared can vary, there are general expectations that treatment providers should keep in mind.

- **Initial Confirmation of Treatment:** Some partners may request simple confirmation that the client was successfully admitted and is currently in treatment.
- **Progress Reports:** For clients receiving treatment as part of a court-diversion or community-supervision based program, regular progress reports inform justice partners that the client is engaged in treatment as expected. Partners who require this information will typically reach out around every 30 days. However, this may vary depending on scheduled court dates, etc.
- **Discharge/Exiting Treatment:** For clients who are receiving treatment as part of a court-diversion or community-supervision based program, justice partners should be notified when the client exits treatment, whether it be a self-discharge, administrative discharge, or planned discharge. This allows justice partners to help plan and work to bring the client into compliance with their program and, ideally, avoid unnecessary legal consequences.

For additional information regarding care coordination activities for the justice-involved individuals, see the [Overview of Care Coordination and Services](#) and [Justice-Involved](#) sections.

Specialty Programs

Substance Treatment and Re-Entry Transition – Community

LASD utilizes Alternatives to Custody (ATC) to allow inmates to serve the remainder of their jail sentence in the community at a residential facility. All individuals need to receive clearance from the LASD Community-Based ATC Division for electronic monitoring in a therapeutic SUD residential treatment community in lieu of incarceration. ATC provides individuals with a foundation for successful reentry post-incarceration, and under DMC-ODS, they will have access to additional services to support successful reintegration.

Clients participating in the Substance Treatment and Re-Entry Transition – Community (START-Community) program will remain under the supervision of LASD while wearing a Global Positioning System (GPS) ankle monitor for the duration of their 90-day residential treatment episode. Although clients must initially meet medical necessity to participate in the program, they may remain in residential treatment for days 61-90 even if medical necessity is not met to prevent their return to custody. For additional information regarding residential length of stay for justice-involved adults, see [Table 16: Residential Authorization and Reauthorization Service Limits](#).

Clients identified as START-Community by LASD or CENS may be authorized for up to 90 calendar days of residential SUD treatment (ASAM LOC 3.1-3.5) if documentation is included with the member's authorization request to SAPC-UM.

Provider agencies are expected to collaborate with the justice system to transition clients to more appropriate LOCs (e.g., residential to OP with RBH) when an agreement can be met without jail time. Upon completion of their sentence, other treatment services are available to the client on a voluntary basis if the client meets medical necessity.

Target Population

Eligibility for the START-Community program is limited to those N3 individuals referred through LASD who meet the following general criteria:

- History of drug and/or alcohol usage and/or drug-related charges for eligibility
- N3 classification
- No past violent, sexual, or arson charges
- Age 18 or older
- No medical or psychiatric conditions that require medications prior to release
- Have a maximum of 90 days left on their sentence and no pending court dates. Individuals who have more than 90 days may be considered for admission on a case-by-case basis, as determined by SAPC.

Screening and Referral Process

Eligible in-custody clients are identified and assessed by LASD using the Correctional Client Management Profiling for Alternative Sanctions. Then, the overall criminal history and other determinants are reviewed to

make an appropriate recommendation for placement in the START-Community program. LASD will provide a referral list of potential in-custody clients to the designated CENS staff. CENS staff will coordinate with LASD to conduct the SUD screening and make the appropriate referral to a community-based residential treatment facility.

Treatment Requirements and Care Coordination

Treatment services are administered based on medical necessity. SUD treatment services for clients referred by LASD may include a combination of services, as outlined in the [Service Benefit and LOC](#) section. Care Coordinators may perform additional Care Coordination activities for justice-involved clients as outlined in the [Overview of Care Coordination and Services](#) and [Justice-Involved](#) sections.

Electronic Monitoring Requirements

LASD requires clients participating in the program to wear GPS equipment at all times. Failure to adhere to this requirement will result in an immediate return to custody. LASD contracts with a dedicated service provider for 24/7 technical support for GPS equipment. Should provider agencies encounter any issues with GPS equipment, they should contact the assigned Representative to report them. The most common concerns reported include, but are not limited to, the following:

- Battery life diminishing;
- Client wandering out of bounds; **and/or**
- Notifying clients when they are being transported to off-site appointments.

Compliance Check Procedures

LASD will conduct periodic compliance checks for all clients receiving SUD treatment services and who are under electronic monitoring. Compliance checks and investigations are conducted at random and may occur in person or by telephone. They require a status report on the client's progress in treatment and/or verification of physical presence at the treatment program.

For provider agencies serving START-Community clients to remain in compliance with LASD supervision requirements, agency staff must supervise clients at all times. Any scheduled recreation activities or off-site appointments need to be cleared with LASD one (1) week in advance by contacting **(213) 893-5345** from 8:30 a.m. to 4:00 p.m. for approval on a case-by-case basis. LASD will arrange GPS clearance for **approved** off-site activities. Clients are to be escorted by staff at all times while off-site.

START-Community clients need to remain in custody while participating in residential treatment. Therefore, should a client abscond from the residential treatment facility, contracted provider agencies must perform the following:

- Immediately contact LASD at (213) 453-4528 (24-hour line) and LASD Community-Based Alternative to Custody at (213) 893-5345 (during business hours listed above) to report that the client has absconded.
- Allow LASD-designated personnel limited access into the relevant treatment facility and/or room to verify client location and/or locate the GPS monitoring device, and to gather relevant information from the Supervisor and/or designated staff on duty for the LASD investigative report on the client

Early Termination

Termination of any justice-involved referred client can occur if the client violates any facility rules, engages in violent behavior, utilizes alcohol and/or drugs, or makes threats to another client. Provider agencies must notify LASD and SAPC within 24 hours and document the reason for termination in the appropriate data-tracking system (e.g., CalOMS/LACPRS). In addition, provider agencies need to complete the [Program Incident Form \(see Appendix G\)](#), which describes the incident being reported, and maintain a copy of the form in the client's file. Completed forms should be submitted within 24 hours via email to SAPC-SOC at SAPC-SOC@ph.lacounty.gov. Termination can occur for the following reasons:

- Absconding or willful violations of program requirements,
- Client poses a safety risk for self or others, **or**
- Client opts out of the project.

Note: Termination of START-Community will require the client to be returned to jail to complete the remainder of their sentence.

Co-Occurring Integrated Care Network

The Co-Occurring Integrated Care Network (COIN) program addresses the needs of adult [AB 109](#) clients who have co-occurring chronic SUD and severe and persistent mental illness. COIN provides integrated SUD and mental health treatment. Treatment is for clients who are at high risk for relapse and are referred through the [AB 109](#) Revocation Court.

In-Custody to Community Referral Program

In-Custody to Community Referral Program (ICRP) is an SUD collaborative designed to provide a warm handoff for individuals transitioning from incarceration to SUD services in the community upon release from custody. The ICRP is a partnership among SAPC, its contracted provider agencies, and the Los Angeles County Department of Health Services, Correctional Health Services (DHS-CHS).

Rapid Diversion Program

Rapid Diversion Program (RDP) is a pre-plea diversion program targeting individuals with a mental health diagnosis or SUD. Individuals participate in programming, receive housing resources, and are case-managed for a period of time recommended by the service provider and approved by the court. Cases are dismissed for individuals who successfully complete the program. RDP is run through the Los Angeles County Justice Care and Opportunities Department (JCOD), and case managers are contracted through Project 180 and Exodus.

Los Angeles Law Enforcement Assisted Diversion

Los Angeles Law Enforcement Assisted Diversion (LEAD) is a pre-arrest, community-based diversion model that diverts individuals with repeated low-level drug-related offenses at the earliest point of contact with law enforcement to harm-reduction-based Care Coordination and social services as an alternative to jail and prosecution. LEAD is run through the Los Angeles County Department of Health Services, Office of Diversion and Reentry (DHS-ODR), with case management contracted through Alma Family Services and the LA Community Health Project.

Community Reentry and Resource Center

The CRRC is a hub station that operates as a one-stop shop for male inmates transitioning back to the community. CENS provides on-site SUD screening to clients being released from the county jail or for LAC-Probation to refer [AB 109](#) clients with a potential need for SUD treatment.

Developing Opportunities Offering Reentry Solution (D.O.O.R.S)

The Developing Opportunities Offering Reentry Solutions (D.O.O.R.S) center is an initiative of LAC-Probation's Adult Services Division and DHS-ODR, which operates countywide under JCOD. The D.O.O.R.S center offers a comprehensive array of supportive services to address barriers to reentry for justice-involved individuals, particularly those on adult felony supervision, their families, and the community. County department staff (DMH, DPSS, and LAC-Probation) and community agencies are co-located in the center, providing and or arranging linkage(s) to a range of rehabilitative services that assist with SUD, mental health care, employment, education, housing, legal issues, family reunification, and other social support.

Division of Adult Parole Operations

The California Department of Corrections and Rehabilitation, Division of Adult Parole Operations (DAPO), supervises the adult parole population. DAPO's headquarters provides statewide oversight, while the Regional Administrators are responsible for the day-to-day operations of supervising adult parolees. The field parole units supervise adult offenders subject to state-supervised parole, as well as those currently serving their sentences in an alternative custody program and those released on medical parole.

The parole population can access the County's DMC-ODS SUD treatment system of care through the CENS, SASH, or direct-to-provider. In addition, provider agencies are encouraged to participate in Parole and Community Team (PACT) resource fairs for parolees. Resource fairs provide the parole population with information about various community resources (e.g., housing, legal counsel). At these PACT Meetings, provider agencies can educate and inform the parole population about their respective SUD treatment services and the services offered under the County's DMC-ODS SUD treatment system of care.

Juvenile Justice-Involved Population

The County's juvenile justice system governs the legal oversight (i.e., LA Superior Courts) and LAC-Probation detention (i.e., juvenile halls/camps) of youth and young adults pre- and post-adjudication. The system's objectives – in addition to maintaining public safety – are skill development, habilitation, rehabilitation, addressing treatment needs, and successful reintegration of youth and young adults into the community.

The County is currently expanding diversion efforts to deter in-custody placements; however, clients dispositioned to the County's juvenile justice system may be placed in custody for short periods - typically less than a year - and should be prepared for rapid reentry transition. Additionally, youth and young adults serving sentences in State juvenile justice facilities have been transferred to the County's Secure Youth Treatment Facilities (SYTF), resulting in longer periods of custody at County facilities.

Given the nature of in-custody settings, service delivery must consider security protocols and the limited access youth have throughout the day-to-day environment. SAPC and its providers will work with LAC-Probation to understand security protocols and advocate for appropriate youth SUD services.

Staffing and Fingerprint Clearance

SAPC and LAC-Probation ensure ongoing compliance with background and security investigations applicable to each department's contracts and contract employees.

Juvenile Justice Crime Prevention Act

The JJCPA funds collaborative projects between SAPC and LAC-Probation. The goals of this collaboration are to:

- Provide youth with skills to resist continued substance use and the associated negative behaviors.
- Demonstrate reductions in subsequent arrests, incarceration, and probation violations.
- Increase completion of probation, restitution, and community service requirements.

JJCPA Target Population

JJCPA services are for at-risk and probation-involved youth, either in custody or under community LAC-Probation supervision.

Referral Process for In-Custody Juvenile Population

- In-custody, pre-adjudicated youth are typically referred when LAC-Probation caseworkers and other county partners have identified an individual who needs SUD screening, intervention, and treatment linkage in preparation for release from custody. However, any entity providing in-custody services to youth may refer to CENS (i.e., DMH, DHS, LACOE, Courts) for appropriate screening and services. JJCPA funds co-located CENS services at the Los Padrinos Juvenile Hall (LPJH).
- All referrals for JJCPA CENS services must utilize the [Juvenile Justice SUD Screening Referral Form for CENS \(see Appendix I\)](#). For additional details on CENS services for this population, see [CENS Standards and Practices](#) available on the SAPC website under the "Manuals & Guides" section on [SAPC's Manual, Bulletins, and Forms](#) webpage.

General Population Camps

The LAC-Probation operates General Population Camps, also known as residential camps, that serve post-disposition youth and young adults. Individuals placed at these camps typically remain for 3, 6, or 9 months. SUD services available at the General Population Camps include SUD education, early intervention, and treatment. These services are supported by LAC-Probation through the Camp Services and Juvenile Growth Funds.

Target Population

The target population includes Youth (age 17 and under) and Young Adults (age 18-20) referred to JJ-SUD and housed at one (1) of the three (3) sites identified by LAC-Probation as residential camps. There are currently three (3) General Population locations:

- Camp Clinton B. Afflerbaugh
- Camp Glenn Rockey
- Camp Dorothy Kirby (Center)

Provider agencies co-located at the General Population Camps offer Early Intervention/Adult-At-Risk and OP Services for suitable clients. Probation case workers and any entity providing in-custody services to the youth may refer (i.e., DMH, DHS, LACOE, Courts) potential clients for these SUD services by completing the [Juvenile Justice SUD Screening Referral Form for SYTFs \(see Appendix J\)](#). In addition, post-adjudicated youth and young adults sentenced to these camps from LPJH are screened by the co-located CENS at LPJH.

Provided Services

Early Intervention Services

Services are available for clients whose screenings show no need for SUD treatment but would benefit from intervention due to high-risk behaviors, including those leading to incarceration. These services, which use evidence-based and County-approved materials (e.g., *“Healthy Youth: An Early Intervention Service Model for Addressing Substance Use Risk and Promoting Wellness Among At Risk Youth”*) for Youth [age 17 and under] and Young Adults [age 18-20], can be delivered individually or in groups and focus on:

- Understanding SUD signs, risks, and associated consequences
- Minimizing harm related to SUD
- Preventing overdose, dependence, and relapse
- Promoting sobriety
- Delivering the curriculum within a timeframe appropriate for individual comprehension

SUD Treatment Services (ASAM 1.0)

OP treatment services are available to individuals who meet the medical necessity criteria for this LOC. Providers receive referrals from on-site LAC-Probation staff and other provider agencies (i.e., DMH, DHS, LACOE, Courts) when individuals are transitioning from other probation facilities or would benefit from ongoing community-based care upon release. The provider shall facilitate a warm handoff.

Secure Youth Treatment Facilities

[SB 823](#), the Juvenile Justice Realignment Bill, resulted in the closure of the State of California Division of Juvenile Justice (DJJ), effective June 20, 2023, and the transfer of individuals aged 15-26 who were convicted of crimes as juveniles back to the County. The Board of Supervisors has identified two (2) site locations as SYTFs to house these high-risk detainees. SAPC has received [SB 823](#) funding via a Direct Service Order with LAC-Probation to implement SUD services for justice-involved Youth and Young Adults.

SYTF Target Population

The target population includes Youth (age 17 and under) and Young Adults (age 18-26) referred for JJ-SUD and housed at one (1) of two (2) sites identified by the Board of Supervisors as SYTFs to house high-risk detainees diverted from DJJ to the County. There are currently two (2) SYTF locations:

1. Barry J. Nidorf Juvenile Hall
2. Camp Vernon Kilpatrick

Provider agencies co-located at these SYTF sites offer Early Intervention/Adult-At-Risk and OP Services for suitable clients (see more information about these services below). SYTF Probation case workers and any entity providing in-custody services to the youth may refer (i.e., DMH, DHS, LACOE, Courts) potential clients for these SUD services by completing the [Juvenile Justice SUD Screening Referral Form for SYTFs \(see Appendix J\)](#). In addition, post-adjudicated youth and young adults sentenced to SYTF sites from LPJH are screened by the co-located CENS at LPJH

SYTF Provided Services

Early Intervention Services

Services are available for clients whose screenings show no need for SUD treatment, but who would benefit from intervention due to high-risk behaviors, including those leading to incarceration. These services, which use evidence-based and County-approved materials (e.g., “*Healthy Youth: An Early Intervention Service Model for Addressing Substance Use Risk and Promoting Wellness Among At Risk Youth*” for Youth [age 17 and under] and Young Adults [age 18-20]), can be delivered individually or in groups and focus on:

- Understanding SUD signs, risks, and associated consequences
- Minimizing harm related to SUD
- Preventing overdose, dependence, and relapse
- Promoting sobriety
- Delivering the curriculum within a timeframe appropriate for individual comprehension

SUD Treatment Services (ASAM 1.0)

OP treatment services are available to individuals who meet the medical necessity criteria for this LOC. Providers receive referrals from on-site LAC-Probation staff and may also get information from other provider agencies (i.e., DMH, DHS, LACOE, Courts) when individuals are transitioning from other probation facilities or would benefit from ongoing community-based care upon release, the provider shall facilitate a warm handoff.

Reporting Requirements and Procedures

- **Reporting to LAC-Probation (Community):** A CBO Note needs to be entered into LAC-Probation’s web-based reporting system (www.probjcpa.lacounty.gov/cbo/) for each JJCPA referral, regardless of admission status, and at least once every 30 days for youth admitted into treatment. For all admissions, the “Enter Service Data” screen in LAC-Probation’s web-based reporting system must be completed monthly and updated as necessary.

- **Reporting to LAC-Probation and other referring departments (In-Custody):** Upon completion of the appropriate ROI, the screening results must be communicated to the referring department (LAC-Probation, DMH, DHS, LACOE, Los Angeles County Department of Youth Development [DYD]) for reporting and documentation purposes, as well as to the court, as needed. For clients receiving ongoing intervention services, monthly progress reports must be submitted to the caseworker and the referring department.
- **Reporting to SAPC:** Provider agencies must electronically submit a Client Data Report that lists all new referrals, youth in treatment, detailed notes on services and their duration, linkages, and closed cases, using the Sage Juvenile Justice Client Data Report form.

People Experiencing Homelessness Population

Homelessness significantly affects many individuals with SUDs, often due to the socioeconomic decline associated with addiction. Estimates suggest that 20-35% of PEH have substance use issues. PEH generally require more intensive treatment and face greater and more diverse needs compared to those with stable housing. They encounter numerous barriers to accessing care, including, but not limited to, social isolation, distrust of authorities, and lack of transportation.

Stable housing is crucial for achieving treatment goals and is a key component of effective services. Early linkage to secure housing during treatment often leads to better outcomes, highlighting the importance of Care Coordination in addressing the diverse needs of PEH. Psychosocial interventions and addiction medications for PEH should adapt successful strategies used with other populations to address their unique needs. Mobile outreach services and motivational enhancement interventions are particularly effective in encouraging ongoing treatment engagement, as PEH generally respond better to supportive rather than confrontational approaches.

Optimal Treatment of PEH Populations

Research indicates that effective programs for PEH should address both their substance use and practical needs, such as housing, employment, food, clothing, and finances. These programs should be flexible, non-demanding, and tailored to the specific needs of different subpopulations, such as by gender, age, or COD. They should also offer long-term, continuous interventions. Therefore, substance use treatment for PEH must integrate a holistic approach that considers the individual's overall needs and environment.

A comprehensive range of services is required to meet the safety, health, social, and material needs of PEH. Common services include food and clothing assistance, shelter/housing, identification papers, financial aid, legal support, medical and mental health care, dental care, job training, and employment services. These services can be provided directly within the SUD program or through connections with community resources. Proactive outreach in a non-judgmental and supportive manner, and addressing identified needs early in treatment, can enhance engagement with this population.

Counselors and clinicians need to address the physical and mental health needs of PEH, considering their high rates of co-morbidity. Medications should be used when clinically indicated, with prescribing practices that consider the environment in which medications will be used and stored (e.g., ensure that medications that

require refrigeration are not prescribed when the client has no way to store such medications). Integrated interventions that concurrently address the multitude of medical, psychiatric, substance use, and psychosocial needs of PEH tend to produce improved outcomes compared to interventions that are provided sequentially or in parallel with other services.

Effective counselors and clinicians often have a particular interest and comfort level with working with this challenging and rewarding population. Staff should be skilled in managing the diverse needs of PEH and knowledgeable about community resources to make appropriate referrals and linkages. Ideally, care teams are interdisciplinary, including medical, mental health, substance use, and social service professionals, working collaboratively.

While treating PEH with SUDs is challenging, successful outcomes are achievable by focusing on access to suitable housing and on providing comprehensive, client-centered services delivered by skilled staff.

Services for PEH

PEH have greater and more varied needs than housed individuals and therefore typically require more intensive treatment that addresses the whole person in the context of their environment. A full continuum of comprehensive services is necessary to treat the whole client and fully address their needs. When providing SUD treatment services for PEH, staff should begin working towards long-term stable housing options upon admission.

PEH: Target Population

All single adults, youth, and families who lack a fixed, regular, and adequate nighttime housing, ranging from sleeping in places not meant for human habitation (cars, parks, streets) to staying in shelters, hotels, or "doubled-up" with others due to economic hardship. It is a temporary, involuntary condition rather than a fixed identity.

PEH: Determination of Appropriate LOC and Linkage to Treatment

- Client is enrolled in treatment:
 - If the client is enrolled in treatment, the provider agency needs to complete the steps noted in PEH under Care Coordination Considerations for People in Vulnerable Groups.
 - Within three (3) calendar days of admission for clients identified as homeless or at risk of homelessness, the SUD counselor/care coordinator shall initiate and complete an HSP.
- Client is not enrolled in treatment:
 - If the client is not enrolled in treatment services, the provider staff needs to conduct the ASAM CO-Triage® Tool for Adults (age 21 and over) or the Youth and Young Adult Screener to determine the appropriate LOC needed.
 - If the client requires residential treatment, the provider agency needs to place the client in residential treatment the same day, if available.
 - If the provider agency does not have an available residential treatment bed or does not offer residential treatment, the provider agency needs to contact a residential provider with available beds to schedule an appointment for the client on the same day.

- If the LOC for the client is OP, IOP, OP-WM, or OTP services, then the provider agency needs to connect the client to RBH/RH as follows:
 - Contact an RBH/RH provider agency with available beds for the client's placement on the same day.
 - If there are no available RBH/RH beds, the provider agency needs to contact shelters and other IH providers with available beds and arrange for the client's housing placement on the same day.

PEH: Assessment

Trained SUD care coordinators with access to the [HMIS](#) will:

- Obtain the client's consent to share information in the HMIS to coordinate housing resources. Administer the Coordinated Entry System (CES) Survey Packet, including the Los Angeles–Housing Assessment Tool (LA-HAT) for homeless adults, families, and the Next Step Tool for Youth (age 17 and under) and Young Adults (age 18-20);
- Enter or update the homeless clients' information into HMIS; **and**
- Coordinate with the CES agency regarding clients' housing within 14 calendar days of the first treatment service or intake appointment; see [CES Access Point Directory](#).

Treatment providers who have not been trained on the CES adult and youth tools and have not received access to HMIS:

- Will need to refer PEH directly to the CES agency within the same SPA within 14 calendar days of the first service or intake appointment.
- To get access to HMIS, email SAPC-SOC at SAPC-SOC@ph.lacounty.gov.

For PEH with their families, the SUD care coordinator will call “211” or refer them to any of the CES for Families agencies countywide to schedule a housing screening appointment. Depending on the availability of resources, adult and young adult clients, and PPW may be offered SAPC's RBH benefit if they prefer a temporary recovery-focused environment prior to securing more permanent housing.

PEH: Care Coordination

The SUD counselor or care coordinator will work with the CES Housing Navigator and/or SAPC-contracted Housing Navigator if the client resides in RBH/RH, to ensure all required documents and forms are uploaded into HMIS and that the client is Match Ready (i.e., all necessary documentation is collected and entered into HMIS). They will also assist the client in completing the required application forms and ensure eligibility for permanent housing vacancies listed in the CES.

Housing Assessment and Intervention Options

Within three (3) calendar days of admission for clients identified as homeless or at risk of homelessness, the SUD counselor/care coordinator shall initiate and complete a SAPC-approved HSP. The HSP is a client-centered document that identifies housing-related needs and establishes a plan to support the client's progression toward housing stability. At a minimum, the SUD counselor/care coordinator will collaborate with the client to document the following:

- Identified barriers to obtaining and maintaining housing
- Action steps to address and mitigate identified barriers
- Client strengths and strategies to support housing stabilization
- Available services, supports, and referral pathways

The HSP shall include both short- and long-term goals with reasonable, measurable timeframes. Goals may include, but are not limited to, housing stabilization, income and benefits acquisition, employment, budgeting, and physical, mental, and/or SUD-related health needs. In cases where permanent housing cannot be secured during SUD treatment, the HSP shall include IH strategies, such as emergency or temporary housing arrangements, to prevent a return to unsheltered homelessness upon discharge.

The SUD counselor/care coordinator will review the HSP with the client no less than every 30 calendar days and update the plan as necessary to reflect changes in the client's circumstances or progress toward goals. All updates and related activities shall be documented in accordance with Sage documentation requirements.

- **Connect Client to the CES:** The CES works to connect the highest-need, most vulnerable persons in the community with available housing and supportive services. All providers should ensure that care coordinators are familiar with CES and the [CES Access Centers](#) within each of the eight (8) SPAs. In LA County, [HMIS](#) is used by homeless assistance providers in the coordinated entry process to coordinate care, manage operations, and enhance service delivery. This secure online database allows organizations to gather and manage client-level and system-wide information on services for PEH and those at risk. SUD treatment providers will utilize HMIS to collect accurate client information, facilitating the best match to available services in the CES. The care coordinator needs to check if the client has a profile in the HMIS system:
 - If there is no record of an existing profile, providers will obtain the client's consent create a client record in HMIS, and complete the appropriate, most recent version of the CES Triage Tools.
 - If the PEH has a client profile in HMIS, a completed CES Triage Tool score in HMIS, an additional CES Survey Packet does not need to be administered unless the care coordinator believes the result of the score does not accurately reflect their vulnerability, because:
 - Their life circumstances have changed;
 - Their triage tool result contains errors; **or**
 - Their condition limits their ability to respond to the questions on the triage tool.
 - If updates are needed, the SUD provider agency will obtain the client's consent and use the CES Triage Tool Score Revision Worksheet to update the client's assessment. This document can be found on [LAHSA's Document webpage](#).
 - If the provider staff is not trained to administer the CES Triage Tools and does not have access to HMIS, the care coordinator needs to refer and set up an appointment with the adult or youth

[CES Access Centers](#) within the same SPA and within 14 calendar days of admission. Homeless families should contact 211 and be referred to the Family Solution Centers within each of the eight (8) SPAs countywide within 14 calendar days of admission. If the client is an RBH or RH resident, the provider agency can coordinate with a SAPC-contracted Housing Navigation agency.

- **Enter or update the Point of Contact:** SUD counselors/Care coordinators need to enter and update the client's information and Point of Contact in HMIS every 90 days to ensure the client remains in the queue so the housing client can be reached in the event of a potential match with a housing resource. Points of Contact work to:
 - Connect clients to services and resources in support of a successful housing placement;
 - Provide document collection support; **and**
 - Provide a warm handoff to any services and resources made available.

The Point of Contact may change while the client is on the path to permanent housing. The current Point of Contact should ensure that the client has a new designated Point of Contact and that the client profile is updated in HMIS. For example, a client's transition from Residential to OP treatment would necessitate a change in the Point of Contact. For additional information about identifying a Point of Contact, see [Table 13: Designing or Updating a CES Client's Point of Contact](#).

Table 13: Designing or Updating a CES Client's Point of Contact

Designing or Updating a CES Client's Point of Contact	
Designating a Point of Contact	The care coordinator will serve as the Point of Contact for clients on their caseload. To enter a Point of Contact, complete the following steps: • Open HMIS and go to the Client Profile Page • Add Point of Contact fields (Date, Name, Phone, Email, Agency, Program)
Reviewing a Point of Contact Before 90 Days	The Point of Contact for CES clients needs to be confirmed at least 90 days before any change or update to remain active in the Community Queue for resource matching. After 90 days without an update, the client will become inactive in HMIS. Records can be made active again when the Point of Contact is updated. • Open HMIS and go to Client Profile • Revise Date
Updating a Point of Contact After Loss of Communication	When the Point of Contact can no longer contact the CES client and/or perform the roles and responsibilities of a Point of Contact, the contact fields should be deleted. • Open HMIS and go to Client Profile • Delete Point of Contact fields (Date, Name, Phone, Email, Agency, Program)
Updating a Point of Contact During an Extended Leave	When the Point of Contact plans an extended absence, they should work to ensure coverage for any of their CES clients by adding a secondary point of contact within their agency, when there is not already a second Point of Contact recorded. • Open HMIS and go to Client Profile • Add Point of Contact fields for secondary Point of Contact (Date, Name, Phone, Email, Agency, Program) • Delete Point of Contact fields for original Point of Contact (Date, Name, Phone, Email, Agency, Program)

**Updating Points of
Contact When
There are Two (2)**

- Open HMIS and go to Client Profile
- If two (2) Points of Contact are already recorded, confirm that both contacts are still working with the client.
- Delete any Points of Contact that are out of date.
- If both are still active, delete the oldest record and replace it with the new Point of Contact's information (Date, Name, Phone, Email, Agency, Program)

PEH: Discharge

When the CES or SAPC-contracted Housing Navigator notifies the SUD counselor/care coordinator that a housing resource has been identified, the SUD counselor/care coordinator will coordinate appointments between the Housing Provider and the client, verify eligibility information, and assist the client with the housing application process. The SUD counselor/care coordinator will link the client to the appropriate supportive services to secure and maintain housing, including income/benefits/employment and transportation.

SAPC aims to prevent situations where clients are discharged into unsheltered homelessness. Requests for continued residential admission for PEH without stable housing will be considered if:

- The client's homelessness status is documented in CalOMS, a current finalized Problem List/Care Plan (updated every 30 days), or the client's EHR.
- The client agrees to ongoing residential admission and treatment.
- The provider has documented efforts to develop a post-discharge housing plan.
- These details are included in a Progress Note submitted with the request for residential LOC reauthorization.

Interim Housing Outreach Program

The Interim Housing Outreach Program (IHOP) addresses current gaps in behavioral and physical health services in IH settings to support stability, facilitate transitions to permanent housing, and prevent recurrence of homelessness. CENS counselors join IH Multi-Disciplinary Teams (MDTs) across LA County, collaborating with staff from DMH, the Los Angeles County Department of Health Services, and Housing for Health (DHS-HFH) to meet clients' comprehensive behavioral and physical health needs.

CENS counselors will deliver on-site substance use outreach, engagement, educational sessions (both individual and group), screening, and referrals to SUD services. This includes connecting clients with SAPC treatment providers that offer MAT at IH sites.

Additionally, CENS counselors will implement harm reduction strategies, coordinate referrals to harm reduction services, such as Engagement and Overdose Prevention (EOP) Hubs, and provide overdose prevention training and kits to residents and staff. For residents needing traditional SUD treatment but unable or unwilling to attend a treatment facility, OP services can be offered on-site through SAPC's network of FBS treatment providers.

Homekey+

Housing stability is a critical determinant of health and directly correlates to substance use disorder rates, recovery from SUDs, and positive treatment outcomes. In addition, stable housing improves overall health and well-being, employment, and mental health. Homekey+ is the permanent housing component of the In March 2024, California voters approved the Behavioral Health Infrastructure Bond Act, which is part of Proposition 1. Homekey+ is a housing initiative aimed to support the development and expansion of PSH opportunities for veterans and individuals with SUD or mental health disorders who are at risk of or experiencing homelessness. It pairs permanent affordable housing with supportive services to address behavioral health challenges. Modeled on the Homekey program, Homekey+ allocates funding for the acquisition and rehabilitation of existing buildings, as well as other project types, including new construction, that can be quickly converted or constructed into permanent affordable housing.

Table 14: Homekey+ Participant Eligibility Requirements

Individual must meet all of the following:	
1	18 years of age or older
2	Resident of LA County
3	Experiencing homelessness, as defined under 24 CFR Part 578.3: • Literally homeless; • At-risk of homelessness; • Fleeing/Attempting to flee DV; or • Homeless under other federal statutes.
4	Has an annual income at or below 30 percent of Area Median Income (AMI)
5	Living with a behavioral health challenge
6	Has received SUD services within the SAPC network in the last nine (9) months
7	Working with a SAPC Housing Navigator

Homekey+ requires the use of the Housing First model, which removes preconditions and barriers to entry or continued tenancy (e.g., sobriety, treatment, or service participation requirements) for permanent housing, thereby mitigating the risk of relapse in SUD and homelessness. In addition, Homekey+ offers individualized Intensive Case Management Services (ICMS) through HSH provider agencies and SUD-focused Supportive Services (SUD-SS) based on individualized client needs, with all services provided on a voluntary basis. SUD-SS assists clients in accessing services and resources that address behavioral health needs while ensuring housing stability, access to services, and benefits.

SAPC is committed to providing rental subsidies and/or SUD-SS at select sites to help clients achieve housing stability and recovery. SAPC's PSH units will be available to clients within the SAPC network who participate in HN services and meet minimum threshold requirements.

For additional information, see [SAPC IN 26-07](#).

Measure A

Effective April 1, 2025, the half-cent sales tax repealed and replaced the quarter-cent sales tax for County homeless services that was set to expire in 2027 (formerly known as Measure H).

As part of LA County's agenda to combat homelessness and effectively serve PEH, Measure A funding was allocated to support RBH for PEH who are exiting from institutions such as jails, prisons, other CFs, hospitals, UCCs, SUD residential treatment centers, mental health treatment facilities, and foster care and probation camps for young adults aging out of these settings. For full benefit details, see [Recovery Bridge Housing](#) section.

Lesbian, Gay, Bisexual, Transgender, Queer, Gender Expansive, Queer Population

LGBTQ+ individuals often experience higher rates of substance use compared to the general population. The stigma and discrimination associated with being part of a marginalized community can lead some LGBTQ+ people to use substances as a coping mechanism. Furthermore, research has also shown that once LGBTQ+ clients do meet the criteria for a diagnosable SUD, they are less likely to seek help. These findings may be due to the various barriers the LGBTQ+ population faces in seeking treatment and the unique needs that SUD programs may not address.

Despite protections intended to shield people in recovery from discrimination, LGBTQ+ individuals frequently face inadequate safeguards. Homophobia, heterosexism, and transphobia can make it challenging for them to access treatment and discuss their sexual orientation or gender identity openly. Internalized negative societal attitudes can lead to feelings of sadness, doubt, and fear, further complicating their trust in healthcare systems.

SAPC offers the ["Ensuring Affirming and Culturally Responsive Care for Transgender Clients Toolkit"](#) as a resource to support providers in offering affirming care to transgender clients.

Important Considerations in the Treatment of the LGBTQ+ Population

Providers need to be aware of some unique aspects of treating LGBTQ+ clients. While group therapies should be as inclusive as possible and encourage each member to discuss relevant treatment issues or concerns, some group members may have negative attitudes toward LGBTQ+ clients. It is crucial for staff to ensure that LGBTQ+ clients are treated with respect, and group rules should foster an inclusive and welcoming environment.

LGBTQ+ clients should have control over whether they discuss their sexual orientation or gender identity in mixed groups, and this decision should not be influenced by other group members. While individual services can reduce the risk of heterosexism, homophobia, or transphobia in group settings, group therapy also offers valuable healing opportunities when LGBTQ+ clients receive acceptance and support from non-LGBTQ+ peers.

In many ways, psychosocial and pharmacologic interventions (e.g., addiction medications) geared toward LGBTQ+ clients are similar to those for other groups. An integrated biopsychosocial approach considers the various individualized needs of the client, including the societal effects on the client and their substance use. Unless SUD providers carefully explore each client's individual situation and experiences, they may miss important aspects of the client's life that may affect recovery (e.g., social scenes that may contribute to substance use, prior experiences of being discriminated against, a history of anti-gay violence and hate crimes, such as verbal and physical attacks, etc.).

As with any client, substance use providers need to screen for physical and mental health conditions in LGBTQ+ persons due to the risk of co-morbid health conditions. As a result of previously discussed challenges confronted by the LGBTQ+ community, members of this group do have higher rates of certain mental health conditions and are also at greater risk for certain medical conditions. Comprehensive screening and assessments can assist LGBTQ+ clients in accessing appropriate physical and mental health care.

The methods of best practice outlined in the counseling competency model are applicable to all populations, particularly when working with LGBTQ+ clients. In this model, a counselor:

- Respects the client's frame of reference;
- Recognizes the importance of cooperation and collaboration with the client;
- Maintains professional objectivity;
- Recognizes the need for flexibility and is willing to adjust strategies in accordance with client characteristics;
- Appreciates the role and power of a counselor as a group facilitator;
- Appreciates the appropriate use of content and processes for therapeutic interventions; **and**
- Is non-judgmental and respectfully accepting of the client's cultural, behavioral, and value differences.

Family dynamics play a crucial role in treating LGBTQ+ individuals, and SUD providers should recognize that family therapy may be challenging due to potential alienation related to the client's sexual or gender identity. Nonetheless, involving family in the treatment process can lead to more positive outcomes. Attention should be given to discharge planning, considering factors such as living environments (for recovery and safety), social isolation, employment, finances, and ongoing issues related to homophobia and transphobia.

Successful treatment for LGBTQ+ clients involves cultural sensitivity, understanding the effects of cultural victimization, and addressing internalized shame and negative self-acceptance. CBTs can help challenge negative beliefs and enhance emotional regulation, which aids in relapse prevention. Motivational enhancement techniques can also boost treatment engagement among LGBTQ+ individuals.

Understanding each client's unique history and background enhances respectful treatment and increases the chances of positive outcomes. SUD treatment staff may sometimes be unaware or insensitive to LGBTQ+ issues, harbor biases, or mistakenly believe that sexual or gender identity causes substance use or can be altered through therapy. In these cases, providers need to be aware of these beliefs in order to prevent them from becoming barriers to the effective treatment of LGBTQ+ clients. An SUD treatment facility's commitment to providing sensitive care for LGBTQ+ clients can be included in its mission statement, administrative policies, and procedures. Providing staff training and education are oftentimes valuable and includes sexual orientation sensitivity training to promote a better understanding of LGBTQ+ issues, trainings that assist staff in better

understanding the needs of transgender individuals and the role that acknowledging gender identity plays in culturally competent treatment services, and other educational areas to ensure that quality care is provided. Providers who understand and are sensitive to the issues surrounding LGBTQ+ issues, such as culture, homophobia, heterosexism, and sexual and gender identity, can help LGBTQ+ clients feel comfortable and safe while they start their recovery journey.

Veterans

According to the 2020-2024 United States Census, LA County is home to 209,570 veterans. While many share similar experiences, their backgrounds and needs are highly diverse. Some may have seen combat in one (1) or more wars, while others may have served in non-combat roles. Likewise, some veterans may have experienced injury, including traumatic brain injuries (TBI), loss of limb or other physical injuries, while others may have emotional trauma. Gender is also a factor, as more female veterans report experiences of harassment, trauma, and Military Sexual Trauma (MST).

These varied experiences can lead to SUDs and present unique treatment challenges. Some veterans may not qualify for [Veterans Affairs \(VA\)](#) benefits due to a dishonorable discharge or “other-than-honorable” discharge. Additionally, some veterans and family members may attempt to secure services from SUD treatment programs due to the long wait times at the VA. Provider agencies need to ensure that their services are tailored to meet the diverse and specific needs of veterans and their families.

Important Considerations in Treating the Veteran Population

Given the high rates of trauma and complex physical and behavioral health issues among veterans, SUD providers should conduct comprehensive assessments that explore trauma, combat or war experiences, and injuries that may impact SUD treatment. When such issues are identified, coordinated care with medical and mental health providers is essential.

Military culture values discipline, loyalty, and hierarchy. Stigma presents an additional challenge. Veterans may experience stigma related to substance use as well as seeking help for any health or mental condition. Understanding this culture can help to establish rapport with veterans. Veterans may therefore require longer and more extensive efforts due to stigma, mistrust of systems, and concerns about how information will be utilized. In addition, anger and personality disorders can make it more challenging to engage in treatment. EBPs, such as MI, can help address these challenges and support more effective care. The use of a peer specialist can also assist with engaging veterans into services, as familiarity with military culture can bridge the gap in recognizing the unique experiences, trauma, and costs that military service can include.

A key time to engage veterans in substance use treatment is right after their military discharge. Veterans may begin using substances due to mental health conditions, difficulty adjusting to civilian life, loss of social support, or pain from injuries sustained during service. While substance use varies, some may turn to sedating drugs, including prescription medications, to cope with untreated or under-treated mental health issues. Physical health conditions and injuries can also lead to higher use of prescription drugs, opioids, or heroin,

putting some veterans at greater risk for fatal overdose. These individuals may benefit from addiction medications.

Care Coordination is an integral part of treatment, as it not only links veterans to appropriate resources but also supports engagement, since navigating the VA system and accessing benefits can be complex. Care Coordination for veterans may include linkages to Transition Assistance Programs that assist veterans with re-entry into civilian life following their military discharge. These programs provide education and resources to GI Bill benefits, veteran readiness and employment programs, information on Veteran Service Officers and filing for service-connected disabilities, and other specialized support programs.

For some, military service can increase risk factors for adverse life outcomes, such as involvement with the justice system. These factors include exposure to trauma and/or other mental health issues, combat experiences, substance use, family separation and conflict, and the lack of social support that further increases vulnerability. For justice-involved veterans, working with veteran advocates and referrals to the specialized veteran treatment courts can ensure they receive appropriate services, legal assistance, and connection to veteran-related community resources (e.g., housing, benefits, employment, and healthcare). These specialized courts focus on public safety, rehabilitation over incarceration, reducing recidivism, and providing holistic support to address factors that impact criminal behavior.

Since the veteran experience is such a unique one with significant variability even within the group, treatment providers may need additional training to fully understand the nuances of the veteran population and how their experiences impact their behaviors in order to adequately treat veterans and their families.

Youth Population

In this document, the term “Youth” refers to individuals under the age of 17. Adolescence presents a critical period for influencing risk factors related to substance use, offering an opportunity to address these issues earlier than with adult clients. In accordance with [DHCS's Adolescent Substance Use Disorder Best Practices Guide \(October 2020\)](#), youth SUD treatment is approached differently from adult treatment due to differences in psychological, emotional, cognitive, physical, social, and moral development. Examples of these developmental issues include newly formed independent living skills, the powerful influence of interactions with family and peers, and the fact that a certain degree of limit-testing is a normal feature of adolescence.

These developmental differences are reflected in clinical practice and in the ASAM criteria, which often necessitate more intensive LOCs for youth than for adults. Consequently, the client-to-counselor ratio for youth cases should be lower than for adults to manage this increased treatment intensity effectively.

Given the rapid progression of substance use among youth, it is crucial to streamline the treatment admission process to promptly identify and address their needs. Engaging youth effectively, maintaining their attention, and retaining them in treatment are essential. Youth treatment should also address their higher rates of CODs, emphasizing the need for coordinated care with mental health services as clinically indicated.

Optimal Treatment of the Youth Population

Generally, optimal treatment of the youth population requires more significant amounts of external assistance and support compared to adults, and more intensive treatment and/or higher LOCs for a given degree of severity or functional impairment, when compared with adults.

Although most youth do not develop classic physical dependence, physical deterioration, or well-defined withdrawal symptoms as is common for adults who have longer durations of substance use, youth may be more susceptible to the functional impact of SUDs. For youth, casual substance use can quickly escalate to highly problematic use. Subsequently, youth often exhibit higher rates of CODs, such as anxiety and depression, because of the negative impact that substance use has on normal youth social and psychological development.

Care planning needs to begin with a comprehensive assessment based on the ASAM criteria or, for youth receiving Early Intervention services, with a Youth and Young Adult Screener. The assessment includes all dimensions and biopsychosocial components of the complete adult assessment, the nuances of the youth experience, and the youth's unique needs and developmental issues. Strengths and weaknesses need to be identified, and youth need to be involved in setting their treatment objectives. Comprehensive youth assessments include information obtained from family and, when appropriate releases are obtained, from community members important to the youth client, such as school counselors, peers, and mentors. The support of family members is important for a youth's recovery, and research has shown improved outcomes for interventions that seek to strengthen family relationships by improving communication and improving family members' ability to support abstinence from drugs.

During treatment, it is important to address the youth's broader life needs, such as medical, psychological, and social well-being, as well as housing, school, transportation, legal services, cultural and ethnic factors, and any special physical or behavioral issues. Flexibility in treatment schedules, such as offering weekend and evening hours, helps accommodate ongoing school and social activities, thereby supporting treatment success.

Behavioral therapies, delivered by trained counselors and clinicians within their scope of practice, need to be employed to help youth clients strengthen their motivation to change. Effective psychosocial interventions may provide incentives for abstinence, build skills to resist and refuse substances and deal with triggers or cravings, replace drug use with constructive and rewarding activities, improve problem-solving skills, and facilitate better interpersonal relationships.

Addiction medications for youth should be considered and used when deemed clinically appropriate by a licensed prescribing clinician. Research and clinical experience have not identified any age-specific safety concerns for addiction medications, and all treatment options should be considered for clients of all ages.

The ASAM LOC criteria for youth differ from those for adults, as they are specifically designed to address the unique needs of younger individuals. Generally, the ASAM criteria assign youth to more intensive LOC than adults.

Youth treatment services should occur in a clinically appropriate and comfortable setting for this population. The environment should be physically separate from that of adult clients. Staff also need to be familiar with and appropriately trained to address the developmental nuances of caring for this unique population. Programming activities and treatment services for youth need to be in alignment with DHCS's most current version of the [DHCS's Adolescent Substance Use Disorder Best Practices Guide \(October 2020\)](#).

Similar to other groups, treatment of the youth population is regarded as a dynamic, longitudinal process that is consistent with the chronic disease model of addiction. As such, effective treatment is expected to continue into adulthood, with a gradual transition to adult SUD services.

Youth clients should be referred to a qualified youth OP provider agency where they will receive a full assessment and referral to an appropriate LOC, as necessary. If the individual initially presents at an SUD treatment provider that does not offer the appropriate provisional LOC, that agency will identify alternate referral options and assist the individual in connecting with the selected agency, or the individual may elect to remain with the initial provider if clinically appropriate. All Medi-Cal eligible members will be referred to and/or served by a DMC-certified agency for DMC-reimbursable services.

Youth ages 12-17 may consent to their own treatment services. The [Medi-Cal Minor Consent Program](#) is available for youth. Youth ages 11 and under may enroll in treatment services with the consent of their parent or guardian.

Youth-friendly Spaces and Engagement

Provider sites serving youth must maintain an environment that promotes engagement and supports developmentally appropriate service delivery. Physical spaces need to be designed to foster comfort, participation, and a sense of safety for youth clients. At a minimum, providers must ensure that service environments include:

- Comfortable seating;
- Clean, safe, and well-maintained facilities; **and**
- Adequate lighting and age-appropriate décor contribute to a welcoming and supportive atmosphere.

Providers also need to ensure that spaces are conducive to engagement and allow for a range of recreational activities. This may include designated areas where youth can complete schoolwork, participate in wellness activities, and engage in skill-building activities while on-site.

In addition, providers must offer a variety of engagement opportunities that are responsive to the diverse needs and interests of youth. Activities need to be age-appropriate, culturally responsive, and designed to promote creativity, independence, social interaction, and emotional well-being. These activities may include arts and crafts (e.g., drawing, painting), interactive games (e.g., board games, team-building activities), reading and literacy activities, music and creative expression, etc.

Providers need to incorporate youth feedback when developing and maintaining these spaces and activities to ensure they remain relevant, engaging, and responsive to client needs.

Building Relationship, Inspiring Development, and Growing Engagement Program

Family involvement in SUD treatment services provides youth with the greatest chance for long-term recovery from the harmful effects of substance use and/or misuse. The Building Relationship, Inspiring Development, and Growing Engagement (BRIDGE) program is aimed at enhancing youth treatment providers' capacity to deliver supportive services for parents, caregivers, and families of Youth (age 17 and under) who are receiving SUD treatment services, including youth with complex needs, juvenile justice-involved youth, and those released from detention or secured facilities.

To strengthen services for parents and caregivers, SAPC will fund a BRIDGE Family Support Specialist (BFSS) position dedicated to enhancing family-focused support for youth in SUD treatment. The BFSS will coordinate and deliver services for parents and caregivers, including one-on-one consultations to help them navigate the treatment process, educational sessions, family support groups, and programs that promote positive family relationships to support youth in recovery.

The BFSS role may be filled by an LPHA, a license-eligible LPHA, a Certified Peer, a Registered SUD Counselor, or a Certified SUD Counselor. Candidates need to have at least one (1) year of experience providing and/or coordinating family supportive services to youth and/or families.

The BFSS will collaborate with the SUD treatment team to develop, implement, coordinate, and integrate family-supportive services for parents and caregivers of youth seeking or receiving SUD services. For a list of services provided under this program and for additional information, see [SAPC IN 24-06](#).

Note: The BRIDGE program is effective October 1, 2024, and will renew each subsequent FY contingent upon the availability of funds and the program's success in achieving its goals and objectives.

Juvenile Justice Referrals in the Community

- LAC-Probation's Prospective Authorization and Utilization Review Unit (PAUR) serves as the centralized unit for reviewing and authorizing JJCPA referrals to youth providers, including those from school-based and other LAC-Probation Officers.
- Within five (5) business days of receiving a referral, the youth provider agency must notify PAUR of family contact via email and the CBO tracking system. If needed, requests for an extension can be submitted via email to PAUR.
- After the first in-person (intake) session, return the referral form with the "Agency Response" section completed (including the start date) to PAUR. If an intake appointment is rescheduled, hold the referral until the intake is complete. If reasonable attempts to schedule an intake are made, including contacting the referring DPO, and the family is unresponsive, please note in the JJCPA tracking system within one (1) business day of the missed or rescheduled appointment.
- If the service is incomplete, return the referral form to PAUR with the Did Not Complete (DNC) date and reason.
- Upon discharge and service completion, return the referral form to PAUR with the completion date to SAPC by the 10th of the month following the reporting month. All JJCPA admissions must also be entered in CalOMS/LACPRS.

Young Adult and Transitional Age Youth Population

In this document, “Young Adult” refers to individuals aged 18 to 20, and Transitional Age Youth (TAY) refers to individuals aged 16 to 25. This group includes young people transitioning into adulthood, some of whom may have received services through the youth system and may now need continued support from the adult system.

Age definitions should be applied flexibly, as developmental maturity does not always align with chronological age. This population presents unique challenges because they are often too old for youth services but may not yet be ready for adult services. Young adults are navigating independence while still depending on their parents or caregivers, which creates complexities around confidentiality, financial support, and shared living arrangements.

Optimal Treatment of the Young Adult Population

The treatment needs of young adults are typically more intensive than those of the average adult but less intensive than those of most youth. Addressing these needs often requires blending elements of youth and adult treatment programs. Ideally, this care would be provided within programs that have specific experience and expertise working with young adults. Treatment approaches should be flexible and adapted to each individual, taking into account their history with the treatment system and their unique clinical needs.

For young adults who previously received services through the youth system of care for substance use or other health-related issues, it is important to coordinate with their prior providers to determine the most appropriate treatment strategy. Early responses to treatment interventions should help shape and guide future care, with the understanding that the treatment approach must remain adaptable as young adults continue their transition into adulthood.

Multidimensional assessments identify each individual's developmental stage and help determine whether a youth-based, adult-based, or blended treatment approach is most appropriate. Treatment planning needs to be individualized, considering the young adult and TAY strengths, goals, and needs. Young adults and TAY need to be involved in their own care planning. Once the appropriate authorizations are obtained, family involvement should be incorporated into the information-gathering and treatment process. Care planning begins with the ASAM full assessment or, for young adults receiving Early Intervention Services, the ASAM Screener for Youth and Young Adults.

Similar to youth, young adults often have broader life needs that must be addressed to support positive outcomes. These needs may relate to medical, psychological, and social well-being, as well as housing, education, transportation, legal services, cultural and ethnic factors, and any special physical or behavioral issues.

Behavioral therapies and addiction medications need to be offered based on clinical need and delivered by trained counselors and clinicians practicing within their scope of practice. As outlined in the [Medication for Addiction Treatment](#) section, there are various medications used for addictions that have been FDA-approved for individuals over the age of 18 (and some for those over the age of 16) and need to be offered to young

adults as part of a comprehensive treatment plan that includes psychosocial support. Effective psychosocial interventions may support abstinence, increase motivation for change and recovery, build skills to resist and refuse substances, help manage triggers and cravings, encourage constructive and rewarding activities, improve problem-solving skills, and support stronger interpersonal relationships.

Staff working with the young adult and TAY populations need to be familiar with and interested in meeting their unique needs and have experience treating Youth (age 17 and under) and Adults (age 18 and over) populations to best blend necessary treatment approaches.

While the ASAM criteria do not specifically explore the specialized considerations of young adults or TAY, they recognize the possibility of establishing an intermediate developmental stage in the future. This would support the creation of individualized treatment approaches tailored to the unique strengths, needs, and vulnerabilities of this group.

Adult Programs

DPSS – General Relief

GR Referral Process

As a condition of eligibility, all adult GR applicants must undergo a pre-screening interview for SUD by their DPSS EW. If there is a reasonable suspicion of an SUD, the GR applicants need to be referred to the DPSS Mandatory Substance Use Disorder Recovery Program (MSUDRP). GR applicants with a positive SUD pre-screen are referred to:

- The CENS area office nearest to the client;
- Directly to a contracted provider agency; **or**
- SASH for a clinical screening and/or assessment.

Treatment Requirements and Care Coordination

Treatment services are administered based on medical necessity. Services may be a combination of various treatment service modalities as outlined in the [Early Intervention and Treatment Service Components](#) section.

The Treatment Progress Report (Form ABP 132) is generated by the California Statewide Automated Welfare System (CalSAWS) and mailed directly to the contracted provider agency for completion every 60 days. It is then returned to DPSS, which monitors the individual's participation. LRS resets this date to generate a new Treatment Progress Report Form.

Contracted provider agencies are required to notify DPSS of all changes in the client's status within five (5) days of the actual change, including:

- Transfers to other sites or treatment modalities
- Dropouts
- Completions

SUD provider agencies are required to notify DPSS within three (3) days of changes in the number of hours clients are in treatment using the Report of Changes form. These changes should correspond to changes in the client's Problem List (non-OTP settings) or Treatment Plan (OTP settings).

In addition, provider agencies are to contact the CENS Area office and notify their dedicated GR CENS of any GR client changes, as the CENS needs to update client data via the [CalSAWS website](#), accessed per the login instructions provided by DPSS.

Older Adults Population

As the number of older adults increases and the long-term nature of SUDs becomes clearer, treatment approaches need to adapt to meet their unique needs. While "older adults" typically refers to those over 65, some under 65 may require similar care due to cognitive decline, medical issues, or social challenges.

Specialized approaches are necessary when treating older adults. Factors such as slower metabolism, changes in brain function, use of multiple medications, and common age-related health conditions can make it difficult to recognize the effects of substance use. Retirement often reduces visible signs like work-related or social impairment. Even small amounts of alcohol or other substances may have a stronger impact on older adults compared to younger individuals. Treatment providers may misattribute symptoms to dementia, depression, or other aging-related conditions rather than substance use. Older adults may also face unique barriers to care. Limited mobility, social isolation, lack of transportation, and feelings of shame or guilt can make it harder to seek treatment. Those who serve as caregivers for spouses with complex needs may find it especially difficult to access services.

Optimal Treatment of the Older Adult Population

SAMHSA panelists recommend the following best practices when treating older adults:

- Use age-specific settings whenever possible, with treatment administered at an appropriate pace.
- Maintain a respectful, supportive, and non-confrontational approach.
- Address age- and gender-specific issues, including depression, loneliness, and loss, while building coping skills and support networks.
- Ensure staff are trained, experienced, and genuinely interested in working with older adults.

Research has demonstrated that age-specific assessment and treatment lead to better outcomes than mixed-age approaches. Assessments should be multidimensional and tailored to the physical, mental, and social needs of older adults. Treatment needs to be paced to fit each individual's cognitive and physical abilities. Program schedules and timelines should reflect the slower pace of progress often seen in older adults.

Studies have generally indicated that cognitive-behavioral techniques are generally effective for older populations, especially those focused on managing depression, grief, and loneliness. In general, confrontational therapy should be avoided. Educational treatment approaches should be tailored to the specific needs of older adults (e.g., coping strategies for loneliness and general problem-solving). Educational sessions work best when they include a clear explanation of goals, an outline of the content, and repeated exposure to

information using both visual and audio formats. Instruction should also include coping and problem-solving strategies.

Since social isolation is common among older adults, group therapy and skills to build support networks are important. Family therapy can also be helpful, but considerations of family involvement and the number of family members involved should be made to avoid overwhelming the client. Involvement of grandchildren may also hinder open discussion, as older adults might hesitate to share personal issues in front of younger relatives.

Medications, including addiction medications, should be prescribed judiciously due to age-related physiological changes. Dosages may need to be adjusted when co-occurring medical conditions are present. When used for WM, medication dosages for older adults should be adjusted to account for age-related changes in medication distribution and metabolism. Concerns or questions about medication safety in the older adult population should be directed toward appropriately trained medical professionals.

Staff working with older adults should ideally have training in aging and geriatric care. Staff need both the interest and skills to offer age-appropriate services. The most effective care comes from staff who understand the physical, emotional, social, and spiritual issues specific to older adults. Ongoing training on EBPs is essential to maintain the quality of care.

SECTION 4: CLINICAL PROCESS STANDARDS

Utilization Management Components

The UM program analyzes how the SAPC provider network delivers services and utilizes resources for eligible clients. The various responsibilities of the UM program include:

- Ensuring adherence to established DMC eligibility verification and medical necessity criteria.
- Ensuring that clinical care and ASAM LOC guidelines are followed.
- Monitoring both under- and over-utilization of services.
- Assessing the quality and appropriateness of care furnished to enrollees with special health care needs.
- Conducting clinical case reviews (prospective/concurrent/retrospective) of requests for select services.
- Authorization of select services.
- Random and retrospective monitoring of a portion of provider caseloads.
- Ongoing monitoring and analysis of provider network service utilization trends.

In summary, the purpose of the UM program is to achieve the following objectives for clients and providers:

- To assure effective and efficient utilization of facilities and services through an ongoing monitoring program designed to identify patterns in under-utilization, over-utilization, and inappropriate utilization of services across the service continuum.
- To ensure fair and consistent UM decision-making.
- To focus resources on a timely resolution of identified problems.
- To assist in promoting and maintaining the optimally achievable quality of care.
- To educate healthcare professionals on the appropriate and cost-effective use of healthcare resources.

SAPC follows Federal and State decisions and notification timeframes for UM determinations. SAPC will make every effort to complete UM determinations expeditiously, facilitating timely treatment for clients served in LA County's specialty SUD system and ensuring compliance with all requirements.

Eligibility Verification

Initial DMC eligibility verification occurs at the point of first contact between a client and the specialty SUD system and includes considerations outlined in [Table 2: Eligibility Requirements for Specialty SUD Services in LA County](#). Providers are required to confirm DMC eligibility monthly to ensure clients are actively enrolled in the DMC program. The initial DMC eligibility verification may be performed by trained support staff and/or registered or certified SUD counselors.

Medical necessity determinations will be made at the provider's site. Medical necessity determinations need to be performed by an LPHA who can render an SUD diagnosis as part of their scope of practice (see [Workforce](#) section) and need to be established regardless of the client's insurance and funding status.

Specialty SUD benefits are available to all clients who meet the DMC eligibility verification and medical necessity requirements. Legal status (e.g., parole, probation), language preference, sexual orientation, and/or identity are not barriers to accessing substance use services.

All clients eligible for specialty SUD services (e.g., clients in qualified County-funded programs/projects) will have access to the same benefit package as DMC members and will be required to follow the same eligibility and medical necessity verification processes. For additional information, see [Eligibility Verification and Member Authorizations](#) on SAPC's website.

Re-Verification Period for DMC Eligibility

- Non-OTP settings: At least every six (6) months
- OTP settings: At least every 12 months

During the re-verification process for DMC eligibility, the LPHA (who can render diagnoses as part of their scope of practice) at the provider agency will be required to justify ongoing eligibility for services by verifying DMC eligibility, submitting applicable request forms (e.g., Financial Eligibility Form; Discharge and Transfer Form, etc.), and submitting clinical documentation including current Problem List (non-OTP settings) or Treatment Plan (OTP settings), full ASAM CONTINUUM™ Assessment or Assessment Tool - Youth (Paper Version) found on the SAPC website (if client's condition has changed), Medical Necessity Justification Progress Note, and laboratory test results (if available).

Sources of information may include, but are not limited to, information from the client or responsible family member, client record, substance use providers, physical/mental health providers, etc. UM staff will use this information, along with clinical judgment, departmental policies and procedures, client needs, recommendations from providers, and characteristics of the system of care, to decide whether SUD services are provided, as needed.

If UM staff determines that DMC eligibility verification and medical necessity criteria have been met, and the proposed or provided services are deemed clinically appropriate, service authorizations will be approved, and the applying treatment provider will be notified in accordance with the notification timeframes outlined in [Table 15: Utilization Management Notification Timeframes](#).

Adverse DMC eligibility and medical necessity determinations result in the denial of reimbursement for services rendered. Denial notifications contain information including, but not limited to:

- Reason(s), including specific plan provisions and clinical judgment used.
- Any additional information needed to improve or complete the authorization.
- Descriptions of the appeal or complaint/grievance process.

Clients or providers acting on behalf of the client can review and respond to the evidence and rationale outlined in the initial denial, and may challenge denials of DMC eligibility, coverage of services, or payment for services. For additional information, see [Complaint/Grievance Process](#) and [Appeals Process](#) sections.

Table 15: Utilization Management Notification Timeframes

Review Type	Written Decision Notification
Initial Pre-Authorizations, Authorizations, and Verifications	
Initial <u>Pre-Authorization</u>: Residential Services (ASAM 3.1, 3.3, 3.5) <i>See Pre-Authorized Services section for instructions on how to submit preauthorizations.</i>	24 hours after receipt of the request for services per BHIN 24-001 .
Initial <u>Authorization</u>: Residential Services (ASAM 3.1, 3.3, 3.5)	Approvals: Within seven (7) calendar days of receipt of request. Other Decisions: See timeframes outlined in Complaint/Grievance Process and Appeals Process sections.
Initial <u>Verification</u>: Non-Residential Services (ASAM 0.5, 1.0, 2.1, 2.5, OTP, and the Recovery Incentive Program)	Approvals: Within 14 calendar days of receipt of request. Other Decisions: See timeframes outlined in Complaint/Grievance Process and Appeals Process sections.
Initial Verification: Withdrawal Management (ASAM 1.0WM, 3.2WM, 3.7WM and 4.0WM)	Approvals: Within seven (7) calendar days of receipt of request. Other Decisions: See timeframes outlined in Complaint/Grievance Process and Appeals Process sections.
Initial Authorization: RBH <i>Only for Young Adults (age 18-20) and Adults (age 21 and over)</i>	Within 14 calendar days of receipt of request.
Reauthorizations and Reverifications	
Reauthorization for ongoing Residential Services (ASAM 3.1, 3.3, 3.5)	Approvals: Within seven (7) calendar days of receipt of request. Other Decisions: See timeframes outlined in Complaint/Grievance Process and Appeals Process sections.
Reverification for Non-Residential Services (ASAM 0.5, 1.0, 2.1, 2.5, OTP, and the Recovery Incentive Program) <i>Need to submit ongoing verification requests at least 21 calendar days but no earlier than 30 days in advance of the end date of current authorization or verification.</i>	Within 14 calendar days of receipt of request.
Recovery Bridge Housing <i>Young Adults (age 18-20) and Adults (age 21 and over) may be authorized for 90 days of RBH and reauthorized for additional 90-day durations of RBH if needed, for a potential maximum stay of 360 days per calendar year, based on concurrent enrollment in non-residential treatment services.</i> <i>Need to submit residential and RBH reauthorization requests no earlier than seven (7) calendar days in advance of the end date of current authorization</i>	Within 14 calendar days of receipt of request.

Note:

- **Timeframes begin only after all required components have been submitted for SAPC's review. An authorization request is not considered complete until both medical necessity and financial eligibility documentation have been submitted in Sage PCNX.**

- *If a provider chooses to deliver services before receiving SAPC authorization, they assume the financial risk if the request is ultimately denied.*
- *SAPC may deny authorization requests that are submitted more than 30 days after the initial date of service, or after the date the client's financial eligibility was established (whichever comes later).*
- *If a client enters treatment for an authorized service but leaves AMA, the provider must still obtain SAPC authorization to be reimbursed for any services delivered during treatment. SAPC will deny reimbursement if financial eligibility is not verified, required information is missing, or medical necessity was not established according to the timeframes outlined in [Table 3: Financial Eligibility Form Process for Medi-Cal Eligible](#) before the client left AMA.*
- *SAPC conducts a financial eligibility check during the review of the Member Authorization Request. SAPC is not responsible, nor does SAPC have control over, eligibility changes in the DPSS system or the DPSS system being misaligned with the effective date on the NOA or the effective date on the CRS. These potential mismatches may result in billing denials. If you encounter a billing denial after authorization has been approved, please contact Netsmart for troubleshooting assistance and/or DPSS. Provider can bill only if the client remains eligible to receive the requested services and has an appropriate funding source. Approved authorizations do not guarantee payment for rendered services.*

QI and UM staff will review clinical cases from SUD treatment providers. The purpose of these case reviews is to establish an ongoing monitoring program to ensure appropriate, high-quality care and appropriate utilization of services across the SUD service continuum. In some instances, these reviews are related to service reimbursement, while in others, they aim to ensure the quality and appropriateness of the services provided.

Provider agencies are required to cooperate with all case reviews conducted by SAPC-QI and SAPC-UM. These reviews are independent of but complementary to SAPC contract monitoring activities.

The following methods of review are utilized by QI and UM staff:

- **Prospective Review:** A prospective review occurs prior to the delivery of the services and applies to an initial request or for services that require authorization. QI and UM staff perform a prospective review, apply pre-established medical necessity and appropriateness criteria, and render a decision to approve or deny authorization and/or reimbursement.
 - Prospective reviews provide an opportunity to ensure the efficient and appropriate provision of care and the utilization of resources, and to continually assess and improve access to and the quality of care.
 - Example of prospective review: Pre-authorization of residential services.
- **Concurrent Review:** A concurrent review evaluates the medical necessity, quality, and appropriateness of ongoing care. As previously mentioned, this review is conducted by QI and UM staff in accordance with pre-established criteria.
 - The main objectives of the concurrent review process are to ensure that care is appropriate and in accordance with generally accepted standards of practice, to continually monitor client progress, and to anticipate treatment needs and transitions that promote recovery.
 - Examples of concurrent review: authorization of RBH, initial authorization of residential services received following admission, reauthorization of ongoing residential services
- **Retrospective Review:** Retrospective reviews examine various aspects of previously provided services. These reviews provide information on the quality of verification of DMC eligibility, service authorization decisions, and other aspects related to client services. This information is used to

evaluate the quality and appropriateness of the services the provider is contracted to deliver. Open and closed cases may be identified for retrospective review through numerous mechanisms.

- Retrospective reviews provide an opportunity to identify service under- and overutilization, utilization patterns and trends, the consistency of the QI and UM review and decision-making processes, and areas for improvement.
- Example of retrospective review: random, focused chart review of services that have already been rendered to ensure fidelity to verification of DMC eligibility, medical necessity criteria, and quality of care.

The QI and UM programs use a variety of review methods during case reviews to monitor care quality and appropriateness, and to inform decisions regarding verification of DMC eligibility and coverage of services. The timely submission of Sage authorization requests by providers is essential for minimizing the potential complications and financial impact of retrospective review denials and is therefore beneficial to the submitting provider.

Timeliness of Authorization Submissions

Member authorizations and reauthorizations must be submitted via Sage within 30 calendar days of admission or of the reauthorization start date.

Five (5) exceptions to the 30-day rule – authorization submissions should be held pending the establishment of financial eligibility in the following circumstances:

- An individual who applied for Medi-Cal but has not established DMC benefits yet.
- Awaiting receipt of an OHC denial.
- Pending resolution of the Sage technical issue that prevented authorization submission (providers need to document the Sage Help Desk Ticket Number related to the technical issue).
- Pending ICT of Medi-Cal benefit.
- Authorizations for RI-CM

All SARs, including those delayed due to the establishment of financial eligibility, must adhere to Medi-Cal standards and requirements for clinical assessment timelines. Provider agency staff need to document in a progress note whether and when an authorization is submitted more than 30 days after the authorization start date, and which of the five (5) exemption criteria listed above the authorization meets.

Transitions in Care

When a client steps up or down in LOC, the Discharge and Transfer Form needs to be completed in Sage by Primary and Secondary Sage Users. To verify eligibility for SUD services, providers treating clients in non-residential LOCs need to either document that there has been no change in the client's SUD and any associated medical or mental health conditions every six (6) months in non-OTP settings and every 12 months in OTP settings or complete the documentation for verification of medical necessity for the LOC the client is receiving.

Required documentation for re-verification of medical necessity may be found in the [Checklist of Required Documentation for Utilization Management](#) on [SAPC's website](#). For information about when a new ASAM assessment is required, see ASAM Assessment Requirements for LOC Transitions on SAPC's website.

Pre-Authorized Services

Services requiring pre-authorization are those for which the treating provider agency needs to request approval before initiating treatment. In these instances, UM staff will conduct prospective reviews of care to determine the medical necessity of proposed services not yet provided, and concurrent reviews of extensions of previous authorizations, as needed. Provider agencies seeking pre-authorization of services should email SAPC.QI.UM@ph.lacounty.gov.

Authorized Services

To support prompt review of member authorizations, providers are required to submit member authorization requests, along with relevant clinical documentation, within 30 calendar days of admitting a client to a treatment or SUD-related benefit program, or within 30 calendar days of reauthorization for continued services. For a list of exemptions to the 30-day authorization submission deadline policy, see [Timeliness of Authorization Submissions](#).

Member authorizations and reauthorizations submitted 30 calendar days after the admission date or the reauthorization start date may result in partial approval due to the delayed establishment of medical necessity. In this scenario, only those services provided after medical necessity is established will be authorized for reimbursement. In addition, providers who submit member authorizations outside the 30-calendar-day requirement will be subject to partial approval for the service dates based on the authorization submission date.

SAPC-QI and SAPC-UM are notified via Sage whenever a provider submits an electronic member SAR. Member SARs from providers need to be submitted. For a list of required documents to be included with member SARs, see the [Checklist of Required Documentation for Utilization Management](#) on SAPC's website. Approval of initial member authorization requests is based on medical necessity, ASAM LOC guidelines, and generally accepted standards of clinical practice. Consideration for ongoing authorization is based on the same criteria, as well as documented progress and engagement in treatment. For services that require authorization, notifications will occur within the review timeframes specified in [Table 15: Utilization Management Notification Timeframes](#).

If a determination cannot be made due to insufficient documentation, SAPC-QI and/or SAPC-UM will notify the provider and offer the provider an opportunity to submit additional information to continue the authorization review accurately and, if appropriate, before issuing an authorization denial. If SAPC-QI and/or SAPC-UM determine that the proposed and provided services are necessary, appropriate, and in accordance with standards of clinical practice outlined in the clinical service standard of this Provider Manual, the authorization will be approved. Reimbursements for services will be retroactive to the authorization start date if all required documentation and authorization submissions are complete and submitted in a timely manner.

Denials of authorization will result in denial of reimbursement for services, and the requesting treatment provider will be notified of the denial decision within the timeframes outlined in [Table 15: Utilization Management Notification Timeframes](#).

Denial notifications will include, but will not be limited to:

- The action SAPC has taken or intends to take.
- The reasons for the action.
- The client's or the provider's right to file an appeal or complaint/grievance.
- The client's right to a State Hearing.
- The procedures for exercising the client's rights.
- The circumstances under which expedited resolution is available and how to request it.

Table 16: Residential Authorization and Reauthorization Service Limits

	Youth (age 17 and under)	Young Adults (age 18-20)	Adults (age 21 and over)	Justice-Involved Adults	Pregnant and Perinatal Adults
Initial Residential Authorizations	Initial authorization of 30 calendar days	Initial authorization of 60 calendar days			
Residential Reauthorizations	Reauthorizations required every 30 calendar days, based on medical necessity				
Initial and Reauthorization Outpatient	End of the 6th month, or in case of initial authorization with existing eligibility verification align with eligibility verification if more than 30 days are left from authorization start date				
Initial and Reauthorization OTP	See MAT Services for Youth (age 17 and under) section.	End of the 12th month, or in case of initial authorization with existing eligibility verification, align with eligibility verification if more than 30 days left from the authorization start date.			
Initial and Reauthorization RBH	N/A	90 calendar days, or clients whose authorizations exceed 360 days in a 365-day period (from clients' first RBH entry) authorizations will align with maximum allowable days.			
DMC Service Limits	DMC service limits are determined by an LPHA, based on medical necessity, and align with EPSDT requirements	DMC service limits are determined by an LPHA, based on medical necessity. Limits on the residential length of stay have been removed.	DMC reimbursable residential length of stay is based on medical necessity. Extensions may be granted based on the clients' continued medical necessity for residential services and take legal requirements into consideration.	DMC reimbursable PPW residential length of stay extends from pregnancy through 365 days postpartum period based on medical necessity for perinatal clients receiving services at contracted PPW sites.	

Residential Treatment

Residential services require authorization before reimbursement can be made. This authorization is required for ALL clients needing residential treatment, with the following considerations:

- Provider agencies need to submit a member authorization request to SAPC-QI and SAPC-UM, who conduct a review and then respond with approval, denial, or a request for additional documentation, in accordance with the notification timeframes outlined in [Table 15: Utilization Management Notification Timeframes](#).
- Authorization will only be reviewed when all required elements are received.
- Requests that are missing required documents or are incomplete will result in a reset of the authorization review time and may be denied due to insufficient information if requested materials are not provided in a timely manner.
- If relapse risk is deemed to be significant without immediate placement in residential care, a residential treatment provider may admit an individual prior to receiving an approved residential authorization. However, the provider assumes financial risk if the request is later denied for lack of medical necessity. If approved, reimbursement will be retroactive to the earliest eligible date. For example, a residential provider agency may choose to assume the financial risk of admitting residential cases over the weekend, knowing that SAPC-QI and SAPC-UM will render an authorization decision within seven (7) calendar days of receiving the completed request.
- Requests to continue residential services must be submitted at least seven (7) calendar days in advance of the end date of the current authorization.
- Authorizations are required when initiating residential care, transitioning from a lower to a higher level of residential care (e.g., ASAM LOC 3.1 to 3.5), transitioning from non-residential to residential LOCs, or transitioning from one residential location to another.
- For additional information regarding residential lengths of stay, see [Table 16: Residential Authorization and Reauthorization Service Limits](#).

Youth (age 17 and under)

- Youth (as defined by EPSDT) – In general, youth clients typically require shorter lengths of residential stay than adult clients and should be stabilized and then moved down to a less intensive LOC. However, care should be individualized to the client's needs. While youth typically require shorter lengths of stay in residential settings than adults, it is also true that they require more external assistance and support and, at times, more intensive treatment and/or higher LOCs. Higher service intensity and longer service duration are not necessarily correlated.
 - Residential authorizations for youth are approved every 30 days.
 - Parental/guardian consent is required for services delivered to youth under the age of 12.

Young Adults (age 18-20) and Adults (age 21 and over)

- Residential reauthorizations beyond the initial 60 calendar days will occur every 30 calendar days, with extensions granted based on medical necessity.
 - Justice-Involved Individuals
 - Clients with in-custody status participating in the START – Community program can serve the final 90 days of their in-custody sentence in a community residential SUD treatment facility while wearing a GPS ankle monitor. START– Community clients may

be authorized for 90 calendar days of residential SUD treatment (ASAM 3.1, 3.3, or 3.5) if providers include documentation from LASD or CEN that identifies the client as a START – Community client.

○ PEH

- PEH at the time of admission to residential treatment are at increased risk of returning to problem substance use if they do not have a place to stay following discharge. Providers should establish a housing plan for PEH during the client's residential admission to ensure the client is discharged with a place to stay. SAPC recognizes that successful housing plans are more feasible for clients who complete residential treatment than for clients who leave AMA.
- SAPC considerations for approval of reauthorization requests for continued residential services for PEH include the following:
 - The client's homelessness status is appropriately documented in CalOMS, on a current Problem List finalized/signed by an LPHA (required every 30 days), and documented within the clinical record.
 - The client agrees to ongoing residential services and treatment.
 - The provider has documented their efforts to establish a post-discharge housing plan for the client.
 - The above is documented in a Progress Note submitted alongside the request for residential LOC reauthorization.
- To meet the “chronic homelessness” definition, an individual needs to be living in a place not meant for human habitation for at least 12 months continuously or on at least four (4) separate occasions in the last three (3) years, totaling 12 months of homelessness. If an individual resides in an institutional care facility, such as an SUD residential treatment facility, for more than 90 days, they will no longer meet the designation for chronic homelessness even if they were homeless prior to entering the facility. This is important to keep in mind when applying for residential treatment reauthorizations and identifying available and appropriate housing placements during discharge planning, as certain PEH resources require the chronically homeless status.
- For a list of required documents to be included with member authorization requests, see the [Checklist of Required Documentation for Utilization Management](#) on SAPC's website.
- Given the fluid nature of clinical progression, the Problem List and Progress Notes are expected to reflect progress regularly during residential treatment, as clinically warranted. Additionally, it is anticipated that certain clients will not require the full period of authorized residential services. In these instances, clients need to be transitioned to a lower LOC as soon as clinically indicated. Providers are required to update problem lists every 30 days to facilitate accurate UM authorization reviews and ensure that clients receive care in the least restrictive, clinically appropriate setting.
- If, upon clinical review, a residential treatment case is determined to be unnecessary based on the aforementioned considerations, the provider may receive a recommendation to consider an alternative LOC. UM staff will have the authority to terminate/modify the current authorization, deny ongoing reimbursement for residential services, and recommend a transition to an appropriate lower LOC. In these instances, reimbursement for previously approved residential services will be maintained, but future reimbursement for the identified episode will be denied.
- SUD treatment providers will be responsible for ensuring successful Care Coordination during all LOC transitions.

- Providers will be required to notify UM staff of residential discharges by submitting a completed Discharge and Transfer Form within 24 hours.

Authorized services require approval from SAPC but do not require authorization prior to being provided. In these instances, UM staff will perform concurrent reviews of care and, when pertinent, extensions of previous authorizations. The provider must notify UM staff of the recommended services within 30 calendar days to begin the authorization review process. Any authorization request may be denied due to untimely submission.

Campus-Like Setting Facilities

Providers identified and approved by SAPC as operating campus-like settings should request member authorizations for the client in the usual and customary manner. These authorizations will also be reviewed and processed by SAPC-UM in the usual and customary manner.

Once these authorizations are approved by SAPC UM, **the specific location will be automatically removed from the approved authorization**, which will enable any of the campus programs to submit claims under those authorizations. Any pending or denied authorizations will still show a location.

Important: Only campus programs that are licensed and contracted to provide services at the approved LOC will have those claims approved. If a program submits a service that they are not licensed or contracted to provide, the claim will be denied with a reason code of "Procedure not on fee schedule".

RBH Authorizations

- If RBH is determined to be appropriate, RBH provider agencies need to submit a member authorization request. For a list of required documents to be included with member authorization requests, see the [Checklist of Required Documentation for Utilization Management](#) on SAPC's website.
- Referring OP provider agencies need to document the need for RBH in the client's Problem List (non-OTP settings) or Treatment Plan (OTP settings).
- Young Adults (age 18-20) and Adults (age 21 and over) are eligible for RBH services if the following criteria are met: they are homeless and currently enrolled in OP services (e.g., ASAM 1.0, ASAM 2.1, OTP). RBH is authorized in 90-day increments. For additional details, see [Recovery Bridge Housing](#) section. Clients do not need to use these days continuously.
- SAPC will not reimburse providers for RBH if the criteria are not met and/or the client is no longer concurrently enrolled in OP services. RS does not meet the RBH criteria and will render the client ineligible for RBH.

Sage Outage Procedure

Although every effort will be made to perform maintenance during low-activity periods, unforeseen circumstances may make the system unavailable. Effective communication, planning, and training for these events through written processes and staff preparations can mitigate the impact on the organization, staff, clients, and the ability to provide or receive treatment.

In the event of a planned outage, providers will receive a notice from SAPC.

If you are experiencing technical issues and are unable to chart in real time, contact the Netsmart Help Desk. If this is impacting the submission of required documentation for a SAR, please note the Help Desk ticket number in the SAR as a comment.

To prepare for such events, SUD provider agencies need to maintain the following blank documents in hard copies or other formats to document services that would not be impacted by their inability to access Sage:

- Current Client Roster
- ASAM Assessment Tool or ASAM Screener for Youth and Young Adults
- Care Plan Template
- Problem List Template
- Progress Note Template
- Discharge and Transfer Form Template (for all LOCs)
- Recovery Bridge Housing Discharge Form
- Billing-related documents
- All required consents
- Admission/Discharge Forms
- Any other documents required by the County or the organization

Approved forms are available on [SAPC's Manuals, Bulletins, and Forms – Clinical Tab webpage](#).

Once the Sage outage is resolved, the above forms should be uploaded as attachments via Provider File Attach in Sage. Documents should be labeled according to the [Standardized Naming Convention](#).

Workforce

Health systems are increasingly adopting a chronic disease and public health approach to SUD care, necessitating a diverse, skilled, and well-trained workforce. SAPC values the contributions of contract providers of all sizes and capacities, recognizing that a successful SUD system must reflect the varied needs of the population it serves. Traditionally staffed primarily by SUD counselors, the specialty SUD system now includes a broader range of disciplines. Increasing the diversification of the SUD workforce is crucial. This diversification is particularly important for meeting the requirements for diagnosing LPHAs to verify medical necessity and eligibility for DMC services, as well as for signing Problem Lists (non-OTP settings) or Treatment Plans (OTP settings). A robust workforce in SUD treatment requires not only proper provider credentials but also comprehensive training to meet the needs of a diverse population. Professional development should include mandatory trainings and CEs on ASAM criteria and EBPs for clinical staff. For additional information, see [Evidence-Based Practices](#) section.

Providers should develop a business plan with a clear hiring and training strategy to ensure their staff have the necessary background and skills to deliver high-quality SUD services. Additionally, DHCS has specified the types of providers qualified to deliver each DMC-ODS service under the [CalAIM 1115 Demonstration & 1915\(b\) Waiver](#), California State Plan, and [SPA 23-0026](#).

Recommended Responsibilities for Medical Directors and Physicians

- Provide MAT
- Provide WM
- Provide clinical supervision for staff
- Refer/treat co-occurring physical and mental health conditions
- Assist other professional staff with challenging cases
- Lead QI functions/projects
- Conduct clinical trainings on issues relevant to professional staff
- Provide physical exams, when necessary

Clinicians in SAPC's network who prescribe medications (MDs, DOs, APRNs, PAs, RNs) should practice at the highest level of their license and receive adequate training in addiction medications to enhance client access to this essential SUD treatment component.

Medical Director

Each SUD treatment site needs to have a DMC Medical Director approved by DHCS through [Form 6010](#). The State contract requires an agreement with the Medical Director that includes:

- Ensure that medical care provided meets the appropriate standard of care and is not influenced by fiscal considerations;
- Duties and responsibilities, and state that these duties may not be delegated to non-physician staff;
- Develop and implement medical policies and standards;
- Lines of supervision; **and**
- Education, training, work experience, and other qualifications for the position.

An agreement and Code of Conduct for the Medical Director need to be clearly documented, signed, and dated by a provider representative and the physician. The Medical Director or their designated physician must be on-site for **a minimum of two (2) hours per month**. If a physician cannot meet this requirement, the provider agency must develop a plan or identify an on-call physician to comply with this contractual obligation. Provider agencies should determine the most effective approach to meet this requirement while addressing their specific needs. For instance, agencies may establish agreements with other SUD providers to address gaps as needed.

Given their advanced education and training, it is beneficial to employ staff at the highest level of their licensure and expertise. Medical Directors at SUD provider agencies should ideally undertake responsibilities that cannot be performed as effectively by other staff members (e.g., different types of LPHAs) within the agency.

Minimum expectations of Medical Directors of treatment sites within the specialty SUD system:

- Comply with clinical standards of best practice, licensing, accreditation standards, and other Federal/State/local regulatory and reporting requirements. Interpret and support the agency's standards of care by leading the development of the agency's treatment workflows that incorporate best practices.
- Research and maintain knowledge of EBPs and updates regarding the treatment of SUDs and recovery-based services.
- Participate in SAPC-related meetings (e.g., Medical Director meetings, Provider meetings).

Recommended Responsibilities of Medical Directors

The following are recommended responsibilities for medical directors and physicians under the DMC-ODS system of care, including, but not limited to, ways to enhance their contributions to maximize their roles:

- Provide addiction medications, when clinically necessary
- Medication management of intoxication and/or withdrawal, when clinically necessary
- Provide clinical supervision for staff
- Refer/treat co-occurring physical and mental health conditions
- Assist other staff with challenging cases (e.g., refractory SUD, CODs, certain special populations)
- Lead QI functions/projects (e.g., QIPs, leading clinical team meetings, etc.)
- Conduct clinical trainings on issues relevant to professional staff (e.g., documentation, ASAM Criteria, DSM5-TR, addiction medications, co-occurring mental health conditions)
- Provide physical exams, when necessary and appropriate, at their facility

Licensed Practitioners of the Healing Arts

DHCS identifies the following professional categories as LPHAs:

- Physician (MD or DO)
- Advanced Practice Nurse (APRN)
- Physician Assistant (PA)
- Registered Nurse (RN)
- Registered Pharmacist (RP)
- Licensed Clinical Psychologist (LCP)
- Licensed Clinical Social Worker (LCSW)
- Licensed Professional Clinical Counselor (LPCC)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Vocational Nurse (LVN)
- Licensed Psychiatric Technician (LPT)
- Licensed Occupational Therapist (LOT)
- Licensed-eligible LPHA working under the supervision of licensed clinicians

LPHAs are professional staff who provide or oversee services within their scope of practice. SAPC further classifies them as Diagnosing or Non-Diagnosing LPHAs. Diagnosing LPHAs have final signatory authority on documentation requiring an LPHA signature, including the Problem List, Treatment Plan, full ASAM, and Medical Necessity Progress Notes. Other LPHA-required documentation may be completed by any LPHA, provided it falls within their scope of practice.

Table 17: Types of Licensed Practitioners of the Healing Arts

Diagnosing LPHAs	Non-Diagnosing LPHAs
Physician (MD or DO)	Registered Nurse (RN)*
Nurse Practitioner (NP)	Registered Pharmacist (RP)
Physician Assistant (PA)	Licensed Vocational Nurse (LVN)
Licensed Clinical Psychologist (LCP)	Licensed Psychiatric Technician (LPT)
Licensed Clinical Social Worker (LCSW)	Licensed Occupational Therapist (LOT)
Licensed Professional Clinical Counselor (LPCC)	
Licensed Marriage and Family Therapist (LMFT)	

***RNs may serve as the final signatory on Problem Lists; however, other non-diagnosing LPHAs may not.**

Licensed-eligible LPHAs are persons who have already earned their advanced degree (e.g., Master of Science [M.S.], Master of Arts [M.A.], Master of Social Work [MSW], Doctor of Philosophy [PhD], Doctor of Psychology [PsyD], etc.), who are properly registered with their respective state board (e.g., California Board of Behavioral Sciences [BBS], California Board of Psychology [BOP], etc.) and are authorized to practice under the license of a fully licensed practitioner with proper supervision as required by the state board with which they are registered. Providers will need to demonstrate compliance with the required supervision and oversight. Within the specialty SUD system, licensed-eligible LPHAs can fulfill the functions of independently licensed LPHAs (e.g., finalize ASAM assessments, make diagnoses²³ (aligned with the scope of practice for making diagnoses as regulated by the relevant licensing board), and sign Problem Lists (non-OTP settings) or Treatment Plans (OTP settings).

Clinical Trainees

Previously referred to as students, interns, or trainees, Clinical Trainees are now credentialed under state plan amendment [SPA 23-0026](#) to provide billable services under DMC-ODS. Additionally, [AB 1860](#) and [BHIN 23-008](#) exempt graduate student trainees from registration or certification requirements as SUD counselors for the purpose of providing reimbursable services. According to [AB 1860](#):

- A graduate student providing counseling services in an AOD program needs to:
 - Be enrolled as a university graduate student in psychology, social work, marriage and family therapy, or counseling.
 - Be completing their supervised practicum hours to meet graduate school requirements; and
 - Provide proof of enrollment as a graduate student in the AOD program on an annual basis.
- A graduate student who is no longer enrolled in a university program identified above needs to notify the AOD program in writing of their withdrawal within one (1) working day. An AOD program needs to immediately remove the former graduate student from providing counseling services.

A Clinical Trainee is an unlicensed individual currently enrolled in an educational/training program or a post-secondary educational program in California that is required to obtain licensure as a Licensed Mental Health Professional or LPHA. This person is involved in a practicum, clerkship, or internship approved by their

²³ Per DHCS, although LVNs, LPTs, LOTs, RNs and RPs are classified as LPHAs, they are not allowed to diagnose.

educational program and meets all relevant program and licensing board requirements to participate in these activities. Clinical Trainees provide rehabilitative mental health or SUD treatment services, including fulfilling coursework and supervised practice requirements. However, they are not authorized to perform administrative duties reserved for LPHAs, such as signing off on Problem Lists (non-OTP settings), Treatment Plans (OTP settings), or finalizing ASAM assessments. They are, however, permitted to deliver clinical services within the scope outlined in the most current version of the SAPC IN for the Rates Matrix and [BHIN 24-023 Standards for Specific Behavioral Health Provider Types and Services; Amends Relevant Sections Within Title 9 and Title 22 of the California CCR](#).

Clinical Trainees, as determined by DHCS, include the following:

- Nurse Practitioner Clinical Trainee
- Clinical Social Worker Clinical Trainee
- Marriage and Family Therapist Clinical Trainee
- Medical Student in Clerkship (Physician Clinical Trainee)
- Occupational Therapist Clinical Trainee
- Pharmacist Clinical Trainee
- Physician Assistant Clinical Trainee
- Professional Clinical Counselor Clinical Trainee
- Psychiatric Technician Clinical Trainee
- Psychologist Clinical Trainee
- Registered Nurse Clinical Trainee
- Vocational Nurse Clinical Trainee

Retroactive to July 1, 2023, Clinical Trainees can submit claims for services provided on or after this date. Claims for Clinical Trainee services will be reimbursed at the same rate as the licensed supervisor's discipline rate. Clinical trainees still need to be credentialed within the Sage system. Provider agencies need to notify the Sage Helpdesk of the primary supervisor's name, National Provider Identification Number (NPI), and credentials to configure the information in Sage during the credentialing process. The supervisor's NPI need to be active as it will be validated against the National Plan and Provider Enumeration System (NPPES) and need to be included on the claim to DMC. Claims need to include the taxonomy code for their discipline and the appropriate provider type modifier.

The sponsoring provider agency provides adequate clinical supervision and oversight of the trainees' clinical activities. These trainee providers are required to have co-signatures on all of their clinical documentation and receive weekly supervision at a minimum. This supervision requirement consists of one (1) hour of individual supervision or two (2) hours of group supervision for every 10 hours of direct clinical service provided by the clinical students, interns, or trainees.

Note: Clinical trainees cannot perform the duties of an LPHA (e.g., sign-off on a Problem List (non-OTP settings) or Treatment Plan (OTP settings) or ASAM assessment).

Certified Peers

Certified Peers provide non-clinical, recovery-oriented, culturally appropriate services that promote engagement, socialization, self-sufficiency, self-advocacy, natural supports, and are trauma-aware. Certification under this policy is designed for individuals who are 18 years of age or older and self-identify as having lived experience with the process of recovering from mental illness, SUD, or both. This includes individuals who have either received these services themselves or are parents or family members of clients. To be certified practitioners in California, peers need to master the [17 Core Competencies](#) and adhere to the [Code of Ethics for Certified Medi-Cal Peer Support Specialists](#).

Once a candidate successfully completes all the requirements outlined in the Medi-Cal Peer Support Specialist Certification Program, they will be awarded a certificate. Their certification number is publicly available via the [CalMHSA Medi-Cal Peer Support Specialist Certification Registry](#). Certified Peers are required to maintain active certification to provide DMC-ODS-reimbursable PSS. Certifications are valid for two (2) years from the issue date.

For additional information regarding the Medi-Cal Peer Support Specialist Certification Program, see [BHIN 21-041](#) or see [CalMHSA's Medi-Cal Peer Support Specialist Certification Program website](#).

Certification Renewal

To maintain certification, Certified Peers need to renew their certification every two (2) years. If a certification is not renewed by its expiration date, it is considered expired. State standards mandate that applicants fulfill renewal requirements, which include completing 20 hours of CE. This education needs to include six (6) hours of law and ethics training. For a comprehensive list of the renewal certification requirements, see [CalMHSA's Guidelines, Standards, and Procedures Manual](#).

Once these requirements are met, applicants can submit a renewal application and pay associated fees. It is important to note that renewal applications can only be submitted up to 90 days prior to the expiration date. Any applications submitted after the certification has expired will incur additional fees and may cause delays in the renewal process. For additional information, see [CalMHSA's Certification Renewal and Continuing Education webpage](#).

If an individual's certification lapses within four (4) years of the certification renewal due date, the individual must meet all Certified Peer Requirements, complete 40 hours of training, and pass the certification exam to reinstate certification. Applicants with a certification that lapsed more than four (4) years from the date the renewal was due do not qualify for recertification. If these applicants are interested in recertification, they need to reapply for initial certification.

Supervision of Certified Peers

Supervision is a crucial component in delivering high-quality behavioral health services, professional development, and overall support. As outlined in [BHIN 22-018](#), a supervisor needs to meet applicable California state requirements, including completing the Medi-Cal Peer Support Specialist Supervisor Training within 60 days of beginning supervision of Certified Peers.

As with all SUD services, PSS needs to be provided as a component of the individualized Plan of Care developed by an LPHA for each client. While the LPHA, directing services per an individualized Plan of Care, assumes overall responsibility for the PSS provided to each client, the LPHA is not required to be present at the time of service delivery. The direct supervisors of Certified Peers do not need to be LPHAs. Using Certified Peers as supervisors is highly encouraged. Opportunities for career advancement are important as the Certified Peer workforce is established.

Certified Peers must provide services under the direction and supervision of an individual who meets at least one (1) of the following qualifications:

- Have a Medi-Cal Peer Support Specialist Certification, two (2) years of experience working in the behavioral health system, and completed an approved supervisory training; **or**
- Be a non-peer behavioral health professional (including registered and certified SUD counselor), have two (2) years of experience working in the behavioral health system, and have completed an approved supervisory training; **or**
- Have a high school diploma or GED, four (4) years of behavioral health direct service experience that may include PSS, and completed an approved supervisory training.

In accordance with the State of California licensure requirements and as listed in the California Medicaid State Plan as a qualified DMC-ODS provider, LPHAs must be licensed, waived, certified, or registered.

For additional guidance regarding Certified Peer Supervisor standards, see [BHIN 21-041](#). For additional information on the Medi-Cal Peer Support Specialist Supervisor Training, see [Training for Supervisors](#) section below.

Training for Certified Peer Supervisors

CalMHSA offers the [Medi-Cal Peer Support Specialist Supervisor Training](#) at no cost. The one (1) hour training is based on Substance Abuse and Mental Health Services Administration's (SAMHSA) best practices for supervising peer support specialists. Objectives include identifying supervisor qualifications, understanding peer work principles and competencies, modeling recovery-oriented supervision, and accessing resources to improve supervisory skills. CalMHSA accepts the certificate of completion towards the Continuing Education (CE) requirements for Medi-Cal Peer Support Specialist Certification renewal. **Certified Peer Supervisors must submit certificates to SAPC-SOC at SAPC-SOC@ph.lacounty.gov.**

Resources to Support the Integration of Certified Peers in SUD Treatment

As Certified Peers enter the workforce, it is important to understand how these services can enrich substance use treatment. SAPC-CST developed the "Enriching Substance Use Treatment with Certified Medi-Cal Peer Support Specialist Services" training to help provider agencies deepen their understanding of Certified Peer roles. For available trainings, see the [SAPC Trainings and Events webpage](#) on SAPC's website and refer to the training calendar to register for upcoming sessions.

CalMHSA provides [Best Practice Guidelines for Employing Certified Medi-Cal Peer Support Specialists](#). These guidelines offer valuable insights and recommendations to help organizations optimize their integration of Certified Peers and enhance the quality of care they provide.

For additional information and resources, see [SAPC's Certified Medi-Cal Peer Support Specialist webpage](#). If you have any questions or need additional support, email SAPC-SOC at SAPC-SOC@ph.lacounty.gov.

Community Health Workers

Community health workers (CHWs) provide tailored preventive services to members with SUDs and/or other behavioral health needs. CHWs must have lived experience that aligns with and enables meaningful connection to the individuals and communities they serve. CHWs' services include, but are not limited to, the following:

- Health education
 - Providing education to promote the member's health or address barriers to physical and behavioral health care, including providing information or instruction on health topics. Health education must be consistent with established or recognized health care standards and may include coaching and goal setting to support improved health outcomes and self-management of health conditions.
- Health navigation
 - Providing information, training, referrals, or support to assist members in:
 - Accessing health care services, understanding the health care system, and engaging in their own care.
 - Connecting to community resources that promote health and address barriers to care, including support with transportation, translation/interpretation services, and other health-related social needs.
- Screening and assessment
 - Conducting screenings and assessments to identify member needs for services.
- Individual support or advocacy
 - Providing support and advocacy to assist members in preventing health conditions, injury, or violence and promoting overall well-being.

CHW services must be delivered by practitioners who meet the following qualifications:

- Possess lived experience that aligns with and connects them to the community being served.
- Meet minimum qualification standards through either the Certificate Pathway and/or Work Experience Pathway, as defined in the [CA DHCS CHW Provider Requirements](#).
- Complete a minimum of six (6) hours of CEs annually.

Minimum Staffing Requirements

Professional staff must be licensed, registered, certified, or recognized under California's scope-of-practice statutes. Professional staff need to provide services within their discipline's scope of practice and receive the supervision required under their respective scope-of-practice laws.

Registered and Certified SUD counselors must comply with all requirements in [CCR Title 9, Division 4, Chapter 8](#), and [California HSC § 11833](#), as amended by Assembly Bill 2473. Counselors need to be registered with or certified by one of the National Commission for Certifying Agencies (NCCA) accredited organizations recognized by DHCS: Addiction Counselor Certification Board of California (ACCBC) – which is affiliated with

California Association of DUI Treatment Programs (CADTP); California Association for Alcohol and Drug Educators (CAADE); and CCAPP.

To be able to conduct contracted treatment services, Registered SUD counselors need to:

- Complete the State-required ASAM A and ASAM B trainings prior to delivering DMC-reimbursable treatment services. The only exception to this requirement is Certified Peers, who are only required to complete their certification as PSS providers and complete ASAM A;
- Complete training on CBT, MI, clinical documentation, and Treatment Planning either through a qualified Continuing Education Unit (CEU) agency such as SAPC-CST, UCLA-ISAP, and CIBHS, or a qualified trainer funded by a provider agency or through their training program;
- Complete annual education hours required to renew registration credential on topics in [CCR, Title 9, Section 13040, subdivisions \(a\)\(1\) through \(5\)](#) or any core competency education requirements in [BHIN No: 25-029](#) in a CAADE, CCAPP, or CADTP-approved SUD education program. Registered counselors who have completed fewer than 315 hours of AOD education must complete a minimum of 50 education hours annually. Registered counselors who have completed 315 hours must complete 20 education hours annually.
- Complete all education requirements per Assembly Bill 2473 Alcohol or Other Drug (AOD) Counselor Educational Requirements as described in [BHIN 25-029](#) and [California HSC § 11833](#). Counselors registered on or after January 1st, 2026, are required to complete and submit proof of eighty (80) hours of education and core competency education topics within six (6) months of their initial registration date to their accredited Certifying Agency. Counselors registered prior to July 1st, 2025, are exempt from the 80 hours of education within six (6) months; **and**
- Complete the Certification process within five (5) years.

Proof of completion needs to be documented in staff files and shared with SAPC staff upon request. Proof of completion may include letters from school administrators, certificates, and school transcripts. **If required education/training is not completed within the required timeframes, SAPC will not pay for the services and will be eligible for recoupment.**

Services in the WM setting may be provided by registered or certified SUD counselors or LPHAs, depending on the nature of the service and its scope of practice. Where noted, physician involvement in evaluating and assessing the severity of WM is required.

All counselors and clinicians (including LPHAs and licensed-eligible LPHAs), whether full-time, part-time, or on-call, have the same training requirements. The training requirements are:

- All provider staff need to be trained in the ASAM Criteria prior to providing DMC billable services; **and**
- Staff conducting ASAM assessments need to complete the two (2) training modules entitled "ASAM Multidimensional Assessment" (ASAM A) and "From Assessment to Service Planning and Level of Care" (ASAM B). *Titles for ASAM A & ASAM B (aka Module I & Module II) may vary depending on where these courses are taken.

In addition, LPHAs (including the Medical Director) need to complete a minimum of five (5) hours of CE related to addiction every renewal cycle. Registered and certified SUD counselors need to adhere to all requirements in [CCR Title 9, Division 4, Chapter 8](#).

The providing agency is responsible for ensuring that its staff is competent, capable, and appropriately credentialed to provide SUD services, including adherence to the ASAM Criteria. Similarly, staff who are unfamiliar with MI and/or CBT are unlikely to effectively utilize one (1) of these required evidence-based approaches.

As such, it is highly recommended that provider agencies ensure their staff are adequately prepared prior to providing treatment. Provider agencies can and should provide workforce development training to their agency's specialty SUD workforce. SAPC does not maintain a list of authorized trainers. Therefore, in addition to the requirements for initial trainings, provider agencies retain responsibility for all further training and development of their staff.

Provider agencies are responsible for ensuring that their staff are appropriately trained on Sage prior to being granted access to the Sage EHR system. Staff who are not trained on Sage will be unable to access the system. SAPC has developed a series of role-specific Sage training modules that are available on the [SACP-LNC Platform](#).

Provider agencies are also responsible for ensuring that their staff are appropriately trained on CalAIM requirements, including documentation requirements, initiating treatment during the assessment period, and treating clients with CODs. SAPC requires providers to send at least one (1) representative per contracted provider agency to all designated trainings.

For available SAPC trainings, including applicable CalAIM trainings, see the [SAPC Trainings and Events webpage](#) on SAPC's website and refer to the training calendar to register for upcoming sessions.

Non-professional staff, including clerical, billing, and facility management support, require appropriate on-site orientation and training prior to performing their assigned duties. Non-professional staff requires supervision by professional and/or administrative leadership. Both professional and non-professional staff are required to have appropriate experience and the necessary training at the time of hiring.

For a full list of services available by provider type, see [SAPC's Manuals, Bulletins, and Forms – Bulletins Tab webpage](#) for the most current version of the SAPC IN for the Rates Matrix. Codes with associated rates reflect services that can be provided by that provider type under DMC-ODS.

Credentialing

Credentialing is the process of verifying that all clinical staff meet the professional, educational, and regulatory standards required to provide services within the agency. This process ensures that providers are appropriately licensed, trained, and qualified to deliver care in accordance with state, federal, and program-specific requirements. Credentialing must be completed before a clinician is granted access to clinical systems and before claims for their services are sent to SAPC.

Non-clinical staff are not required to be credentialed but must be assigned an appropriate non-clinical user role (e.g., clerical, operations, audit, or financial).

It is the responsibility of the contracted provider to verify all educational requirements, privileging, and appropriate malpractice coverage, as well as license/certification verification for contracted practitioners.

Required documentation may include:

- Professional license with active status and expiration date
- ASAM Criteria – ASAM A and B or ASAM for Prescribers (only available to PAs, NPs, MDs/DO's)
- DEA registration, if applicable
- Proof of education or training (degrees, transcripts, certificates)
- Credentialing Attestation form, Community Health Workers Attestation form, and Student-Intern Attestation form
- SAPC-LNC Sage-PCNX training certificate of completion

Once documentation is submitted, the credentialing team will verify all information through primary sources, including licensing boards, certification bodies, and federal databases. Any discrepancies must be resolved before approval can be granted. Providers may be contacted to supply updated documents or clarification when needed. Credentialing approval is not final until all verifications are complete, and the provider has been formally notified.

System access is granted only after credentialing is fully approved. User roles must align with the provider's verified credentials and assigned duties. If a provider becomes credentialed after initially being onboarded as a non-clinician, their account will be updated to reflect the new role once all supporting documents are received and verified.

Providers are responsible for always maintaining active licensure and certifications. The agency is to ensure continued compliance with regulatory and contractual requirements.

Re-Credentialing

Re-credentialing is the periodic process of re-verifying a practitioner's qualifications, competency, and compliance after they have already been initially credentialed. It ensures the practitioner continues to meet all regulatory, licensing, and organizational standards. The re-credentialing process will be conducted every two (2) years or at any time that there has been a change in or loss of their credentialing status (e.g., change from Registered to Certified Counselor; Change from Associate Clinical Social Worker to Licensed Clinical Social Worker; If a licensed provider has their license suspended).

DMC requires that all reimbursable clinical services be delivered by individuals who meet licensure, certification, and scope-of-practice requirements. If a practitioner's license is expired, suspended, or otherwise invalid, none of their services can be billed. Any claims tied to services provided by an unlicensed or improperly credentialed practitioner are treated as invalid, triggering recoupment of those funds and potentially requiring the program to complete a Corrective Action Plan (CAP) to address the compliance failure.

For additional information on the credentialing and recredentialing process, or how to access Sage, see [Sage User Enrollment](#).

Personnel File Requirements

All provider agencies need to maintain a personnel file for staff funded under their SAPC service contract. All personnel files need to include, but are not limited to, the following documents:

1. Signed employment confirmation statement/duty statement
2. Job description
3. Performance evaluations
4. Health records/status as required by the provider, AOD Certification, or [CCR Title 9](#)
5. Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries)
6. Training documentation relative to SUDs and treatment (e.g., staff participation in trainings delivered or contracted through SAPC)
7. Current registration, certification, intern status, or licensure
8. Proof of Continuing Education (CEs) Unit completion, compliance with SAPC annual CE requirements, as well as compliance with licensing board or certifying agency requirements regarding CE or Continued Professional Development (CPD) (CA Board of Psychology)
9. Provider's Code of Conduct

Data Exchange & Release of Information

Data exchange and ROI are structured processes that support the appropriate, secure transfer of information between individuals, providers, entities, or information systems consistent with state and federal guidelines. These processes are key to supporting care coordination by enabling information to be shared among SUD providers, physical health providers, mental health providers, MCPs, social service organizations, and other service providers who support a client's unique needs. Care coordination relies on the principle that the appropriate and authorized sharing of health information enables providers to deliver more effective care, which leads to better health outcomes. A critical part of data exchange includes obtaining informed voluntary client consent, validating the consent, making and responding to ROI requests in a timely manner, receiving and disclosing the records for compliant requests, and tracking all authorized record disclosures. Providers are expected to make and respond to records requests as needed for Care Coordination, as well as to receive, validate, and process ROI requests for both current and former clients. Providers looking to obtain records from another provider should contact that provider directly.

SAPC's Health Information Management (SAPC-HIM) section supports the management of authorized ROI requests received by SAPC as a Specialty Behavioral Health Plan and manages data exchange initiatives with other health systems. Providers may be contacted by SAPC-HIM for records requests. If agencies receive a records request from SAPC-HIM, they are expected to provide the records within three (3) business days of receipt. Providers that fail to meet these timelines for records requests from SAPC-HIM may be subject to compliance findings, with repeat offenders being placed on a Corrective Action Plan (CAP).

For additional information about SAPC-HIM ROI requests or if you have any questions, email SAPC-HIM at SAPC-HIM@ph.lacounty.gov.

Quality Assurance – Regulations

In healthcare, quality assurance refers to activities and programs intended to improve and maintain the quality of care. Oftentimes, these activities involve ensuring compliance with regulations established by governmental and/or administrative entities. In all cases, key components of quality assurance involve:

- Assessing quality
- Identifying problems with care delivery and designing QI activities to overcome them
- Follow-up monitoring to make sure activities achieve their intended aims

In addition to the requirements outlined in this manual, all SUD treatment programs need to operate in accordance with Federal and State laws and regulations, including those identified below, as well as those outlined in BHINs and relevant SAPC All Providers Letters, INs, and Bulletins.

Confidentiality

Maintaining appropriate confidentiality is of paramount importance. All provider agencies are required by contract to establish confidentiality policies and procedures and must comply with [42 CFR Part 2](#), [HIPAA](#), and California State law regarding the confidentiality and disclosure of SUD and other medical records.

Health Insurance Portability and Accountability Act

HIPAA establishes federal standards to protect the privacy and security of individuals' medical information.

- HIPAA for Professionals: <https://www.hhs.gov/hipaa/for-professionals/index.html>
 - Summary of the HIPAA Rule: www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html
- HIPAA for Individuals: <https://www.hhs.gov/hipaa/for-individuals/index.html>

HIPAA should not be viewed as a barrier to delivering coordinated, integrated care. Provided that the appropriate client releases and/or consents for treatment are obtained, every effort should be made to share clinical information with relevant providers across the continuum of SUD care and systems of care (physical and mental health, etc.).

Under the requirements of laws and regulations governing confidentiality in the provision of health services, all providers within the specialty SUD system must cooperate with system-wide efforts to facilitate the sharing of pertinent clinical information to improve the effectiveness, integration, and quality of health services.

42 CFR Part 2 - Confidentiality of SUD Client Records

Covers all records relating to the identity, diagnosis, and/or treatment of any client in a specialty SUD program that is conducted, regulated, and/or assisted in any way by any Federal agency. On February 8, 2024, the U.S. Department of Health & Human Services (HHS) announced a final rule modifying the Confidentiality of SUD Client Records regulations at 42 CFR part 2 ("Part 2 Final Rule 2024").

- Part 2 Final Rule 2024 has a compliance date (enforcement may formally begin) of February 16, 2026. All organizations must comply by updating consent forms and required notices, revising organizational policies and procedures, and ensuring staff knowledge through training.
- For a summary of 42 CFR Part 2 Final Rule 2024 modifications, see: <https://www.hhs.gov/hipaa/for-professionals/regulatory-initiatives/fact-sheet-42-cfr-part-2-final-rule/index.html>
- Subpart A covers introduction to the statute (e.g., purpose, criminal penalty, reports of violations, etc.).
- Subpart B covers general provisions (e.g., definitions, confidentiality restrictions, minor clients, etc.).
- Subpart C covers disclosures allowed with the client's consent (e.g., consent requirements, notice and copy of consent to accompany disclosure, disclosures permitted with written consent, use and disclosures to prevent multiple enrollments, etc.).
- Subpart D covers disclosures that do not require client consent (e.g., medical emergencies, scientific research, evaluation, and audit activities, disclosures for public health).
- Subpart E includes information on court orders around disclosure (e.g., legal effects of order confidential communications, etc.).

42 CFR Part 438 – Managed Care

As a member of LA County's DMC-ODS Waiver, SAPC became a Specialty Behavioral Health Plan (BHP) responsible for overseeing the specialty SUD system. As a component of becoming a managed care entity, SAPC and its specialty SUD network need to abide by the [42 CFR Part 438](#) requirements.

The primary aim of [42 CFR Part 438](#) is to achieve delivery system and payment reforms by focusing on the following priorities:

- Network adequacy and access to care standards (e.g., timeliness of services, distance standards)
- Client/consumer protections
- Quality of care

Title 9 – Certification of Alcohol and Other Drug Counselors

CCR Title 9, a section titled Certification of Alcohol and Other Drug Counselors, provides minimum requirements for the level of credentials counseling staff must hold prior to providing services. The minimum standards are designed to ensure baseline quality and effectiveness of treatment services. The County has built on these requirements and established minimum staffing standards specific to LA County.

For additional information, see [SAPC's Manuals, Bulletins, and Forms – Bulletins Tab webpage](#) for the most current version of the Provider Staffing Guidelines.

Evidence-Based Practices

EBPs are interventions that have been shown to be effective and are supported by evidence. In LA County, although other psychosocial approaches may be used (e.g., relapse prevention, trauma-informed treatment, and psychoeducation), provider agencies need to, at a minimum, implement MI and CBT and ensure their staff are appropriately trained to deliver both. Providers are also expected to present and support the use of addiction medications as an evidence-based intervention when clinically appropriate.

Motivational Interviewing

MI is a client-centered and empathic counseling strategy designed to explore and reduce a person's ambivalence toward treatment by paying particular attention to the language of change. This approach frequently includes other problem-solving or solution-focused strategies that build on clients' past successes. According to *Motivational Interviewing: Helping People Change and Grow, 4th Edition* (Miller & Rollnick, 2023), MI "is a particular way of talking with people about change and growth to strengthen their own motivation and commitment."

Cognitive Behavioral Therapy

CBT is among the most extensively studied psychotherapy treatments for substance use. The CBT model of relapse prevention focuses on cognitive, affective, and situational triggers for substance use and provides skills training specific to coping alternatives. CBT treatment often includes the following strategies: (1) identifying intrapersonal and interpersonal triggers for relapse, (2) coping-skills training, (3) drug-refusal skills training, (4) functional analysis of substance use, and (5) increasing nonuse-related activities.²⁴ The Matrix Model is an example of an integrated therapeutic approach that incorporates CBT techniques and has been empirically shown to be effective for the treatment of stimulant use.²⁵

Other Contractor Selected Practices

Relapse Prevention

According to SAMHSA's National Registry of Evidence-Based Programs and Practices²⁶, relapse prevention is "a behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment.

Coping skills training strategies include both cognitive and behavioral techniques. Cognitive techniques provide clients with ways to reframe the habit-change process as a learning experience, with errors and setbacks

²⁴ Magill, M., & Ray, L. A. (2009). Cognitive-behavioral treatment with adult alcohol and illicit drug users: A meta-analysis of randomized controlled trials. *Journal of Studies on Alcohol and Drugs*, 70(4), 516–527.
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2696292>.

²⁵ SAMHSA. (2023, October). Matrix Intensive Outpatient Treatment for People with Stimulant Use Disorders: Counselor's Treatment Manual. <http://store.samhsa.gov/product/matrix-intensive-outpatient-treatment-people-stimulant-use-disorders-counselors-treatment>.

²⁶ SAMHSA. (n.d.). Evidence-Based Practices Resource Center. <https://www.samhsa.gov/resource-search/ebp>.

expected as mastery develops. Behavioral techniques include the use of lifestyle modifications such as meditation, exercise, and spiritual practices to strengthen a client's overall coping capacity.”

Trauma-Informed Treatment

According to SAMHSA's concept of a trauma-informed approach²⁷, “a program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization.” Seeking Safety is an example of evidence-based trauma-informed practice.²⁸

Psychoeducation

Psychoeducational interventions educate clients about substance use, SUDs, and related behaviors and consequences. The information provided may be broad, but it is intended to lead to specific objectives. Psychoeducation about substance use and SUD is designed to have a direct application to clients' lives, to instill self-awareness, suggest options for growth and change, identify community resources that can assist clients in recovery, develop an understanding of the process of recovery, and prompt people using substances to act on their own behalf.

Documentation

Clinical documentation includes any part of the client's health record that describes the care provided and the reasoning behind it. It is observational and narrative in nature, and it is written by counselors, clinicians, and Certified Peers to analyze both the process and content of client encounters. Clinical documentation is a vital part of delivering quality healthcare and serves multiple important purposes, including the following:

1. **Ensure comprehensive and quality care:** The process of writing initial assessments and progress notes requires thought and reflection. Preparing accurate and thorough clinical documentation is essential to ensuring quality client care. It allows practitioners to think critically about their clients, review and reflect on therapeutic interventions, consider the effectiveness of their clinical work, and explore alternative approaches to care. Good documentation organizes clinical details into a case formulation that guides care planning, and it is a fundamental part of professional practice and the delivery of quality services. It also promotes the effective use of team members from different disciplines by drawing on their unique strengths and enhancing the overall quality of services provided.
2. **Ensure efficient organization and communication with other providers:** Clinical documentation helps organize care and facilitates clear communication with other providers involved in a client's treatment. This promotes coordinated care and reduces the risk of fragmented service delivery.
3. **Protect against risk and minimize liability:** Accurate and comprehensive clinical documentation is essential for delivering quality care and effective risk management. Detailing and justifying the thought processes that contributed to the clinical decision-making process helps support the adequacy of the

²⁷ SAMHSA. (2026, February). SAMHSA's Trauma-Informed Approaches and Programs. <https://www.samhsa.gov/mental-health/trauma-violence/trauma-informed-approaches-programs>.

²⁸ SAMHSA. (2023, August 23). Seeking Safety. <http://www.samhsa.gov/resource/dbhis/seeking-safety>.

clinical assessment and the appropriateness of the treatment/service plan, and demonstrates the application of professional skills and knowledge in providing professional services.

4. **Comply with legal, regulatory, and institutional requirements:** Good documentation practices help ensure compliance with requirements imposed by Federal and State (including licensing boards) laws, regulations, and rules. It also helps ensure that documentation meets the standards set by specific accreditation programs (e.g., Commission on the Accreditation of Rehabilitation Facilities [CARF], The Joint Commission), when applicable, as well as by healthcare institutions, facilities, and agencies.
5. **Facilitate QI and UM:** Clinical documentation plays a key role in explaining the processes and content of assessments, treatment, and service planning, as well as in informing clinical decision-making, medical necessity, and the effectiveness of services provided. It is essential to the utilization review process, as it supports the need for further assessment, testing, treatment, or additional services, and it also helps justify changes to or the termination of treatment. From a quality improvement perspective, documentation supports supervision, consultation, and professional development. It helps identify service delivery issues and provides the information needed to implement effective preventive or corrective actions. Accurate recordkeeping also contributes valuable data for staff training, policy development, program planning, and research within agency settings.
6. **Clinical documentation needs to be credible, complete, and protected under [HIPAA](#) and [42 CFR Part 2](#).** It encompasses all aspects of clinical care, including initial assessments, progress notes, and relevant client encounters that occur outside of scheduled appointments. Documentation of initial assessments follows the same format as the multidimensional ASAM assessment, reflecting a comprehensive biopsychosocial approach. Progress Notes are written during/after follow-up appointments to gauge clinical progress and assess whether the client's needs have changed and if modifications to the treatment approach/plan are required. The documentation style needs to be consistent and standardized throughout the agency/institution.

In general, clinical documentation includes the following characteristics:

- Assessment and Progress Notes include the typed or legibly printed name, signature of the service provider, and date of signature (requirement is met via Sage electronic signature)
- Client name and identifier are included
- Client's race, ethnicity, and primary language, as recorded at admission and on demographic forms
- Referral information
- Sources of information are clearly documented
- The type(s) of service(s) being offered as described within the clinical record
- Duration of the service(s) being provided, including travel and documentation time
- The date that the service was provided to the client
- Documentation of any changes in the client's status (e.g., change in LOC provided or discharge status)
- Description of how services provided reduced impairment, restored functioning, and prevented significant deterioration
- For clients with LEP, documentation indicating whether interpreter services were offered and provided, along with the client's response

Note: Documentation, including forms and assessments in Sage, must be completed and signed on the indicated date. Providers may not back-date or forward-date documentation so that it appears to have been completed and signed on a date other than the actual date.

Assessment

An ASAM Criteria® assessment is required. The assessment includes the LPHA's determination of medical necessity and service recommendation. The Problem List and Progress Note requirements identified below support the medical necessity of each service provided.

Problem Lists and Treatment Plan for Non-OTP and OTP Settings

Client-centered care is critical and requires that clients be provided the opportunity to actively shape their treatment.

As clients advance through treatment, the corresponding Problem List (Non-OTP) and Treatment Plan (OTP) are reviewed and updated on an ongoing basis to reflect the client's current presentation, including stability and the likelihood of rapid changes in client condition. Problem Lists and Treatment Plans are updated more frequently when an individual is unstable or when a notable event requires a change to the Plan of Care. For additional details regarding minimum requirements for Problem Lists (non-OTP settings) and Treatment Plan (OTP settings) reviews and updates, see [Table 18: Problem List Minimum Requirements for non-OTP Settings](#) and [Table 19: Treatment Plan Minimum Requirements for OTPs](#).

Note: These are maximum allowable timeframes. Ideally, the Problem List (in non-OTP settings) or Treatment Plan (in OTP settings) should be completed and signed as promptly as possible, preferably close to the client's treatment admission date.

Table 18: Problem List Minimum Requirements for non-OTP Settings

Problem List Activity	LOC	Minimum Requirement*
Initial Problem List <i>Note: Initial Problem Lists need to be performed as instructed by SAPC on standardized templates in Sage or Problem List or Treatment Plan forms approved by SAPC.</i>	All WM LOCs	Complete upon intake and signed by an LPHA within the treatment episode.
	Residential	- Within seven (7) calendar days of first service or first intake appointment for Young Adults (age 18-20) and Adults (age 21 and over), including signature by LPHA; or - Within 14 calendar days of first service or first intake appointment for Youth (age 17 and under) including signature by LPHA.
	- OP - IOP - RS	- Within 30 calendar days of the first service or first intake appointment for Adults (age 21 and over), including signature by LPHA; or - Within 60 calendar days of first service or first intake appointment for populations that need a longer engagement period in order to establish a diagnosis. These populations are Youth (age 17 and under) and Young Adults (age 18-20), and for Adults (age 21 and over) who are documented as a PEH²⁹ including signature by LPHA.

²⁹ Documentation of homelessness status must be indicated in a Progress Note.

Problem List Activity	LOC	Minimum Requirement*
Problem List Review <i>Note: If the review of the Problem List results in a determination that changes to the Problem List are not necessary, a Progress</i> <i>Note: (with Problem List-Treatment Plan Development Review Service Type) stating that a Problem List Review was completed need to be included in the client's record. When Problem Lists require modification, an updated Problem List should be documented.</i>	Residential	Every 15 calendar days, at minimum.
	- OP - IOP - RS	Every 30 calendar days, at minimum.
Problem List Update <i>Note: Problem List updates involve a review, documenting any updates, and the LPHA signing the updated Problem List at the required intervals. Problem List updates need to be completed as instructed by SAPC on LPHA, certified or registered counselor standardized SAGE templates on Sage or Problem List or Care Plan forms approved by SAPC.</i>	Residential	No later than 30 calendar days after the signing of the initial care plan, and no later than 30 calendar days for each problem list thereafter, or when there is a significant event, whichever occurs first.
	- OP - IOP - RS	No later than 90 calendar days after the signing of the initial care plan, and no later than 90 calendar days for each problem list thereafter, or when there is a significant event, whichever occurs first.

***DHCS does not require the Problem List to be updated within a specific timeframe or have a requirement about how frequently it should be updated after a problem has initially been added. However, DHCS requires that providers update the Problem List within a reasonable time and in accordance with generally accepted standards of practice, which for LA County are those outlined in the [Table 18: Problem List Minimum Requirements for non-OTP Settings](#).**

If a client's condition does not show improvement at a given LOC or with a particular intervention, a review, an abbreviated assessment, and an update of the Problem List should be conducted to enhance therapeutic outcomes. Any change in LOC or intervention should be guided by a reassessment and adjustment of the Plan of Care to achieve better results.

The Problem List, maintained by the practitioners responsible for the client's care, includes symptoms, conditions, diagnoses, and risk factors identified through assessments, diagnostic evaluations, and other service interactions. If a new problem is identified during a service encounter, it may be addressed by the documenting practitioner (within their scope of practice) and added to the Problem List. This list should be updated regularly to accurately reflect the client's current condition.

The Problem List needs to include, but is not limited to, the following:

- Diagnoses identified by a provider acting within their scope of practice
- Applicable diagnosis-specific specifiers from the current DSM
- Problems identified by a provider acting within their scope of practice, if any
- Problems or illnesses identified by the member and a significant support person, if any
- The name and title of the provider who identified, added, or removed the problem, and the date the problem was identified, added, or removed
- Providers need to add to or remove problems when there is a relevant change to a member's condition

Table 19: Treatment Plan Minimum Requirements for OTPs

Treatment Plan Activity	Minimum Requirement
Initial Treatment Plan <i>Note: Initial Treatment Plans need to be performed using standardized Treatment Plan templates approved by SAPC.</i>	Need to be completed and signed by the client and LPHA within 28 calendar days of admission.
Treatment Plan Review <i>Note: If the Treatment Plan Review results in a determination that changes to the Treatment Plan are unnecessary, a Progress Note stating that a Treatment Plan Review was completed need to be included in the client's record. If Treatment Plans require modification, a Treatment Plan Update should be performed.</i>	Not less frequently than every 30 calendar days following completion of the initial Treatment Plan.
Treatment Plan Update <i>Note: Treatment Plan Updates involve reviewing a Treatment Plan. If the review results in a determination, changes to the Treatment Plan are needed. Treatment Plan Updates need to be performed on standardized templates on Sage or approved by SAPC.</i>	Whenever necessary, and not less than every three (3) months from the day of admission.

Suppose a client's condition does not show improvement at a given LOC or with a particular intervention. In that case, a review, an abbreviated assessment, and a Treatment Plan Update should be conducted to improve therapeutic outcomes. Changing the LOC or intervention should be based on a reassessment and modification of the Treatment Plan to achieve an improved therapeutic response.

Treatment Plans need to meet the requirements specified in [Title 9 CCR § 10305](#) and [Title 22 CCR § 51341.1\(h\)\(2\)\(B\)](#). At a minimum, Treatment Plans should include:

- Thorough documentation of case details, including a diagnosis and statement of problems to be addressed.
- Goals mutually established by the client and provider for each identified problem.
- Action steps to be taken by the provider and/or client to achieve the identified goals.
- Target dates for the achievement of identified action steps and goals.
- Description of the type(s) and frequency of services to be provided. If the frequency changes, a Treatment Plan update needs to be completed to prevent disallowances.
- Required documentation, as specified in Title 9 and Title 22, including documentation of physical examinations.
- The client needs to review, approve, type, or legibly print their name, sign, and date the initial Treatment Plan and Treatment Plan Update, indicating whether they participated in the preparation of the plan, within seven (7) calendar days for Young Adults (age 18-20) and Adults (age 21 and over) **or** 14 calendar days for Youth (age 17 and under) of the first service or first intake appointment. Suppose the client refuses to sign the Treatment Plan. In that case, the provider staff needs to document the reason for refusal and the provider staff's strategy to engage the client in treatment; see [Table 5: SAPC Access and Services Delivery Standards](#).
- If the LPHA determines that the services in the Treatment Plan Update are medically necessary, the LPHA must type or legibly print their name, sign, and date the Treatment Plan Update within 15 calendar days of the SUD counselor's signature.
- LPHAs who sign off on Treatment Plans in OTP settings need to be licensed prescribers.

Care Planning Requirements

Effective July 1, 2022, DHCS no longer requires prospectively completed, standalone treatment plans for DMC-ODS services, except in OTP settings. The change reflects DHCS's intent to recognize care planning as an ongoing, interactive component of service delivery rather than a one-time event.

For DMC-ODS services, where care planning requirements remain, applicable providers shall:

- Adhere to all applicable Federal and State care planning requirements;
- Document all required care plan elements within the client's record; **and**
- Ensure the care plan can be produced and, as appropriate, communicated to other providers, the member, and Medi-Cal behavioral health delivery systems, in accordance with applicable Federal and State privacy laws.

Table 20: Care Planning Documentation Requirements

Non-OTP Settings	OTP	PSS
SAPC recommends the providers document Care Planning in the Plan section of each progress note. This includes documenting next steps, which may consist of: • Planned action steps by the provider and/or the client • Collaboration with the client • Coordination and collaboration with other providers	• Treatment Plans are still required in OTP settings in accordance with Federal regulations. • Care planning shall be documented on a treatment plan for OTP services.	In accordance with CMS State Medicaid Directors Letter 07-011 and BHIN 23-068 , providers must document an approved PSS Plan of Care that includes specific individualized goals within the client's record. Within the SAPC network, the PSS Plan of Care shall be documented as a progress note using the designated <i>Service Type: Peer Support Services- Plan of Care</i> .

Progress Notes

Provider agencies/staff need to document the care provided to clients with SUDs in Progress Notes. Each Progress Note must provide sufficient detail to support the services billed (as indicated by the service code descriptions) for each treatment episode. All Progress Note documentation would be entered directly into the Progress Note form within Sage or an approved Progress Note template in a provider's own EHR if a secondary provider.

Progress Notes need to include:

- The type of service rendered.
- A narrative describing the service, including how the service addressed the client's SUD and/or mental health need (e.g., symptom, condition, diagnosis, and/or risk factors) in accordance with the ASAM Criteria.
- The date that the service was provided to the client.
- Duration of the service, including travel time.
- Location of the client at the time of receiving the service.
- Justification of discrepancy if the LOC suggested by ASAM criteria is not recommended by the counselor/clinician (if applicable).

- Justification of discrepancy if the discussed LOC is not agreeable to the client (if applicable)
- Justification of discrepancy if the LOC the client was referred to does not match the LOC suggested by the ASAM criteria (if applicable).
- A typed or legibly printed name, service provider signature, and signature date (electronic signatures are acceptable).
- An appropriate ICD-10 and HCPCS/CPT code(s) must appear in the clinical record for each encounter and be consistent with the description in the Progress Note, as this is required for Medi-Cal claims to be valid. This requirement is managed in Sage by linking the various items during the claiming process.
- Next steps including, but are not limited to, planned action steps by the provider or by the client, collaboration with the client, collaboration with another provider(s), and any update to the Problem List (non-OTP settings) or Treatment Plan (OTP settings) as appropriate.

Provider staff need to complete Progress Notes within three (3) business days of providing a service, except for crisis services, which need to be completed within one (1) calendar day. The day the service is provided counts as day zero (0).

For services billed daily, such as residential treatment, at least one (1) Progress Note daily is required. For services provided in residential services not included in the bundled rate and can be claimed separately, a separate progress note is required to support the unbundled service.

Providers should document the appropriate ICD-10 codes in the Diagnosis Form in Sage and use the applicable HCPCS code for billing, as outlined in the [Finance Management](#) section. This ensures that claims associated with Progress Notes include the necessary diagnostic and procedure code elements for DMC-ODS.

Progress Notes must be documented for all client encounters and services across all settings. Documentation is necessary for providers to demonstrate that services have been delivered in accordance with the service hour requirements associated with the LOC the client is receiving and with the client's clinical needs.

Standardized documentation by SUD counselors and clinicians helps increase treatment consistency and quality of care and reduce reimbursement disallowances. As such, SAPC requires that the multidimensional components of the ASAM criteria be incorporated into the initial documentation of the first complete assessment. Progress Notes for both individual and group sessions do not require a specific format under CalAIM; however, SAPC recognizes that providers with other accreditations, such as CARF, may still need to use one (1) of four (4) formats: SOAP, GIRP, SIRP, or BIRP.

SOAP (Subjective, Objective, Assessment, and Plan) is an acronym that describes the structure of a specific style of Progress Note documentation. The SOAP format is widely used and improves the quality and continuity of client services by providing a consistent, organized framework for clinical documentation that enhances communication among healthcare professionals and improves recall of the details of each client's case. This format allows providers to identify, prioritize, and track client problems so they can attend to them promptly and systematically. It also provides an ongoing assessment of both the client's progress and the treatment interventions. While a full review of the SOAP note format is beyond the scope of this document, [Table 21: SOAP Progress Note Format](#) outlines a summary of its components, and providers should refer to additional resources for additional information.

Table 21: SOAP Progress Note Format

S	Subjective – Client statements that capture the theme of the session. Brief statements as quoted by the client may be used, as well as paraphrased summaries.
O	Objective – Observable data or information supporting the subjective statement. This may include the client's physical appearance (e.g., sweaty, shaky, comfortable, disheveled, well-groomed, and well-nourished), vital signs, results of completed lab/diagnostics tests, and medications the client is currently taking or being prescribed.
A	Assessment – The counselor's or clinician's assessment of the situation, the session, and the client's condition, prognosis, response to intervention, and progress in achieving clinical goals/objectives. This should also include the list of problems documented on the Problem List (non-OTP settings) or Treatment Plan (OTP settings), including a diagnosis and/or a list of symptoms and information around a differential diagnosis.
P	Plan – The Plan of Care is based on the assessment and clinical information acquired.

The **GIRP**, **SIRP**, and **BIRP** Progress Note formats also record similar clinical information in a structured format. The information included in these Progress Note formats includes client goals/situation/ behavior, staff interventions used during the session, client response to the session, and the plan for future sessions or progress made toward resolving the problems documented in the Problem List (non-OTP settings) or the Treatment Plan (OTP settings). Like the SOAP note format, GIRP, SIRP, and BIRP notes provide a standardized structure for documentation that helps ensure comprehensive, consistent quality of care. [Table 22: GIRP Progress Note Format](#), [Table 23: SIRP Progress Note Format](#), and [Table 24: BIRP Progress Note Format](#) summarize the key components of GIRP, SIRP, and BIRP Progress Notes, although a full review of these standardized formats is beyond the scope of this document. Providers should refer to additional resources for detailed information. For clients with multiple health problems, the problems can be numerically prioritized by severity and treatment need in the plan section of the respective Progress Note format.

Table 22: GIRP Progress Note Format

G	Goal – Client's current focus and/or short-term goal, based on the assessment and Problem List (non-OTP settings) or Treatment Plan (OTP settings).
I	Intervention – Provider's methods used to address the client's statements, the provider's observations, and the treatment goals and objectives.
R	Response – The client's response to intervention and progress toward individual plan goals and objectives.
P	Plan – The Plan of Care moving forward, based on clinical information acquired and assessment.

Table 23: SIRP Progress Note Format

S	Situation – Client's presenting situation at the beginning of the intervention. It may include counselor/clinician observations, the client's subjective report, and the intervention setting.
I	Intervention – Provider's methods used to address the client's statements, the provider's observations, and the treatment goals and objectives.
R	Response – The client's response to intervention and progress toward individual plan goals and objectives.
P	Progress – The progress made toward treatment goals and objectives and the plan for future interventions as determined by the clinical picture.

Table 24: BIRP Progress Note Format

B	Behavior – Client statements that capture the theme of the session and provider observations of the client. Brief statements as quoted by the client may be used, as well as summaries that closely adhere to client statements. Provider observations may include the client's physical appearance (e.g., sweaty, shaky, comfortable, disheveled, well-groomed, well-nourished), vital signs, results of completed lab/diagnostic tests, and medications the client is currently taking or being prescribed.
I	Intervention – Provider's methods used to address the client's statements, the provider's observations, and the treatment goals and objectives.
R	Response – The client's response to intervention and progress toward individual plan goals and objectives.
P	Plan – The Plan of Care moving forward, based on clinical information acquired and assessment.

Group Session Progress Notes

When documenting group services, provider agencies need to keep a list or sign-in sheet of all clients attending the group session. If multiple practitioners are involved in a group session, one (1) Progress Note for each client attending the group needs to be completed and signed by one (1) practitioner. The Progress Note needs to detail each practitioner's involvement and time during the session. This note shall meet all requirements listed in the above Progress Notes section.

Group Session Progress Notes need to include:

- The type of service rendered.
- A narrative describing the service, including the title of the group session and how the service addressed the client's SUD and/or mental health need (e.g., symptom, condition, diagnosis, and/or risk factors) in accordance with the ASAM Criteria.
- A brief description of the client's response to the service³⁰.
- The date that the service was provided to the client.
- Duration of the service, including travel time.
- Location of the client at the time of receiving the service.
- A typed or legibly printed name, service provider signature, and signature date (electronic signatures are acceptable).

Residential Progress Notes

Residential Progress Notes can be documented either by individual encounter or as daily summaries. Documenting by encounter involves recording each service or activity a client participates in as it occurs within the residential setting. Alternatively, daily documentation involves summarizing all services and activities the client engages in during the day.

Regardless of the method used, Residential Progress Notes need to include details about the service or activity, how it supports the client's progress toward care goals, attendees, the start and end times of both the

³⁰ BHIN 23-068 provided examples and additional details regarding the documentation of client's response in group session. For example, a group note for a participant that chose not to speak during the group service may not include the same level of detail as a note for a group participant who engaged more actively, or a note for an individual counseling or therapy session.

service/activity, and any relevant information about the client's response. Progress Notes need to be signed or initialed by the LPHA or counselor responsible for the service, with signatures placed adjacent to each other when both are required.

SAPC recommends documenting by encounter because it is difficult to capture all services and activities within a day, especially when multiple staff members are involved. Encounter-based documentation can be more efficient than daily summaries, which often require extensive tracking. However, the minimum requirement is daily documentation of Residential Progress Notes in residential settings. If notes are written for each encounter, a daily summary is not necessary.

Medical Necessity Justification Progress Notes

A Medical Necessity Justification Progress Note is essential for documenting medical necessity. This note should concisely explain how the client meets the criteria for the requested LOC, including details about the client's SUD history, current clinical condition, and treatment progress. This note should address the following discrepancies between sources of information:

- Justification of discrepancy if the LOC suggested by ASAM criteria is not recommended by the counselor/clinician (if applicable).
- Justification of discrepancy if the discussed LOC is not agreeable to the client (if applicable)
- Justification of discrepancy if the LOC the client was referred to does not match the LOC suggested by the ASAM criteria (if applicable).

Medical Necessity Justification Progress Notes need to be finalized by a diagnosing LPHA or LE-LPHA staff.

Discharge Summary and Transfer

Provider agencies need to submit discharge or transfer summaries to SAPC when clients are discharged or when care transitions. These summaries document the treatment episode, discharge reason, overall prognosis, follow-up plans, and other essential details for effective Care Coordination and high-quality SUD service delivery. In Sage, the Discharge and Transfer Form needs to be submitted by all treatment providers, both Primary and Secondary Sage Users, when:

- A client is stepping up or stepping down between residential LOC **or** between OP LOC (e.g., ASAM level 2.1 to level 1.0); **or**
- A client is being discharged from any LOC (e.g., they are not stepping up or down to other LOCs).

The Recovery Bridge Housing Discharge form is required to be completed in Sage by all providers on the same day of discharge from the client's RBH stay.

Both the Discharge and Transfer Form and the Recovery Bridge Housing Discharge form need to be completed within Sage, as it is used in reports to calculate current active clients and length of stay.

Artificial Intelligence

The use of artificial intelligence (AI), including generative AI, is expanding within health care settings and may include applications such as generating clinical documentation, supporting therapeutic interventions, and facilitating interactions through digital platforms (e.g., mental health applications). To ensure transparency in care delivery, [AB 3030](#) establishes requirements for providers and facilities that use generative AI to create written or verbal communications containing clinical information. These requirements are intended to ensure that clients are informed when AI is used in their care.

At this time, SAPC's EHR system, Sage, does not incorporate any AI technologies. Provider agencies that elect to use AI in the delivery of clinical or administrative services must:

- Comply with all applicable Federal, State,³¹ and local laws and regulations;
- Ensure appropriate safeguards are in place to protect client privacy and confidentiality; **and**
- Inform clients when communications or materials containing clinical information are generated, in whole or in part, by AI, as required by applicable law.

Providers are responsible for ensuring that any use of AI does not compromise the accuracy, integrity, or quality of care provided to clients.

Complaint/Grievance and Appeal Process

The complaint/grievance and appeal processes are available for clients, their authorized representative, or provider agencies acting on behalf of the client ("involved parties"). It is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination (see [Notice of Adverse Benefit Determinations](#) section). A complaint and a grievance are the same. There is no distinction between an informal and formal complaint/grievance.

Complaints/grievances may include, but are not limited to:

- Quality of care or services provided.
- Aspects of interpersonal relationships, such as a provider's or employee's rudeness.
- Failure to respect the client's rights regardless of whether remedial action is requested.
- Right to dispute an extension of time proposed by the County to make an authorization decision.
- Situations where the client's participation in filing a formal appeal is not feasible.

Inquiries are requests for information that do not express dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to:

- Eligibility
- Benefits
- Other fee-for-service processes

³¹ [HSC § 1339.75](#); [BPC § 4999.9](#); [AB 489](#)

When a complaint/grievance and an inquiry are indistinguishable, it must be considered a complaint/grievance unless it meets the definition of an “Adverse Benefit Determination”.

The provider agency cannot discourage the filing of complaints/grievances. A client does not need to use the term “complaint/grievance” for it to be captured as an expression of dissatisfaction and processed as a complaint/grievance. Even if a client expressly declines to file a complaint/grievance, the provider agency must still process it as a complaint/grievance.

At any time, the client, the authorized provider agency, or an authorized representative acting on behalf of the client may file a complaint/grievance, either orally or in writing. All reasonable efforts need to be made to assist clients in completing forms and taking other procedural steps related to a complaint/grievance. This assistance includes, but is not limited to, providing auxiliary aids and services upon request, such as interpreter services and toll-free numbers with adequate Teletypewriters/Telecommunications Devices for the Deaf and interpreter capability.

Provider Agency Expectations: Complaint/Grievance Process

Each contracted provider agency site must ensure that clients and any authorized representatives know how to contact SAPC directly to express or report dissatisfaction (i.e., a complaint/grievance) and understand that they are not required to complete any provider agency process first. This means prominently posting SAPC contact information and reporting instructions, at a minimum, in the lobby of the primary entrance of each site and including the same information on any related provider agency forms and postings.

Provider agencies are also required to maintain a clear, accessible, and up-to-date complaint/grievance policy for clients and any authorized representative who chooses to initiate the process with their treating provider. Clients may choose to initiate a complaint/grievance with their provider; however, all complaints/grievances, regardless of where they are initiated, must be reported to SAPC, including any actions taken and resolutions, in accordance with the criteria and timelines below. This ensures SAPC maintains full oversight, tracking, and compliance with required standards.

Minimum standards for provider agency complaints/grievance processes are as follows:

- Maintain written policies and procedures that outline how clients and/or authorized representatives submit complaints/grievances to the provider agency and SAPC; how complaints/grievances are logged, reviewed, processed, escalated, and resolved; how resolution and acknowledgment timelines are met; and when and how complaints/grievances are reported to SAPC.
- Include SAPC contact information and reporting instructions on all complaint/grievance-related postings and forms, and verify continued posting in primary client access areas at all sites.
- Ensure clients have access to complaint/grievance reporting forms and processes at all sites without requiring staff assistance, to support confidentiality and minimize concerns of retaliation or intimidation.
- Accept complaints/grievances from clients, authorized representatives, or providers acting on behalf of the client at all sites and in multiple formats, including verbal, written, phone, email, fax, in person, or electronic methods.
- Attempt to resolve complaints/grievances received in-person (e.g., told to staff or forms turned in at treatment site) or over the phone to the client’s satisfaction by the close of the next business day when

appropriate; however, complaints/grievances received by mail or email must follow required acknowledgment and resolution timelines.

- Ensure that staff making decisions on complaints/grievances were not involved in the underlying issue, any prior level of review, or subordinate to individuals involved in the matter.
- Ensure that staff making decisions on clinically related complaints/grievances, or those involving denial of expedited resolution, have appropriate clinical expertise in treating the client's condition or disease.
- Actively investigate and address complaints/grievances and make a good-faith effort to resolve concerns prior to SAPC escalation, where appropriate and consistent with required timelines.
- Maintain a comprehensive complaint/grievance log that includes at minimum: date and time of receipt; date and time of acknowledgement [must be within five (5) calendar days of receipt]; client name and contact information; representative information (if applicable); name of accused person(s) and contact information (if applicable), contracted site, original complaint/grievance description, actions taken to investigate and resolve, final resolution, staff responsible for resolution, date of client notification, investigation results and corrective actions, and any related documents such as affidavits/statements, and/or resolution letters.
- Ensure that complaints/grievances are not redirected, delayed, or handled in a manner that creates barriers to access or interferes with required timelines for acknowledgment and resolution.
- Report all complaints/grievances, including actions taken and resolutions, to SAPC in accordance with required criteria and timelines, and align practices with SAPC's Risk-Based Complaint/Grievance Management System expectations, standards, and submit information to SAPC_Monitoring@ph.lacounty.gov by the deadline.
- Fully cooperate with SAPC inquiries and investigations, including providing timely access to all relevant records, staff, and documentation, and implementing corrective actions as directed.
- Maintain policies, procedures, logs, training documentation, client-facing materials, and reporting records sufficient to demonstrate compliance during SAPC monitoring, audits, or investigations.

Required Timelines

All grievances must be acknowledged within five (5) calendar days of receipt and resolved within 30 calendar days. Expedited appeals must be resolved within 72 hours when standard timeframes would jeopardize the client's health or functioning.

SAPC Risk-Based Complaint/Grievance Management System

The Risk-Based Complaint/Grievance Management System ensures every complaint/grievance is accepted, logged, and processed in full compliance with requirements set forth in [BHIN 25-015](#) and SAPC policy. Under this model, all complaints/grievances—regardless of severity—are treated as valid expressions of dissatisfaction and are immediately subject to required timelines for acknowledgment and resolution. Complaints/Grievances are stratified based on risk, complexity, and potential impact to beneficiary safety, rights, or access to care, with defined roles and expectations for both provider agencies and SAPC, which vary based on the “level” of complaint/grievance. Importantly, SAPC retains full oversight and accountability for all complaints/grievances, including monitoring provider actions, enforcing compliance with regulatory timeframes, and issuing the final determination to the beneficiary.

Table 25: Complaint/Grievance Triage

SAPC Level	Description	Handled By
Level 3	High-priority concerns such as abuse, neglect, discrimination, fraud, serious legal violations, professional misconduct, safety risks and adverse benefit determination.	SAPC-led investigations
Level 2	Medium-priority concerns such as access to care, service delays, recurrent Level 1 issues raised by a single or multiple individuals and Level 1 issues submitted by mail or email.	SAPC resolution with provider support
Level 1	Low-priority or administrative issues that are isolated or non-recurrent and that are resolved to the client's satisfaction within one (1) business day such as minor interpersonal or communication problems, dissatisfaction with types of activities/services offered, nutrition/meals, cleanliness, and cell phone access.	Provider resolved and logged

Level 1: Provider Agency Led Resolution

When a client or the client's representative files a complaint/grievance directly with the provider agency, either in-person (e.g., told to staff or forms turned in at treatment site) or over the phone, that provider agency may resolve the issue without direct SAPC involvement only if all of the following conditions are met:

- The issue aligns with the definition of Level 1 complaints/grievances.
- The issue is resolved to the member's satisfaction by the close of the next business day.
- The issue does not involve an Adverse Benefit Determination.
- The issue does not involve a discriminatory action based on a protected class.
- The issue was not submitted by mail or email.

Under these circumstances, provider agencies must enter all required elements in their log and submit them to SAPC by the 30th of the month for all grievances/complaints received that month and send them to SAPC_Monitoring@ph.lacounty.gov with the subject line "Complaint/Grievance Monthly Report". This is a firm deadline because SAPC must verify compliance and report on-time resolution to DHCS. SAPC will review submissions and determine if the provider agency misclassified complaints/grievances as Level 1 and take any necessary action due to failure to properly report.

Level 1 complaints/grievances submitted directly to SAPC will be processed and resolved by SAPC in accordance with [BHIN 25-015](#). Clinical matters will be handled by SAPC-QI and SAPC-UM, and programmatic matters by SAPC-CCD.

Level 2: SAPC and Provider Agency Led Resolution

When a client or the client's representative files a complaint/grievance directly with the provider agency that best aligns with a Level 2 complaint/grievance, the provider agency will transmit information to SAPC on the same day received to SAPC_Monitoring@ph.lacounty.gov with the subject line "Complaint/Grievance Level 2 Notification". SAPC and the provider agency will work together to resolve the issue, but SAPC retains responsibility for the resolution process. SAPC is responsible for preparing and sending the acknowledgment notice within five (5) calendar days and ensuring resolution within 30 calendar days.

Level 2 complaints/grievances submitted directly to SAPC will be processed and resolved by SAPC in accordance with [BHIN 25-015](#). Clinical matters will be handled by SAPC-QI and SAPC-UM, and programmatic matters by SAPC-CCD.

Level 3: SAPC Led Resolution

When a client or the client's representative files a complaint/grievance directly with the provider agency that best aligns with a Level 3 complaint/grievance, the provider agency immediately transmits information to SAPC and no later than close of business on the same day received to SAPC_Monitoring@ph.lacounty.gov with the subject line "Complaint/Grievance Level 3 Notification". SAPC will work independently to resolve the issue and investigate the matter by gathering information from relevant parties. Provider agencies must submit all relevant documentation to SAPC within 10 business days. SAPC is responsible for preparing and sending the acknowledgment notice within five (5) calendar days and ensuring resolution within 30 calendar days.

A professional conduct-related complaint/grievance alleges misconduct by an individual whose professional practice is governed by a licensing authority under the California Department of Consumer Affairs (DCA), an affiliated licensing board, or a recognized certifying body, including, but not limited to, physicians, nurses, LCSWs, MLFTs, LCPs, and Certified Substance Use Disorder Counselors. Matters related to professional misconduct include, but are not limited to, a potential violation of professional ethics or standards of practice; a potential violation of applicable state or federal law; working outside the scope of licensure or certification; conduct that constitutes reportable misconduct within the jurisdiction of a licensing or certifying authority; behavior that poses a risk to a client's health, safety, or welfare; and/or behavior that is fraudulent or reflect waste and abuse. SAPC complies with mandated reporting requirements and will refer or report these matters to the appropriate licensing board or certifying authority.

A discrimination-related complaint/grievance alleges unlawful discrimination based on any characteristic protected under federal or state law, including sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation. Failure to report or adequately address a discrimination-related complaint/grievance constitutes noncompliance and may result in corrective actions, sanctions, or alternative remedies as determined by SAPC. The SAPC Discrimination Coordinator is responsible for managing all discrimination-related complaints/grievances separately to ensure compliance with applicable nondiscrimination laws and regulations.

Level 3 complaints/grievances submitted directly to SAPC will be processed and resolved by SAPC in accordance with [BHIN 25-015](#). Clinical matters will be handled by SAPC-QI and SAPC-UM, and programmatic matters by SAPC-CCD.

SAPC Expectations: Complaint/Grievance Process

As the specialty SUD managed care plan under DMC-ODS, SAPC is responsible for ensuring compliance with DHCS and for the complaint/grievance process, which includes expressions of dissatisfaction presented to contracted provider agencies and those submitted directly to SAPC. For this reason, provider agencies are required to submit all complaints/grievances to SAPC as outlined in the Risk-Based Complaint/Grievance Management System. SAPC retains oversight responsibility for all complaints/grievances, monitors provider

handling, ensures compliance with required timelines, and issues final resolution determinations using DHCS-approved templates.

Some complaints/grievances may involve circumstances that meet the definition of an Adverse Benefit Determination (ABD), which are subject to separate notice and appeal requirements, as outlined below.

Notice of Adverse Benefit Determinations

A Notice of Adverse Benefit Determination (NOABD) is a formal letter sent to a Medi-Cal member when the Plan or, in certain cases, the Provider Agency acting on behalf of the Plan, takes specific actions that affect a member's services or benefits. These notices are governed by federal and state regulations to standardize the process and protect members' rights.

An Adverse Benefits Determination (ABD) is distinct from a complaint/grievance and includes actions such as denial, reduction, suspension, or termination of services; denial of payment; failure to provide services in a timely manner; or failure to act within required timeframes. All ABDs require the issuance of an NOABD and trigger the member's right to appeal.

When an NOABD Is Issued

A NOABD needs to be issued for any of the following actions:

- Denial or limited authorization of a requested service
- Reduction, suspension, or termination of a previously authorized service (if the member disagrees)
- Modification of a service request with approval of an alternative
- Partial or full denial of payment for a service
- Failure to provide services in a timely manner
- Failure to make authorization decisions in the required timeframe
- Failure to meet required timelines for acknowledgment or resolution of complaints/grievances or appeals constitutes an ABD
- Denial of a request to dispute financial liability

Note: NOABDs ONLY apply to Medi-Cal members.

Purpose of the NOABD

The NOABD informs members in writing of their rights under the Medi-Cal program, and needs to include the following:

- The reason for the decision
- The member's right to appeal
- How to request a State Hearing
- The right to continue receiving benefits during the appeal process (if applicable)

NOABD Templates and Requirements

DHCS provides standardized NOABD templates that:

- Should not be modified (unless SAPC or DHCS policy is permitted to provide additional detail)
- Are required to include:
 - NAR Your Rights
 - Member Non-Discrimination Notice
 - Notice of Availability

NOABD Issuance

Multiple SAPC units are involved in issuing or reviewing NOABDs. Decision-makers are not incentivized to deny services.

Provider Agency Roles and Responsibilities in NOABD Issuance

Provider agencies need to:

- Support clients who receive NOABDs by explaining their rights and guiding them on the next steps
- Issue provider-initiated NOABDs when:
 - A previously authorized service is terminated
 - There is a failure to provide services in a timely manner
- Include the following three (3) required attachments with each provider-issued NOABD:
- NAR Your Rights
 - Non-Discrimination Notice
- Notice of Availability
- Track and report all NOABDs by completing the NOABD/Appeal/Complaint/Grievance Log and submitting it to SAPC quarterly

For NOABD timelines and procedures, see [Table 27: Notice of Adverse Benefit Determination and Appeals Process Timeline](#). Approved NOABD templates and related materials are available on the SAPC website: [SAPC's Manuals, Bulletins, and Forms – Clinical Tab webpage](#).

Appeals Process

Appeals apply only to Adverse Benefit Determinations (ABDs) communicated through a Notice of Adverse Benefit Determination (NOABD). An appeal is a request to have a decision related to a NOABD reviewed. For a full list of actions that require issuance of an NOABD, refer to the section above.

The Appeals Process allows Medi-Cal members, their authorized representatives, or providers (with written consent) to request reconsideration of adverse benefit determinations made by SAPC staff or providers. These determinations may involve:

- Denials of DMC benefit verification
- LOC decisions
- Payment for services

Note: The appeals process ensures that Medi-Cal members have the opportunity for a full and fair review of adverse decisions.

Oral inquiries about appeals are considered formal appeals to establish an early filing date, but they must be confirmed in writing unless an expedited resolution is requested. Appeals are processed by SAPC-QI and SAPC-UM with support from other areas, as applicable.

SAPC will assist clients in completing forms and navigating procedural steps, including providing interpreter services and toll-free numbers with TTY/TTD and interpreter capabilities. Clients, their authorized representatives, or providers with the client's written consent may file appeals.

Involved parties may review and respond to evidence provided by SAPC-QI and SAPC-UM and challenge denials of DMC eligibility verification or service authorizations for LOCs.

Filing an Appeal

An appeal may be filed by:

- Clients, their authorized representatives, or providers (with the client's written consent)
- Submit a completed Appeal Request Form (signed by the client) to SAPC, either electronically or via fax, within 60 calendar days from the date of the NOABD.
- Verbally made oral appeals are accepted but must be followed by a written, signed appeal unless an expedited resolution is requested.

Note: If the appeal is filed without the client's involvement (e.g., no written consent), the appeal needs to include an explanation as to why the client could not participate. If client involvement is not documented, the appeal will be treated as a complaint or complaint/grievance.

Available SAPC Assistance

- Assist the client in completing appeal forms and other procedural steps, including preparing a written appeal.
- Notify the client of the location of the appeal forms on the Plan's website or provide forms upon request.
- Assist in requesting continued benefits during the appeal of an adverse benefit determination.

Appeal Review

- Upon receipt, SAPC-QI staff will log the appeal and send a receipt notification to the requesting party within the timeframes outlined in [Table 27: Notice of Adverse Benefit Determination and Appeals Process Timeline.](#)
- SAPC-QI Clinical staff will investigate the initial denial, potentially contacting the treating provider, reviewing the ASAM criteria, and using relevant clinical resources.
- Clients will be given a reasonable opportunity to present evidence and arguments—both in writing and in-person.

Appeal Timeframes and Extensions

After reviewing all case information, a final decision will be made. The rationale and outcome will be communicated to the appealing party within the timeframes outlined in [Table 27: Notice of Adverse Benefit Determination and Appeals Process Timeline](#). If additional information is needed, SAPC may request an extension of up to 14 calendar days to resolve the appeal, if it is in the client's best interest.

Notice of Appeal Resolution

A Notice of Appeal Resolution (NAR) will be provided, and need to include:

- Date and outcome of the appeal
- Reasons and rationale for the decision (including criteria/clinical guidelines or policies used, if the appeal is denied)
- Contact information for the reviewer
- Information on the State Hearing process and the client's right to continue benefits during the hearing process.

Note: If the appeal is denied, the client will be informed of their right to request a State Hearing and how to do so, including their right to continued benefits during the appeal process.

Expedited Appeals

- **Expedited Appeal Request:** If the client's life, health, or functional status could be seriously jeopardized by waiting for a standard resolution, an expedited appeal can be requested. SAPC will process the appeal accordingly and notify the SUD treatment provider within the timeframe outlined in [Table 27: Notice of Adverse Benefit Determination and Appeals Process Timeline](#).
- **Residential Authorizations:** Appeals for initial Residential Authorizations and WM follow an expedited appeal timeframe, whereas residential reauthorizations follow the standard appeal timeframe.

Continued Benefits During the Appeal

The client will continue receiving benefits during the appeal process if the appeal involves:

- Termination, suspension, or reduction of a previously authorized treatment plan;
- Services were ordered by an authorized provider; **and**
- The client or their representative requests continued benefits during the appeal.

Conditions for Continued Benefits:

Benefits continue until one (1) of the following occurs:

- The client withdraws the appeal.
- A State Hearing issues an unfavorable decision.
- The time or service limits for a previously authorized service have been met.

Potential Outcomes

- If the appeal results in an unfavorable decision (e.g., the denial is upheld), SAPC may seek to recover the cost of services provided during the appeal period—if those services were provided solely due to the pending appeal.
- If the appeal results in a favorable decision (e.g., services are approved), SAPC will authorize and promptly provide the services.
- If a State Hearing overturns a denial, SAPC is required to cover the cost of services provided during the appeal.

Note: *SAPC will not dismiss or delay an appeal resolution even if written confirmation of the appeal is not received.*

Client Access to Case Information

Before and during the appeals process, the client and their representative should have access to the following:

- Case file, including medical records
- Any other documents and records considered during the appeals process

Quality Improvement and Follow-Up

- **Appeals Trends:** The Quality Improvement and Risk Management Committee will review trends in the appeals process during their bimonthly meetings to identify areas needing improvement.
- **Learning Opportunity:** Concerns that arise during the appeals process will be discussed with SUD treatment providers and may lead to corrective actions to improve the SUD care system.

Contact Information

For any questions or additional assistance regarding the appeals process, contact:

County of Los Angeles
Department of Public Health
Substance Abuse Prevention and Control Bureau
Office of the Medical Director and Science Officer (OMDSO)
1000 South Fremont Avenue, Building A-9 East, 3rd Floor
Alhambra, California 91803
(626) 293-2846

Note: *Clients who have exhausted the Appeals process may request a State Hearing with DHCS.*

Table 26: Notice of Adverse Benefit Determination and Appeals Process Timeline

Type of Action	Notification Requirements	Responsible Party for Notification	Appeals <i>Client/provider/authorized representative MUST file within 60 days of NOABD³²</i>				State Hearing <i>Clients must exhaust the appeal process prior to requesting</i>
			Written Acknowledgment of Receipt	Appeal Resolution (Standard)	Appeal Resolution (Expedited)	Extension (max. 14 calendar days)	
Termination Suspension or Reduction of previously authorized service	CLIENT in writing (mail) at least <u>10 days</u> before the effective date of the action using NOABD³³ Template & attachments (Exceptions 42 CFR 431.213 and 431.214)	PROVIDER AGENCIES	Postmarked within <u>5 calendar days</u> of appeal receipts. • Date received • Contact info of County staff client may contact (date received, name, phone, address)	May not exceed <u>30 calendar days</u> from receipt of appeal. NAR & attachments template 1. Upheld NAR; or 2. Overturned NAR*	Resolved as expeditiously as health condition requires, but <u>no longer than 72 hours</u> after request. 1. Request Denied • Prompt Oral notice • Written Notice within 2 calendar days of decision. Applicable NOABD; reverts to standard resolution time (30 days) 2. Request Approved Resolve within 72 hours or request 14-day extension. • Upheld NAR ³⁴ • Overturned NAR* - If resolved wholly in favor of client	1. Initiated by client 2. Initiated by County ONLY due to need for more information <u>AND</u> in best interest of client. County needs to provide: • Prompt Oral Notice • NOABD Complaint/grievance Delay Resolution template & attachments Sent in <u>2 calendar days</u> of decision to extend.	Client needs to request within 120 days of NAR or County failure to adhere to requirements. Standard Hearing: County needs to notify clients that the State must reach its decision within 90 calendar days of date or request for hearing. Expedited Hearing County needs to notify client that the State must reach its decision within 3 days of the request. Overturned Hearings: County shall authorized/ provide disputed services as expeditiously as health condition requires, but no later than 3 working days

³² Oral Appeals – see oral appeals bullet point in [Appeals Process](#) section.³³ NOABD must include: 1) adverse benefit determination the County has made/plans to make; 2) clear explanation of the reasons for the determination, including clinical reasons if it involves medical necessity criteria, specifying why the client's condition does not meet the criteria; 3) description of criteria used; 4) client's right upon request and free of charge to access to and copies of all documents/records related to Adverse Benefit Determination.³⁴ NAR – see [Appeals Process](#) section to see what must be included.

Type of Action	Notification Requirements	Responsible Party for Notification	Appeals <i>Client/provider/authorized representative MUST file within 60 days of NOABD ³²</i>				State Hearing <i>Clients must exhaust the appeal process prior to requesting</i>
			Written Acknowledgment of Receipt	Appeal Resolution (Standard)	Appeal Resolution (Expedited)	Extension (max. 14 calendar days)	
Failure to Provide Services in Timely Manner	PROVIDER via fax/phone <u>within 24 hours</u> of decision. CLIENT in writing <u>within 2 business days</u> of the decision NOABD Template & attachments	SAPC & PROVIDER AGENCIES					
• Denial of authorization (residential) • Denial of Payment • Failure to resolve complaint/grievance/appeals • Denial of request to dispute financial liability	CLIENT in writing at least <u>10 days</u> before action using NOABD Template attachments (Exceptions 42 CFR 431.213 and 423.214)	SAPC	Dated within <u>5 calendar days</u> of appeal receipts. • Date received • Contact info of County staff client may contact (date received name, phone, address)	May not exceed <u>30 calendar dates</u> from receipt of appeal NAR & attachments template 1. Upheld NAR; or 2. Overturned NAR**	Resolved as expeditiously as health condition requires, but <u>no longer than 72 hours</u> after request.	1. Initiated by Client 2. Initiated by County ONLY due to need for more information <u>AND</u> in best interest of client. County must provide: • Prompt Oral Notice • NOABD Complaint/grievance/ Appeal Delay Resolution template & attachments	Client must request w/in 120 days of NAR or County failure to adhere to requirements. Standard Hearing: County notify clients that the State must reach its decision within 90 calendar days of date or request for hearing. Expedited Hearing: County must notify client that the State must reach its decision within 3 days of the request. Overturned Hearings: County shall authorized/ provide disputed services as expeditiously as health condition requires, but no later than 3 working days

* Plans need to authorize/provide services (not furnished during the appeal process) no later than 72 hours from the date it reverses the determination.

Risk Management and Reportable Incidents

Risk management involves coordinated strategies to reduce the likelihood of adverse outcomes while promoting safe, high-quality care. Effective risk management enhances client safety, supports quality improvement, and reduces organizational liability. These efforts must be grounded in established standards of care, continuous quality improvement efforts, and the systematic collection and analysis of data.

Risk Management Committee at the Provider Level

Each provider agency must maintain an active Risk Management Committee responsible for implementing, monitoring, and continuously improving agency-wide risk management practices.

The Committee's responsibilities must include, at a minimum:

- Establishing and maintaining policies and procedures related to risk management, including incident reporting, QI, fire safety, disaster preparedness, and hazard reporting.
- Ensuring staff are trained on incident identification and reporting requirements
- Maintaining a centralized log and tracking systems for all incidents, including the status of investigations and corrective actions
- Conducting timely review and investigation of reportable incidents
- Identifying trends and patterns and implementing corrective actions or Quality Improvement Plans (QIPs) as needed
- Monitoring service and billing integrity, including detection and prevention of fraud, waste, and abuse (FWA)
- Ensuring follow-up actions are completed and documented until resolution.

Adverse Events

Adverse events are incidents that directly or indirectly affect the community, clients, staff, and/or the provider agency as a whole, and must be investigated and evaluated at the provider agency level. This information should be used on a routine basis to improve accessibility, health and safety, and address other pertinent risk management issues. These events must be:

- Documented internally
- Reviewed by the Risk Management Committee
- Tracked for trends and quality improvement

Examples may include, but are not limited to:

- Minor injuries not requiring medical intervention
- Verbal altercations without escalation
- Environmental safety concerns

Adverse events are not required to be reported to SAPC unless they escalate or form part of a concerning pattern or trend that may pose increased risk.

Reportable Incidents (Mandatory Reporting to SAPC)

Reportable incidents are serious client safety events that result in:

- Death
- Permanent harm
- Severe temporary harm
- Intervention required to sustain life

Provider agencies must report provider-preventable conditions in accordance with [MHSUDS 17-046](#) and the [DMC-ODS Provider Preventable Conditions Reporting Form \(DHCS 5261\)](#).

Reportable incidents must be investigated by the provider's Risk Management Committee and reported to the SAPC Quality Improvement and Risk Management Committee in accordance with required reporting timeliness and protocols. These incidents may result in corrective actions and should inform improvements to care and risk management practices.

Incident Reporting Requirements and Process

- 1. Immediate Response**
 - Ensure client and staff safety
 - Provide or arrange for necessary medical care
 - Notify appropriate internal leadership
- 2. Internal Documentation**
 - Complete an internal incident report
 - Document, at minimum:
 - Date, time, and location
 - Individuals involved
 - Description of the incident
 - Immediate actions taken
- 3. Notification to SAPC**
 - Reporting the incident to SAPC in accordance with required reporting timelines
 - Submit required documentation, including applicable DHCS forms, as appropriate
- 4. Investigation and Follow-Up**
 - Conduct an internal review through the Risk Management Committee
 - Identify contributing factors and implement corrective actions, as needed
 - Monitor for trends and ensure follow-up actions are completed
- 5. Documentation and Record Retention**
 - Maintain all incident-related documentation, including:
 - Initial reports
 - Investigation findings
 - Corrective actions
 - Ensure records are available for SAPC review upon request

Resident Death Reporting Requirements

In accordance with [BHIN 26-007](#), SUD recovery or treatment facilities must comply with updated reporting requirements related to the death of a resident, as outlined in [AB 1356](#) and [California HSC § 11830.01](#).

SUD recovery or treatment facilities are required to:

- Submit a telephonic report to DHCS within one (1) working day of a resident's death
- Submit a written report to DHCS within seven (7) calendar days of a resident's death

Reports must include all information known at the time of the report, including:

- A description of the event (time, location, and nature of the incident)
- Immediate actions taken, including individuals contacted
- Planned follow-up actions, including steps to prevent future occurrences

In addition, SUD recovery or treatment facilities must:

- Submit any additional relevant information not known at the time of the initial report within 30 days of the resident's death

Failure to submit required information within the required timeframe may result in a written notice of deficiency issued by DHCS. If DHCS identifies violations during the investigation of a resident's death, the facility will receive a written notice of deficiency outlining the required corrective actions and response timelines. Facilities must submit a corrective action plan or verification of correction in accordance with applicable statutory and regulatory requirements.

SAPC Oversight

All reportable incidents are subject to SAPC review and may result in requests for additional information, corrective actions, or follow-up monitoring, as appropriate. Failure to report required incidents, delayed reporting, or incomplete documentation may result in compliance findings and required corrective action.

Note: Reportable incidents, as defined above, must be reported to the SAPC Quality Improvement and Risk Management Committee in accordance with required timelines and reporting protocols.

Adverse events and other risk management or quality-related issues that do not meet the threshold of a reportable incident are not required to be reported to SAPC and should be managed through the provider agency's internal risk management and quality improvement processes.

However, provider agencies are strongly encouraged to report such events to SAPC at the discretion of agency leadership when:

- There is uncertainty about whether an incident meets reportable criteria
- The issue reflects a pattern, trend, or systemic concern
- The event may pose an elevated risk to client safety, staff safety, or public safety
- The issue may have broader system implications or visibility

Guidance on Federal Immigration Enforcement Activities at Service Sites

SAPC recognizes that federal immigration enforcement activities, including those conducted by Immigration and Customs Enforcement (ICE), may impact clients' willingness and ability to access prevention, harm reduction, and treatment services. At this time, the County has not issued formal policy guidance specific to these activities. However, SAPC encourages provider agencies to take reasonable steps to ensure continuity of services, maintain safe environments for staff and clients, and prepare for potential interactions with federal agents.

Provider agencies should:

- Maintain operations in a manner that supports access to care for all clients, regardless of immigration status
- Ensure staff are aware of agency policies and procedures related to interactions with external entities
- Develop internal protocols for responding to the presence of federal agents at service sites
- Train staff on how to appropriately respond to external inquiries or requests for access to facilities or information
- Ensure that client information is protected and only disclosed when legally required, in accordance with applicable confidentiality laws (e.g., [HIPAA](#), [42 CFR Part 2](#))

SAPC has shared publicly available resources to support provider preparedness, including guidance from the [National Immigration Law Center \(NILC\)](#) regarding workplace responses to immigration enforcement activities and Additional "Know Your Rights" resources are available from organizations such as:

- [National Immigration Law Center \(NILC\)](#)
- [American Civil Liberties Union \(ACLU\)](#)
- [Immigrant Legal Resource Center \(ILRC\)](#)

These resources are provided for informational purposes only. Provider agencies are responsible for conducting their own review and consulting with legal counsel as needed to develop agency-specific policies and procedures.

Operational Considerations

Provider agencies may consider the following as part of their internal preparedness planning:

- Establishing clear internal protocols for responding to the presence of federal agents
- Training staff in facility access policies, including distinctions between public and private areas
- Identifying appropriate points of contact within the organization for escalation and response
- Documenting interactions with external agents, as appropriate
- Communicating with clients in a manner that supports continued engagement in services

Communication with SAPC

Provider agencies are encouraged to notify SAPC of any significant incidents or concerns related to federal enforcement activities that may impact service delivery. SAPC will continue to share updates and information as it becomes available.

SECTION 5: PROVIDER QUALITY IMPROVEMENT EXPECTATIONS

Quality Improvement Expectations

Treatment providers within the specialty SUD system need to establish a culture and infrastructure to support Continuous Quality Improvement (CQI) to best serve their vulnerable client population. This focus on quality necessitates internal processes that support assessment, evaluation, identification of opportunities for improvement, and follow-up or action. The following describes the required QI processes that will facilitate this desired quality-focused culture and infrastructure at the provider agency level.

Peer Reviews

Provider agencies within the specialty SUD system need to incorporate peer reviews into their CQI activities and establish a formal process for regularly identifying processes or variations in care/services that may lead to undesirable or unanticipated events affecting clients or clinical care. The goal of the peer review process is to establish an educational and evaluative mechanism for providers to identify opportunities to improve care and services.

As part of the peer review process, SUD counselors and clinicians from various disciplines review their colleagues' client charts and provide feedback on the care recommended and delivered in a professional, non-adversarial manner. Practitioners should conduct reviews within their appropriate scope of practice, and when possible, supervisors should review and follow up with counselors and clinicians to provide feedback based on the peer review process. Analyses of clinical decisions and practices should be based, as appropriate, on objective evidence drawn from relevant scientific literature, clinical practice guidelines, departmental historical experience and expectations, peer department experience and standards, and national standards.

The focus of these reviews may vary depending on needs determined by the provider agency and may highlight an individual event or aggregate data and information on clinical practices. However, at a minimum, peer reviews need to include:

- Review of diagnosis/diagnoses and assessment(s)
- Review of documentation clarity and organization
- Ensure Problem Lists (non-OTP settings) or Treatment Plans (OTP settings) are documented and updated accordingly
- Ensure documentation is signed by appropriate individuals

The quantity and frequency of reviews may also vary depending on needs determined by the provider. An agency for each site, but no fewer than three (3) client charts for each counselor/clinician, need to be reviewed twice (2x) annually.

All records and information obtained during peer review functions should remain confidential and be used solely to review the quality and appropriateness of care to improve practices.

Quality Improvement Projects

A QIP is a focused effort on an identified problem within a provider agency. It involves systematically gathering information to identify and clarify issues or problems, and intervening to improve. A QIP aims to examine and improve care or services in high-priority areas that the agency identifies as needing attention, which will vary depending on variables including, but not limited to, the population served, workforce, and unique scope and capabilities of services provided. The QIP is not meant to replace other QIPs that organizations may already be using, which may be used or adapted to qualify as their QIP. Each provider is expected to be involved in at least one (1) QIP at all times. SAPC staff will review provider agency QIPs on an annual basis.

All QIPs should follow the CQI model and target improvement in relevant areas of clinical care, either directly or indirectly. Areas of focus may include improving access to and availability of services, enhancing continuity and coordination of care, improving the quality of specific interventions, and enhancing service provider effectiveness. In general, a clinical issue chosen for study should influence a large segment of the client population served and could notably affect health, functional ability, or satisfaction. Over time, areas selected for improvement should focus on a broad spectrum of care and services.

Each provider agency must be involved in a minimum of one (1) QIP at all times.

QIPs will be reviewed on an annual basis by SAPC staff.

Performance Improvement Projects

Healthcare providers, including SUD providers, share the common goal of providing high-quality care. Performance Improvement Projects (PIPs) measure performance and outcomes. This helps organizations and providers understand how well they're meeting their quality care goals. It also allows for an analysis of where and what changes are needed in the process of striving for continual improvement.

Metrics allow providers to understand what is working well so that others can learn from their success, and what is not working well so that the necessary steps can be taken to improve. The Performance Management System outlined in [Figure 2: Public Health Performance Management System](#) provides a framework for how data from performance and outcome measures can be used for process improvement.

Performance and outcome measurement differ as follows:

- **Outcome measures** are used at the client level to examine substance use behaviors and psychosocial functioning changes. They are used to understand the effectiveness of treatment services in improving substance use and related functioning of individuals who have received treatment.
- **Performance measures** are used at the program level to evaluate how well a program is achieving quality standards. Performance measures can help identify where service problems exist, which programs are meeting or exceeding expectations of treatment quality, and what, if any, changes should be made to improve service delivery. They inform QI strategies aimed at changing *clinical practices* and *organizational cost management*.

Figure 2: Public Health Performance Management System

Source: Public Health Foundation. (n.d.). About the Performance Management System Framework.

http://www.phf.org/focusareas/performancemanagement/toolkit/Pages/PM_Toolkit_About_the_Performance_Management_Framework.aspx.

Although performance and outcome measurement in the field of addiction is challenging due to the nuances of care that are not always easy to capture in metrics, performance and outcome metrics play a crucial role in advancing the field.

As a result, treatment providers operating within the specialty SUD system in LA County are required to enter data into CalOMS/LACPRS, the electronic data collection system within Sage. **SUD providers are also required to have ongoing mechanisms for quality assessment and performance improvement.** These metrics help ensure that LA County has an evaluation system for its specialty SUD system, allowing for continuous improvement and high-quality clinical care at the system, provider, and client levels. As such, ensuring data integrity is of the utmost importance, and, to the benefit of providers and clients, providers are required to develop internal processes to support these efforts.

SAPC recognizes the importance of sharing performance and outcome data with its provider network and encourages providers to leverage available data analytics tools within Sage and their EHRs to enable detailed analysis of provider- and client-level data. SAPC will also make every effort to provide metrics to assist providers in their CQI efforts.

SECTION 6: BUSINESS PROCESS STANDARDS

Contract Management

SAPC-CCD works with all contracted provider agencies to ensure a full and accurate understanding and efficient management of contract requirements and applicable Federal, State, and County regulations. This includes:

- Updating Provider's Contract
- Ongoing Compliance Monitoring, including review of provider adherence to contract and regulatory requirements and identification of non-compliance.
- DHCS Auditing and Corrective Action Plan (CAP) Support, including coordination and oversight of corrective actions to address identified deficiencies
- Contractual and Regulatory Technical Assistance

Additionally, SAPC-CCD is responsible for maintaining an avenue for new and existing DMC-certified providers to join the DMC-ODS provider network or add new services to their contract. To achieve this, SAPC-CCD develops and maintains a solicitation process that is fair, open, and reflective of the County's needs while establishing minimum qualification standards for participation to ensure the highest level of treatment services for SUD clients. Participation in the network is contingent upon meeting SAPC requirements and ongoing compliance with contract and regulatory standards.

Certification and Licensure Requirements

All contracted DMC-ODS LOCs and sites are required to maintain the mandated certifications and licenses in accordance with State and County requirements, including when a Provider Agency seeks to add or expand services. Providers are responsible for ensuring all certifications and licenses remain active and aligned with the services delivered. Lapses or discrepancies may result in denial of claims or other contract actions.

DMC-ODS Provider Qualifications

DMC-ODS services are provided to members by DMC-certified providers. DMC-certified providers offering these services are required to:

- Be licensed, registered, enrolled, and/or approved in accordance with all applicable Federal and State laws and regulations;
- Comply with the definitions, rules, and requirements for stabilization and rehabilitation services established by DHCS;
- Sign a provider agreement with the DMC-ODS county(ies) in which DMC-ODS services will be rendered; **and**
- Maintain compliance with SAPC requirements for documentation, reporting, and care coordination for contracted services.

DHCS DMC Certification Application

DMC certification is required for all treatment LOCs except RBH and RH. New providers to the network or current providers seeking to offer additional services under their existing contract need to apply for DMC certification. The link below provides information on the DMC certification application. Providers should note the following:

- DHCS is solely responsible for administering and processing the DMC certification process.
- Certification is site-specific. Providers are responsible for identifying all sites where treatment is offered and ensuring that the DMC certification application accurately reflects this information.
- Accuracy is key. Providers are responsible for ensuring their applications are complete and accurate. The DMC certification process can be timely; a provider's careful attention may increase the likelihood of approval.
- All providers delivering Residential (ASAM 3.1, 3.3, 3.5) billed to DMC-ODS need to have either a DHCS LOC Certification and/or an [ASAM LOC Designation](#).
- DMC-ODS residential treatment providers are subject to County verification of licensing by a state agency other than DHCS and need to also obtain an [ASAM LOC Designation](#).
- Incomplete or inaccurate applications may delay certification and may impact a provider's ability to deliver and be reimbursed for services.

To access, Provider Application and Validation for Enrollment (PAVE), see [DHCS's DMC Application Information webpage](#). Provider agencies cannot deliver or bill for services at new or modified sites until all required certifications, licenses, and SAPC approvals are obtained.

Inpatient-Withdrawal Management (ASAM 3.7-WM and ASAM 4-WM)

A valid license from the California Department of Public Health (CDPH) is acceptable for DMC Certification of Chemical Dependency Recovery Hospitals (CDRHs) or freestanding Acute Psychiatric Hospitals (APHs). For additional information, see [CDPH's Licensing and Certification Program webpage](#).

DHCS AOD Certification

In accordance with [BHIN 23-058](#), effective January 1, 2025, DHCS AOD certification is required for all OP services, except DUI and OTP. DHCS AOD certification is and will continue to be required for residential LOCs. Providers delivering services without the required certification are subject to claim denials and other contract actions.

DHCS ASAM Designation

In addition to the DMC certification, all provider agencies must have the appropriate ASAM designation on their AOD licenses. Much like the DMC Certification application process, this is a State-run process, and providers are responsible for submitting accurate and complete information to support the timely processing of their application. Failure to obtain or maintain the appropriate ASAM designation will impact a provider's ability to deliver services under their SAPC contract. For additional information, see [DHCS's Level of Care Designation webpage](#).

Updating the Service Provider's Contract

Contracts may be updated to reflect changes at the Federal, State, and local levels that impact the delivery of SUD treatment. Contracts may also be amended at the request of provider agencies seeking to update organizational information or to add, modify, or remove services. For additional information, see [SAPC IN 22-14](#) or the most recent version regarding Amendments.

All requested changes are subject to SAPC review and approval. Provider agencies cannot implement changes to services, sites, or organizational information until formal approval is granted.

Contract amendment processing timelines vary depending on the type and complexity of the requested changes. Once a request is submitted to SAPCMonitoring@ph.lacounty.gov, as indicated on the [Contract Amendment Form](#), SAPC will send an email within five (5) business days. Following this acknowledgment, SAPC will review the request to determine whether to proceed with the contract amendment process (see [Table 28: Contract Amendment Process](#)).

Incomplete or inaccurate submissions may delay processing or prevent the request from moving forward. A determination whether the request will proceed will be communicated within 14 business days of the receipt of the acknowledgment email.

When adding a new site, the following documentation must be included in the email submission:

- DMC sites - DMC certification and AOD licensing/certification
- CDSS/CCL License – Group Home (if Youth Residential)
Professional license(s)
- Floor plans that include square footage

SAPC Updates

Amendments may be implemented either as a new contract or through SAPC Bulletins or INs. Provider agencies will receive timely notifications about all pending changes and are expected to follow all updates communicated through SAPC Bulletins and INs. Provider agencies are also required to attend training sessions or meetings related to these changes.

Provider Agency Changes

Provider agencies may request updates, additions, or removals to their contracts to reflect organizational changes. All changes are subject to SAPC review and approval. For additional information on the contract amendment process, see [Table 28: Contract Amendment Process](#).

Table 27: Contract Amendment Process

Contract Action	When do I do this?	How do I do this?	How long does this take?
Funding Augmentation	Provider agencies should monitor their funding utilization and request any increases or decreases as needed. Funding augmentations are approved based on utilization (providers need to have utilized at least 50% of their contracted allocation), performance, and community needs.	Provider agencies need to justify all requests with relevant data and supporting documentation and submit the request using the "Contract Amendment Form" in SAPC IN 22-14 or the most recent version regarding Amendments. All required and applicable fields of the Contract Amendment Form need to be completed, and appropriate justification, documentation, and attachments need to be provided that support the need for additional services and/or sites.	3 to 4 months
Add/Remove Services or Locations	Provider agencies may request to add or remove services (including adding beds) based on new certification or as a result of organizational changes. SAPC reserves the right to approve or deny any request for additional sites and/or services based on the provider agency's performance or in the interest of the County.	The same information is listed above.	2 to 3 months
Update Staff Names	As part of the contract, provider agencies are required to notify SAPC of any program leadership changes. Staff may be subject to credentialing requirements.	Notify SAPC in writing of the new staff and describe their role and title. If staff are required to be credentialed, the provider also needs to include the required documents. Requests can be sent to SAPCMonitoring@ph.lacounty.gov and your assigned CPA.	1 month
Other Changes	Much of the provider agency's information is entered into a database. To ensure the most current and accurate information, any organizational changes must be reported to SAPC.	Notify SAPC in writing of any organizational changes. Requests can be sent to SAPCMonitoring@ph.lacounty.gov and your assigned CPA.	Varies

Required Information

Provider agencies are required to justify all requests with relevant data supporting the need for additional services or sites. Requests must include:

- Needs assessments demonstrating how the requested service or capacity increase addresses community needs.
- Supporting evidence that existing network capacity does not meet community needs.
- Documentation of experience serving high-risk and/or special populations, if applicable.
- Any additional information necessary to support the requested change to the contract or agreement.

Ongoing Compliance Monitoring

As the steward of taxpayer funds and SUD treatment in LA County, SAPC is responsible for ensuring services are delivered appropriately, effectively, and in accordance with contractual, Federal, State and local requirements. To meet these obligations, all provider agencies are subject to multiple types of monitoring, including:

- SAPC Compliance Monitoring
- State Monitoring
- County Fiscal Monitoring

SAPC Compliance Monitoring

SAPC-CCD conducts ongoing compliance monitoring activities to assess provider agency adherence to contractual and regulatory requirements. Each provider agency is assigned a CPA, who serves as the primary point of contact for non-clinical matters. The CPA works collaboratively with provider agencies to support compliance and address identified issues. SAPC-CCD conducts compliance reviews and works with provider agencies to correct identified deficiencies. SAPC-CCD also partners with SAPC-QI to conduct clinical documentation reviews. Core compliance activities include:

- **Personnel Review:** Review of staff records, including credentialing documentation.
- **Administrative Review:** Review of policies, procedures, protocols, licenses, certifications, and other administrative documentation.
- **Documentation Review:** Review of client records, including authorization forms documentation, assessment notes, Progress Notes, including whether addiction medications were offered as a component of treatment, Problem Lists (non-OTP settings), and Treatment Plans (OTP settings), ROI authorization forms, acknowledgments, and other mandated documentation.
- **Client Interview and Activity Observations:** Contact clients and/or observe treatment activities to verify service delivery.
- **Training and Meeting Compliance:** SAPC-CCD staff will monitor provider agencies' participation in required trainings, including CalAIM-related trainings and All Treatment Provider Meetings, which require the in-person attendance of at least one (1) agency representative at the Executive Leadership level.
- **Complaint/Grievance Review:** Investigation and resolution of complaints/grievances submitted to SAPC.
- **Other compliance activities:** Additional monitoring activities, including data review, staff interviews, and facility inspections, as needed.

The CPA works with provider agencies to develop and implement CAPs to address identified deficiencies or instances of non-compliance. In accordance with regulations governing the use of taxpayer funds and program standards, certain deficiencies may necessitate the repayment of funds to the County. If repayment is necessary, the CPA can assist in developing and implementing a repayment plan.

Additionally, SAPC may take contractual action for any non-compliance that remains unresolved by the identified deadline. These actions may include, but are not limited to:

- Recoupment of funds
- Holding payments
- Denial of the requested contract action, including augmentations.

Instances of fraud, waste, or abuse, including suspected or intentional misconduct, may result in contract action up to and including termination. As required, SAPC-CCD will report any suspected fraud, waste, or abuse to DHCS.

Emergency Preparedness Requirements

In accordance with [SAPC IN 25-13](#), all contracted provider agencies are required to develop, implement, and maintain a written Emergency Preparedness Plan to ensure the safety of staff and participants and to support continuity of services during emergencies.

At a minimum, provider agencies must ensure their Emergency Preparedness Plan:

- Identifies potential emergency scenarios relevant to the agency's operations
- Establishes clear roles and responsibilities for emergency response
- Includes procedures for evacuation, shelter-in-place, communication, and emergency response
- Provides for staff training and regular emergency drills
- Addresses continuity of operations and service delivery during and after an emergency
- Is reviewed and updated regularly
- Maintains current emergency contact information

Provider agencies are required to submit and maintain their Emergency Preparedness Plan in accordance with SAPC requirements. Plans will be reviewed as part of routine monitoring and contract compliance activities.

For full requirements and implementation guidance, provider agencies must refer to [SAPC IN 25-13](#).

State Monitoring

DHCS conducts audits of treatment providers in accordance with AOD licensing and DMC Certification requirements. These audits may include Fiscal Reviews and Post Services/Post Payment reviews. SAPC-CCD will work with the Provider Agency to support resolution of audit findings, including development and resolution of CAPs, as outlined in the flowchart below.

Provider agencies are also required to obtain an external audit of their financial statements. Additional information is provided under County Fiscal Monitoring.

County Fiscal Monitoring

SAPC partners with the County Auditor-Controller to conduct mandated fiscal monitoring. Fiscal monitoring involves reviewing the Provider Agency's financial records to verify compliance with the contract's financial terms and generally accepted accounting principles. Fiscal compliance reviews remain required under County and funding policies and are a critical tool for effective fund management, including verifying their appropriate use. Compliance requirements remain in effect and are not affected by state-level changes resulting from CalAIM. Fiscal monitoring will review financial records annually, but for the prior closed FY.

Fiscal monitoring focuses on the following areas:

- **Accounting Records:** To review overall contractor operations
- **Cash Position:** To determine if the contractor is fiscally viable
- **Financial Condition:** To verify that the contractor maintains a positive working capital position
- **Billing/Expenses:** To confirm the accuracy of service units and operating expenses
- **Payroll:** To ensure staffing is appropriate, and payroll taxes are not delinquent

Provider Agencies must collaborate with their accounting teams to establish strong internal systems that support accurate financial tracking and documentation. Key areas to address include:

- Cost Allocation Plan
- Ensure all expenditures are supported with adequate and acceptable documentation
- Internal Controls
- Accounting and Financial Reporting
- Fiscal Viability

Additional information can be found in the most current version of SAPC IN Annual Fiscal Compliance Reviews for Substance Use Prevention, Harm Reduction, Treatment, and Related Service Agreements. The IN includes guidance on preparing for annual fiscal compliance reviews and best practices.

Annual Audited Financial Statement Requirement

In accordance with the [Los Angeles County Board of Supervisors Policy 4.051](#), the County must conduct an annual analysis of all contracted provider agencies. As part of this analysis, SAPC must collect Audited Financial Statements from all provider agencies that have an active contract agreement(s) with SAPC. All contracted provider agencies, regardless of corporate status (for-profit or non-profit) or the services provided, must conduct an annual audit of their financial records to maintain compliance with relevant accounting practices and verify financial accuracy.

Furthermore, provider agencies that expend over \$1,000,000 in federal funds during the entity's fiscal year must ensure their Audited Financials include the Single Audit Report requirement(s) and submit to SAPC. A Single Audit is required for provider agencies that expend \$1,000,000 or more in federal funds during their fiscal year, an increase from the previous \$750,000 threshold. These audits ensure that provider agencies' financial records are accurate, reliable, compliant with Generally Accepted Accounting Principles (GAAP), and in compliance with laws and regulations related to federal awards.

Table 28: Financial Audit Submission Requirements and Timelines

Type of Audit	Provider Agency Requirement	Due Date
Audited Financial Statements	All Contracted Service Provider Agencies must complete an independent financial audit on an annual basis.	30 calendar days after provider agency receives the report or nine (9) months from close of fiscal year (whichever is earlier).
Single Audit Report	Provider agencies who expend over \$1,000,000 or more in federal funds, during entity's fiscal year, as a federal requirement in provider agency's Audited Financials.	30 calendar days after provider receives the report or nine (9) months from close of fiscal year (whichever is earlier).

To ensure the validity of the report, the financial audits must include, but not limited to, the following:

- Must be conducted by an external, non-related, independent third-party Certified Public Accountant
- Opinion Letter: Certified Public Accountant's objective opinion on the presentation of financial statements and compliance with Federal laws and regulations for Single Audits.
- Must include the full prior fiscal year
- The audit must include, but not limited to, the following audited statements:
 - Balance Sheet
 - Income or profit/loss statements,
 - Statement of cash flows
 - Statement of changes in owners' equity

Contracted Provider Agency and Staff Credentialing

SAPC-CCD will work with all treatment providers to credential and re-credential all providers and their staff. In accordance with [MHSUDS 18-019](#), provider agencies need to submit an attestation as part of the contracting process. For additional information, see the most current version of the [Prospective DMC Contract Application](#) published on SAPC's website.

- Appropriate licenses, registrations, certifications
- History of loss of license or felony conviction
- Evidence of completed required education and training, including medical residency and ongoing education, if applicable
- Work history
- Any limitations or disabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation
- Hospital and clinic privileges in good standing
- History of any suspension or curtailment of hospital and clinic privileges
- History of loss or limitation of privileges or disciplinary activity
- Current DEA identification number
- National Provider Identifier number
- Current malpractice insurance in an adequate amount, as required for the particular provider type
- History of liability claims against the provider
- Provider information, if any, is entered in the [National Practitioner Data Bank webpage](#), when applicable

- History of sanction, termination from Medicare and/or Medicaid/Medi-Cal providers, or those who appear on the [Suspended and Ineligible Provider List webpage](#), may not participate in the Plan's provider network
- History of sanctions or limitations on the provider's license issued by any state agency or licensing board
- A lack of present illegal drug use
- The application's accuracy and completeness

Staff Vaccination Requirements

SAPC provider agencies must adhere to the latest SAPC Bulletins or INs describing COVID-19 testing and vaccination requirements.

Protected Health Information Requirements

All provider agency staff who access or assist with the disclosure of PHI or Personally Identifiable Information (PII), or who provide direct services to clients, need to complete the following before gaining access or starting client work:

- Complete a criminal background check through the California Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI), including fingerprint-based Live Scan submission.
 - Each provider agency needs to implement a protocol to ensure background checks are conducted before employment begins.
 - The criminal background check is processed through a qualified Live Scan vendor.
 - Records are retained for three (3) years after the individual leaves the organization.***Note for Youth Providers: All staff (including volunteers, interns, and contractors) who work with minors need to complete DOJ/FBI fingerprint-based Live Scan checks and enroll in the DOJ Subsequent Arrest Notification service. Youth providers need to include DOJ/FBI clearances for their staff.***
- Be enrolled in the DOJ's Subsequent Arrest Notification service for the duration of their employment.
- Complete annual information security and privacy training.
 - Each provider agency needs to implement a protocol to ensure that annual training is completed.
 - Provider agencies need to maintain training records for compliance monitoring purposes.
- Sign an annual confidentiality statement acknowledging their responsibilities related to the protection of PHI/PII.
 - Each provider agency needs a process to ensure that statements are completed and signed annually.
 - Signed statements are retained for six (6) years following contract termination or staff separation.

Contractual, Programmatic, Fiscal, and Regulatory Technical Assistance

Understanding all the regulations that govern services is critical to implementing a successful program. SAPC-CCD staff work with provider agencies to ensure understanding and appropriate implementation of all contractual and regulatory requirements. Additionally, SAPC-CCD and SAPC-QI teams monitor agencies' programmatic compliance with agency contracts and the most recent version of the Provider Manual. Service providers should contact their CPA with any questions or request technical assistance.

Regulations to be familiar with:

- Contract/Agreement with SAPC
- Substance Use Disorder Treatment Services Provider Manual (this manual)
- [CCR Title 22](#) & [CCR Title 9](#)
- [DHCS BHINs](#)
- Certification Standards (DMC and AOD)
- [DHCS's Adolescent Substance Use Disorder Best Practices Guide \(October 2020\)](#)
- [HIPAA](#) & [42 CFR Part 2](#)
- [42 CFR Part 438](#)
- Federal Register
- Special Terms and Conditions (STCs) of the DMC-ODS waiver
- Los Angeles County Auditor-Controller's Contract Accounting and Administration Handbook
- Los Angeles County Auditor-Controller's County Fiscal Manual
- [DHCS's Substance Use Disorder Perinatal Practice Guidelines \(November 2025\)](#) (Contracted Perinatal Programs)
- [CMS - Provider Reimbursement Manual](#)
- [DHCS DMC Billing Manual](#)

SAPC Provider Policy Requirements

In accordance with the County's State contract, providers are mandated to develop and implement policies to ensure adherence to laws and guidelines that regulate SUD treatment. In addition to those mentioned throughout this manual, below is a partial list of policies that providers are required to have:

- **Record Retention:** Ensure both clinical administrative and financial records.
- **Program Integrity:** Develop a committee comprised of high-level staff to implement policies aimed at detecting and preventing fraud, waste, and abuse, see [SAPC Bulletin 22-10](#).
- **Organizational Changes:** Develop a procedure to ensure SAPC is notified of any organizational changes, including changes to services, locations, or high-level staff.
- **Training:** Ensure that staff are properly trained on aspects of the DMC-ODS, including ASAM,
- **Hepatitis Program:** Develop policies and procedures to prevent and/or reduce the risk of Hepatitis A, B, and C transmission to staff and clients, and make HAV/HBV/HCV resources readily available to clients; see [SAPC Bulletin 19-01](#).

Note: Providers should work with their CPA to identify all the required policies and procedures.

Finance Management

Provider agencies' reimbursement methods continue to adapt due to LA County's participation in the DMC-ODS Waiver and CalAIM. Therefore, key business management practices need to be in place and monitored regularly (e.g., monthly) to ensure that the people served and units of services claimed align with costs incurred. Any excess funds resulting from rates exceeding actual costs should be reinvested in allowable business and clinical capacity-building efforts well before the end of the FY. Long-term viability and sustainability will depend on the agency's ability to grow and reduce costs and expenditures based on staff productivity improvements resulting from delivering medically necessary treatment services at the right LOC.

Rates and Allowable Service Codes

The Rates Matrix details allowable HCPCS and Current Procedural Terminology (CPT) codes billable for treatment and RBH services. It lists each approved code along with the corresponding reimbursing rate based on the performing provider's license type. The Rates Matrix also details the billing rules for each code, as defined by DHCS. SAPC releases an updated Rates Matrix each FY, with rates effective for the designated FY. Since codes and rates may change from FY to FY, it is the responsibility of Secondary Sage Users to ensure that their EHR systems are configured with the appropriate billing codes and rates for each FY.

Provider agencies should review the most current version of the Rates Matrix to identify their applicable reimbursement rates, codes, and other applicable information based on their contracted services and tier. The most current version of the rates matrix is available at the SAPC website, under Provider Bulletins.

Investments to Support a Modern SUD System

As SAPC continues to advance its value-based strategy, provider agencies are expected to take a deliberate, forward-looking approach to strengthening client care and service delivery. Progress within SAPC's value-based framework requires intentional planning and ongoing investment across financial, clinical, organizational, and workforce domains. Provider agencies that do not reinvest revenue into program services (e.g., clinical training, competitive salaries, technology infrastructure) risk limiting their capacity to improve client outcomes and may reduce their ability to earn future performance-based revenue.

To remain aligned with SAPC's strategic direction, provider agencies should regularly assess their operational and clinical practices to determine if current strategies:

- Reflect evidence-based or emerging best practices
- Support a coordinated, efficient, and effective system of care
- Identify priority areas for targeted investment to address service gaps and enhance quality

SAPC's implementation of Behavioral Health Payment Reform, including SAPC's Value-Based Incentives (formerly Capacity Building and Incentives), provides agencies with opportunities to earn additional revenue tied to performance and client care. These funds are intended to be reinvested to strengthen service delivery and improve client care. Additionally, agency contract budgets have been revised to include a Program Investment Fund, enabling providers to allocate a specific amount to program investments.

Provider agencies are strongly encouraged to make timely, targeted investments that directly strengthen service delivery. This involves focusing on staffing improvements, especially offering competitive salaries, to ensure workforce stability and retain employees. Strategic financial decision-making requires a clear understanding of how a provider agency's budget aligns with its fee-for-service (FFS) revenue and service utilization patterns. Provider agencies should routinely analyze both projected and actual utilization data, such as the number of clients served or units of service delivered, to ensure that the financial decisions are sustainable and aligned with program needs.

Figure 3: SAPC's Payment Reform 10-Year Roadmap

Phase 1		Phase 2		Phase 3		Phase 4		Phase 5	
Investing in the Foundation		Implementing Outcome-Focused Reforms		Delivering Quality + Value		Managing Risks + Rewards		Operating in an Advanced Value-Based or Population Health Environment	
2023-24	2024-25	2025-26	2026-27	2027-28	2028-29	2029-30	2030-31	2031-32	2032-33

For the SUD system of care to fully transition into a modern, outcomes-driven healthcare delivery system, all provider agencies must recognize the value of making intentional investments that strengthen both clinical care and the broader service environment. Provider agencies are expected to assess their organizational needs, prioritize areas for improvement, and implement meaningful changes.

The investment categories outlined in [Table 30: Recommended Clinical and Business Investments](#) represent strategies that are strongly encouraged and aligned with Federal, State, and local requirements. Implementing these and other allowable investments will better position provider agencies to meet the expectations of this Provider Manual and successfully operationalize the system-wide reforms underway.

Table 29: Recommended Clinical and Business Investments

Investment Area	Recommended Investments
Finance and Business Operations: Strengthen financial and operational efficiency by aligning service delivery with reimbursement structures. Ensure that appropriate, billable treatment services are provided to generate sufficient revenue to sustain and grow operations.	• Data systems and infrastructure, including data aggregation, reporting, and analytics, as well as related implementation, consulting, or staffing support • EHR costs (if not using Sage), or tools and enhancements to optimize clinical documentation and workflow efficiency • Accounting systems and financial management tools, including consulting services and staffing to build internal financial capacity • Quality management systems, including tools, infrastructure, and staffing to support continuous quality improvement and performance monitoring
Workforce Development: Recruit, retain, and develop a skilled workforce prepared for future value-based care models. Equip staff to serve an increasingly complex client population and to succeed in a treatment environment where measurable outcomes drive reimbursement.	• Workforce recruitment, hiring, and retention strategies for qualified clinical and non-clinical staff • Training and certification support for SUD Registered and Certified Counselors • Employee benefits and retention initiatives (e.g., wellness programs, career pathways, health insurance, and retirement benefits, etc.) • Staff training in emerging and evidence-based treatment modalities, including

Investment Area	Recommended Investments
	ASAM Criteria 4th Edition Language access planning, including hiring and retaining staff proficient in threshold languages
Access to Care: Reduce barriers to care across the SUD system through intentional improvements in policies, practices, and service delivery. Expand access, improve responsiveness, and ensure individuals can engage in care when and where they need it.	- Initiatives to improve service access, engagement, and retention, particularly for underserved or hard-to-reach clients (i.e., Reaching the 95% [R95] Initiative) - Expansion of service availability, including extended hours, additional service days, or FBS to increase availability and accessibility of care - MAT capacity, including prescribing clinician staffing, training, technology, and referral systems - Care coordination enhancements, including staffing, technology, and training to support client navigation across services - Intake, scheduling, and referral capacity, including staffing and systems to respond to SASH services requests and other referral sources - Facility improvements (e.g., paint, furniture) that enhance the client's experience and care environment

In the past, many operational and clinical decisions were made by program or clinical administrative staff, at times without adequate funding support. Under these new service standards, the increased emphasis on client choice and the need to meet utilization projections make it essential for finance staff to play a more active role in ensuring that budgets align with service needs. Ultimately, the more effectively an organization engages and retains clients in medically appropriate services that address individualized needs and preferences, the better positioned it will be to reinvest in improvements that support business growth and long-term sustainability.

A strong understanding of the relationship between clinical and business operations is critical within the managed care model. Strategic clinical and business investments will support provider agencies in navigating this organizational-level transition. Effective communication across provider agency staff, combined with ongoing research and analysis, will be essential in determining which investments will most effectively strengthen service delivery and improve client outcomes.

Budget Development Process

Now that the County and its Provider Agencies are operating under a managed care model, it is even more critical that the budget and expenditures clearly align with the organization's business and clinical needs. Therefore, when agencies develop the annual budget for all agency-operated locations, it is crucial to clearly articulate the essential expenditures that will support compliance with Federal, State, and local regulations, as well as the expectations outlined in this Provider Manual and other contract-related documents, and make a substantive contribution to positive client outcomes.

As outlined in [SAPC IN 25-03](#), the Budget Approval System (BAS) will be used by all Provider Agencies when submitting a contract budget. Each Provider Agency will submit one (1) budget that complies with the guidance in the IN and the attached instructions, including details by agency-operated site address. Any costs associated with FBS need to be estimated and detailed under the associated agency-operated site.

Costs can either be direct or indirect:

- **Direct Costs:** Typical direct costs include, but are not limited to, compensation for employees who provide treatment, related fringe benefit costs, material costs, and other treatment-related expenses. These costs can be specifically identified with a particular final cost objective ([2 CFR § 200.413](#)).
Note: Meal costs are only allowable in residential and inpatient programs (ASAM 3.1, 3.3, 3.5, 3.2-WM, 3.7-WM, 4-WM); snack costs are only allowable when provided to minors (ASAM 0.5, 1.0, 2.1). Non-SAPC funds need to be used for all other food purchases. Food costs need to be reported under the "Food and Snacks" line item in the "Services and Supplies" category and clearly tracked and managed.
- **Indirect Costs:** Typical indirect costs include, but are not limited to, depreciation, cost of operating and maintaining facilities, general administration, and general expenses, such as the salaries and expenses of executive officers, personnel administration, accounting, and utilities. These costs are incurred for common or joint objectives and cannot be readily identified with a particular final cost objective ([2 CFR § 200.414](#)).

Provider Agencies are encouraged to review [SAPC IN 25-03](#) and the accompanying instructions to better understand how to complete program budgets. Additional guidance, including an instructional video, is available on the SAPC website under the "Finance" section on [SAPC's Manual, Bulletins, and Forms - Finance webpage](#).

Claims Submission and Reimbursement Process

Provider Agencies submit claims through the electronic billing system (e.g., Sage) by the 10th of each month. Claims submitted for treatment services need to be submitted to SAPC via:

- Sage Fast Service Entry Submission form for Primary Sage Users
- EDI files submitted via the SFTP for Secondary Sage Users

Treatment services submitted to SAPC are generally processed within 24 hours and are subject to claim adjudication rules configured in Sage. These rules prevent approval and payment for services that do not comply with the policies outlined in the Provider Manual and Rates Matrix. Claims for services submitted against a service authorization in a pending status will be denied upon submission.

SAPC staff retrieves the Providers' billing invoices by contract number and by reporting period to determine the appropriate payment amount. SAPC staff then verifies the payment amount information calculated by the system for the reporting period. Adjustments for Accounts Receivable are also applied due to Audit findings, Cost Report Settlements, State denial takebacks, and refunds. SAPC's reasonable timeline for processing payments is 15 calendar days after receipt of an invoice, which falls on the 25th of each month. The County Auditor-Controller's Office issues payments to providers via direct deposit.

Treatment services billed to SAPC that are DMC reimbursable are generally billed to DHCS for second-level adjudication within two (2) to three (3) months of local-level (SAPC) approval. DHCS adjudication further evaluates the service information and member eligibility to determine if DHCS will reimburse SAPC for the service delivered. Upon DHCS denial of a service, the payment made to the provider may be subject to recoupment and takeback on a future date.

Provider support for claim denials or payment inquiries should be directed to the [Sage Help Desk ticketing system](#). Providers should use the Request Billing Assistance form in the ticketing portal to submit the appropriate ticket type and include detailed information about the request. It is essential that no PHI is sent to SAPC via email or other electronic systems, except through the secure Help Desk portal, to minimize the risk of PHI exposure. General requests for information on finance policies or processes, not specific to a client or specific claim, can also be emailed to SAPC-FSD at SAPC-Finance@ph.lacounty.gov.

Fiscal Reporting

Effective FY 2023-2024, SAPC implemented a streamlined Fiscal Reporting process for all service agreements, including treatment contracts. This revised process aligns with CalAIM's objectives to reduce administrative burden while still meeting local funding requirements. This tool focuses solely on key expenditures, allowing treatment providers to submit a single report for the entire organization.

For FY 2022-2023 and prior, contracts will continue to adhere to DHCS' Cost Reporting process and forms, as required by law ([California HSC § 11852.5](#) and [California WIC § 14124.24](#)), which mandate that cost reports be submitted to the State to determine how Federal and State funds are spent.

Provider Agencies should establish separate, unique cost centers for each contracted ASAM LOC, for other services provided under an SAPC contract (e.g., RBH services), and for non-treatment services (e.g., prevention programs). Establishing cost centers to capture all contracted treatment and non-treatment services will enable efficient, accurate tracking of associated costs and revenue for each service. This information is essential to ensure fiscally viable services and to identify resources for reinvesting in the program. Additionally, provider agencies are required to submit a narrative for each report that expands visibility into how funds were utilized and invested. This information will help SAPC better design programs and opportunities for providers. For additional information, see the most current version of [SAPC IN Implementation of Fiscal Reporting Process for All Substance Abuse Prevention and Control Bureau Service Providers](#).

Overview of Fiscal Report Process

SAPC-FSD will issue the fiscal reporting tools for the prior FY at the start of the FY. The tool is designed to collect cost information at the agency level and should be completed within a reasonably short period of time, approximately two (2) weeks. SAPC-FSD will review the submitted information, finalize the report, and issue a final report letter by the end of the calendar year.

Note: For FY 2022-2023 and prior years, DHCS will continue to manage reporting according to its internal timelines. Once released, SAPC-FSD will distribute the reports and supporting documentation in accordance with DHCS's instructions. Any changes to the cost report template format or formulas will render the cost report null and void.

DMC Cost Reconciliation Methodology

For FY 2022-2023 and prior, the rate at which a provider bills for DMC services is an interim rate until the cost report is finalized. SAPC will settle for the lower cost or charges.

Fiscal Report Records and Supporting Documentation

Provider agencies need to maintain a formal set of financial records, including a general ledger and books of original entries (e.g., cash receipts journal/register, cash disbursements journal/register, and a general journal). Entries in these record books of original entry need to be traceable to source documentation. Evidence of expenditure needs to be sufficient to substantiate that the expenditure was incurred and that the expenditure was necessary for the provision of the service. This evidence includes paid invoices, canceled checks, contracts, purchase orders, and receiving reports.

In addition, provider agencies need to maintain fiscal and statistical records for the period covered by the cost report that are accurate and sufficiently detailed to substantiate the cost report data. All documentation needs to be retained until the later of the following:

- A financial audit is conducted; **or**
- A period of 10 years following the date of the interim cost settlement.

All records of funds expended and costs reported are subject to review and audit by DHCS and/or the Federal government pursuant to the [California WIC § 14124.24\(g\)\(2\)](#) and [California WIC § 14170](#).

Fiscal Report Training and Preparation

The county provides cost report training to all providers every year during the month of August. If you do not receive an invitation from us, email SAPC-FSD at SAPC-Finance@ph.lacounty.gov.

To prepare a cost report, the following documents will be needed:

- County contract
- General ledger for each site
- Units billed for the FY
- Download cost report forms and instructions from SAPC's website; see:
<http://www.publichealth.lacounty.gov/sapc/providers/manuals-bulletins-and-forms.htm?tm#finance>.

Fiscal Report Submission

Submit the complete set of cost reports via email to SAPC-FSD at SAPC-Finance@ph.lacounty.gov and mail with the original signature to:

County of Los Angeles
Department of Public Health
Substance Abuse Prevention and Control
Fiscal Reporting Unit
1000 S. Fremont Avenue., Building A-9 East
3rd Floor, North Wing, Unit # 34
Alhambra, California 91803

Fiscal Report Delinquent

SAPC may impose sanctions for non-receipt of the fiscal report. Under contract Section 6.G:

“If the Annual Cost Report is not delivered by Contractor to County within the specified time, Director may withhold all payments to Contractor under all service contracts between County and Contractor until such report is delivered to County and/or, at the Director’s sole discretion, a final determination of amounts due to/from Contractor is determined on the basis of the last monthly billing received. Failure to provide the annual cost report may constitute a material breach of the Contract, at the sole discretion of the County, upon which the County may suspend or terminate this Contract.”

Information Technology Management

As the specialty SUD system better integrates into mainstream health care, there is a need to transition from a largely paper-based SUD system to an electronic, technology-based system to support integration and enhance service delivery. As such, it is essential for SUD provider agencies to incorporate information technology (IT) considerations (e.g., staff, hardware, software, infrastructure) into their business planning to establish a solid foundation for technological success from both a business and clinical perspective.

Sage and Electronic Health Record Requirements

SUD services are part of a specialty health system that operates under a managed care model. To participate in this system, provider agencies need to utilize EHR systems. EHRs enable providers to document, organize, bill for services, and share information with others within the SUD network and with external providers.

EHRs are digital client records that authorized providers can create, manage, and share with other providers. Interoperability among EHR systems supports Care Coordination and information exchange, ultimately enhancing client care. Additionally, EHR systems often contain information beyond client records, including assessment tools, processes to support UM, data reporting, and billing, among other functionalities.

Using a centralized platform to collect and share client information helps providers make more confident decisions when planning, delivering, monitoring, and billing for SUD services. For this reason, EHR systems are a core component of strong provider organizations and effective health systems.

All SUD provider sites are required to have a certified EHR to support the delivery of high-quality specialty SUD services within a managed care setting.

Sage

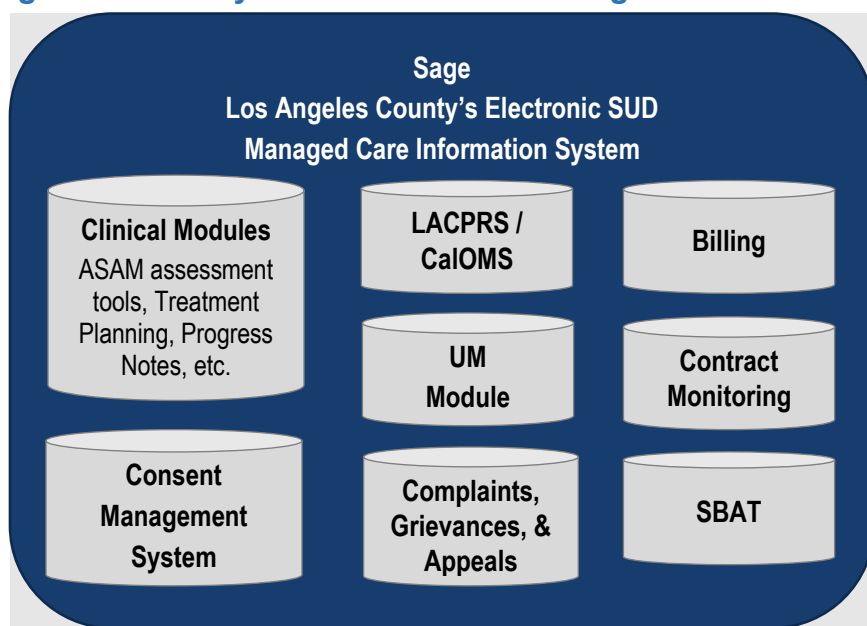
Sage is a certified, web-based SUD EHR system comprising clinical, administrative, and data-reporting modules that meet mandatory government reporting and interoperability requirements. Sage provides the structure needed to oversee and deliver SUD services in a managed care setting. The system is compliant with both [42 CFR Part 2](#) and [HIPAA](#).

Figure 4: Sage – LA County’s Electronic SUD Managed Care Information System shows Sage’s range of features, which cover all essential functions a specialty SUD provider needs to operate within the SAPC network. The provider-facing platform is called Sage-PCNX, also known as ProviderConnectNX.

SAPC continues to fund the development, implementation, ongoing maintenance, and support for Sage. SUD provider agencies will be responsible for ongoing training.

For additional information on Sage, including training details, User Access Groups, billing, and ASAM CONTINUUM™ Assessment trainings, see www.publichealth.lacounty.gov/sapc/Sage/Sageinfo.htm.

Figure 4: Sage – LA County’s Electronic SUD Managed Care Information System



Providers Eligible for Sage

Selecting an EHR system is a personalized business decision for specialty SUD providers. While providers are not required to use Sage as their agency’s primary EHR system, all provider agencies must use a certified EHR approved by SAPC.

Some functions need to be completed in Sage by all providers, regardless of whether they have their own EHR system. These include activities related to billing and authorizations, such as completing the following forms or processes directly in Sage:

- Patient admission (Admission (Outpatient) form)
- ASAM CONTINUUM™ Assessment and ASAM CO-Triage® Tool
- Youth and Young Adult Screener
- Financial Eligibility
- SAR
- Diagnosis

- Provider Site Admission
- Discharge and Transfer form
- RBH Discharge Form
- Real-Time Eligibility 270 Request
- Referral/Service Connections Log
- Women's Health History and Reproductive Health (for PPW clients)
- CalOMS Forms

Note: Additional forms may be required to be completed in Sage, depending on business needs.

Sage is available to SUD providers who do not currently have an EHR. Providers who elect to continue using a SAPC-approved EHR may do so, provided they coordinate with SAPC IT to ensure necessary data exchange capabilities. **Once a provider elects to use their own EHR system, they may not switch to Sage as their primary EHR in the future.**

For OTP providers, Sage cannot be used as the primary EHR due to specific system requirements. OTPs provider agencies need to maintain their own EHR system. Sage will be used to document admissions, access ASAM assessments, access the UM module, and report data. Otherwise, OTPs' clinical and billing functions will remain on their current EHR systems.

For non-OTP providers who elect to utilize Sage, it must be used for all treatment services within SAPC's specialty SUD system.

Note: Prevention and DUI services do not utilize Sage at this time.

Sage User Roles

To fully utilize Sage's benefits, SUD providers should actively manage the user roles assigned to their staff. Sage supports a wide range of staff roles, enabling providers to carry out various functions, including but not limited to:

- Varying Clinical Levels in LPHA, Counselors, and license-eligible LPHA, and those who also conduct financial tasks
- Financial Staff
- Clinical Trainees
- Audit User
- Operations
- Clerical
- Peer Support Specialist (also known as CMPSS or Certified Peer)
- LVN & MA

For additional information on managing access groups for staff on Sage, see the [Sage User Enrollment webpage](#) on SAPC's website.

Note: SAPC will review all user roles to ensure that roles are appropriately assigned.

Provider Responsibilities

SUD providers have several responsibilities related to the use and management of their EHR systems. These include:

- Acknowledging the essential role EHR systems play in delivering high-quality SUD care.
- Including IT planning as part of agency business operations. This includes maintaining appropriate hardware, up-to-date anti-virus protection, and the latest Windows security patches, as well as IT staff to support their EHR.
- Ensuring staff are properly trained to use the EHR effectively.
- Notifying SAPC of issues to identify collaborative solutions.
- Developing downtime procedures to avoid service disruptions during scheduled or unexpected system outages. To prepare for downtime, provider agencies need to keep hard copies or other formats not impacted by Sage of the following documents:
 - Current client roster
 - ASAM Assessment tool, Service Request Form template
 - Problem List (non-OTP settings) or Treatment Plan (OTP settings) template
 - Progress Note template
 - Discharge and Transform template (for all LOCs)
 - RBH Authorization Request form and Discharge form
 - Billing required documents
 - All required consent forms
 - Admission/Discharge forms
 - Any other documents required by the County
- Complying with SAPC policies and procedures by immediately reporting any potential data breaches or concerns related to data integrity.

Sage Trainings

SAPC will provide support for initial credentialing training for SAPC Provider Agencies using Sage. It is the responsibility of the provider agencies to ensure their staff receive ongoing training. This includes maintaining proficiency, staying current with new system features, and planning for staff turnover by developing internal super-user expertise.

All staff who will access Sage need to complete required trainings. To support this, SAPC has developed a series of enduring Sage learning modules available through the [SAPC-LNC platform](#), along with user guides published on SAPC's website for most major Sage User Roles for providers to acquire the necessary knowledge and skills to use Sage effectively and to ensure quality and consistency of training across the network. The web-based trainings are accessible 24/7 on the [SAPC-LNC platform](#) and are module-based, allowing for completion in multiple sessions. Prior to being granted access to Sage, users must demonstrate proficiency by completing the required trainings, reviewing the user guides, and passing the competency exam included in this training.

All practitioners for whom a provider agency intends to bill for services need to be credentialed in the Sage system, even if the performing provider will not use Sage directly. Failure to credential staff will result in claim denials. Provider Agencies that use their own EHRs must complete the regular onboarding process to be

credentialed in the SAPC provider network. This process includes requesting an LA County C-number and submitting a Sage Help Desk ticket with the SAPC Sage User Creation Form. The form should include the practitioner's credentials (e.g., license number) and select Access Group #13 "Clinical Visible Only—No Login". This allows Sage to store practitioner data for billing purposes without granting full system access. This requirement applies to all billable staff, including those administering medications in OTP settings, but who will not access the Sage system directly.

SAPC Learning and Network Connection Platform

The SAPC-LNC is a learning and network management platform that provides a gateway to SAPC's programmatic and network training resources. This platform offers a range of free, on-demand trainings and content designed specifically created for SAPC Network Providers to support all types of substance use services. The trainings and content aim to strengthen clinical practice and address the operational needs of Provider Agencies.

Providers at contracted provider agencies can register for and complete on-demand trainings at their own pace. Certificates of completion are available for download once training is finished. Many clinical trainings on the SAPC-LNC platform also offer CEs for eligible disciplines.

To access the SAPC-LNC platform, service providers/practitioners from contracted provider agencies need to register for an account directly on the [SAPC-LNC platform](#). For guidance on registration, navigation, and technical support, refer to the [SAPC-LNC Getting Started Guide](#).

SAPC-LNC also provides functionality that allows provider agencies to designate supervisor users to manage their staff, including SAPC-LNC enrollment, assignment of training(s), running training reports, and sending training reminders. To request access to the SAPC-LNC supervisor user role, providers should have their SAPC Application Management Liaisons submit a SAPC-LNC Supervisor User Role request form to SAPC's Access Management Section (SAPC-SAMS).

SECTION 7: APPENDICES

Appendix A. Glossary

TERM	DEFINITION
ASAM CO-Triage® Tool	This is a short screener based on ASAM criteria used to determine whether adults and young adults need SUD treatment and the provisional LOC, which would most likely benefit them.
Assessment	The process for defining the nature of an issue, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis. ASAM-based assessments examine six (6) dimensions: 1. Acute intoxication and/or withdrawal potential 2. Biomedical conditions and complications 3. Emotional, behavioral, or cognitive conditions and complications 4. Readiness to change 5. Relapse, continued use, or continued problem potential 6. Recovery environment At a minimum, comprehensive assessments include the following elements: • History of the present episode • Substance use and addictive behavior history • Developmental history (as appropriate) • Family history • Medical history • Psychiatric history • Social history • Spiritual history • Physical and mental status examinations, as needed • Comprehensive assessment of the diagnosis and pertinent details of the case • Survey of assets, vulnerabilities, and supports • Treatment recommendations • Financial status/history • Educational history • Employment history • Criminal history/Legal status
BenefitsCal	BenefitsCal is a portal where Californians can get and manage benefits online. This includes food assistance (CalFresh) formerly food stamps, cash aid (CalWORKs, General Assistance, Cash Assistance Program for Immigrants), and affordable health insurance (Medi-Cal). Review the BenefitsCal How-to Videos on YouTube for additional information regarding BenefitsCal.
Campus Provider	State DMC certification/approval with multiple addresses under one (1) NPI#, one (1) Provider ID, and one (1) DMC Number.
Care Coordination	A service to assist clients in accessing needed medical, educational, social, prevocational,

	vocational, rehabilitative, or other community services. It is a collaborative process of assessment, planning, facilitation, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes. In order to link clients with services and resources (e.g., financial, medical, or community services), care coordinators need to have a working knowledge of the appropriate services needed for the client to optimize care through effective, relevant networks of support.
Care Planning (also known as <i>Treatment Planning</i>)	The provider (certified SUD counselor or LPHA) needs to prepare an individualized Plan of Care that is reflected in the clinical notes documenting the client's care and aligned with the Problem List (non-OTP settings) or Treatment Plan (OTP settings). The requirements for this Problem List and Treatment Plan documentation are described in and , respectively.
Certified Medi-Cal Peer Support Services (also known as <i>Peer Support Services or PSS</i>)	PSS may be delivered in various settings; however, if a Certified Peer does not provide services, then they may not be reimbursable by Medi-Cal. PSS need to be based on an approved Plan of Care. The Plan of Care needs to be documented within the Progress Notes in the member's clinical record and approved by any treating provider who can render reimbursable Medi-Cal services. Certified Peers give and receive nonprofessional, nonclinical assistance to achieve long-term recovery for members. The support is provided by individuals who have experiential knowledge. Certified Peers provide assistance to promote a sense of belonging within the community. Another critical component that Certified Peers provide is the development of self-efficacy through role modeling and assisting their peers with ongoing recovery through mastery of experiences and finding meaning, purpose, and social connections in their lives.
Certified Medi-Cal Peer Support Specialists (CMPSS) (also known as <i>Certified Peers</i>)	CMPSS or Certified Peers are peer support specialists who have completed the specific certification requirements set by the DHCS and CalMHSA. To get certified, individuals need to apply, complete 80 hours of training, and pass a certification exam. Certified Peers are qualified to deliver PSS, which are reimbursable by Medi-Cal.
Chronic Homelessness defined by HUD	• A homeless individual with a disability as defined in section 401(9) of the McKinney-Vento Assistance Act (42 U.S.C. 11360(9)), who: ◦ Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter, and ◦ Has been homeless and living as described for at least 12 months* or on at least four (4) separate occasions in the last three (3) years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least seven (7) consecutive nights of not living as described. • An individual who has been residing in an institutional care facility for less, including jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria of this definition before entering that facility**: or • A family with an adult head of household (or, if there is no adult in the family, a minor head of household) who meets all of the criteria of this definition, including a family whose composition has fluctuated while the head of household has been homeless. *A "break" in homelessness is considered to be seven (7) or more nights. **An individual residing in an institutional care facility does not constitute a break in

	homelessness.
Co-Occurring Disorder (COD)	A concurrent substance use and mental or medical disorder.
Cognitive Behavioral Therapy (CBT)	A short-term, goal-oriented psychotherapy treatment that takes a hands-on, practical approach to problem-solving. CBT focuses on exploring relationships between a person's thoughts, feelings, and behaviors. During CBT, a therapist will actively work with the client to uncover unhealthy patterns of thought and how they may be causing self-destructive behaviors and beliefs. By addressing these patterns, the client and therapist can work together to develop constructive ways of thinking that will produce healthier behaviors and beliefs.
Culturally and Linguistically Appropriate Services (CLAS)	Providers are required to ensure that treatment services are delivered in a way that effectively interacts with people representing culturally, linguistically, and developmentally diverse groups, addresses their individualized needs, and optimizes treatment engagement. Organizational policies, procedures, and practices need to be consistent with the principles outlined in the National Standards for CLAS in Health and Health Care and embedded into the organizational day-to-day operations.
Discharge and Transfer Form	The document that details the client's planned discharge. The Discharge/Transfer Form needs to include, but not be limited to, the following: • A description of each of the member's relapse triggers • A plan to assist the member to avoid relapse • A support plan
Discharge Planning	The process of preparing the client for referral into another LOC, post-treatment returns or reentry into the community, and/or the linkage of the individual to essential community treatment, housing, and human services. The discharge planning process should be initiated from the onset of treatment services. This serves to ensure sufficient time to plan for the client's transition to subsequent treatment or RS and, from a clinical standpoint, to convey that recovery is an ongoing life process not a unit of service.
Documentation	SAPC will require that providers generate initial documentation based on the ASAM Criteria. The documentation needs to provide justification for the care provided, including the demonstration of medical necessity. Documentation templates developed by SAPC are used for Problem Lists (non-OTP settings) or Treatment Plans (OTP settings), Progress Notes, and other documentation developed by the SAPC-QI and SAPC-UM sections. Services provided in the community, by telephone, or by telehealth require equivalent quality and comprehensiveness of documentation as in-person services provided within a certified facility.
Drug Testing	While there is currently no widely agreed upon standard for drug testing in SUD treatment, it is often a useful tool to monitor engagement and provide an objective measure of treatment efficacy and progress to inform treatment decisions. The frequency of drug testing should be based on the client's progress in treatment, and the frequency of testing should be higher during the initial phases of treatment when continued drug use has been identified to be more common. Additionally, drug testing is best when administered randomly as opposed to being scheduled, and the method of drug testing (e.g., urine, saliva) would ideally vary as well.
Early and Periodic Screening, Diagnostic and Treatment	A benefit that provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. It is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, substance use, developmental, and specialty

(EPSDT)	services.
Evidence-Based Practice (EBP)	Practices that have been implemented and are supported by evidence. Providers will be expected to implement, at a minimum, the two (2) EBPs of MI and CBT. Other EBPs include relapse prevention, trauma-informed treatment, family therapy, and psychoeducation.
Face-to-Face	Occurring in-person at a certified facility. Telephone contacts, telehealth, home visits, and hospital visits are not considered face-to-face.
Family Services	Services are provided to clients and their family members to strengthen, enhance, and preserve the family unit. These services may include but are not limited to care coordination, childcare, crisis counseling, transportation, family therapy, or counseling.
Family Therapy	Psychotherapy involves the client and their family members, using specific techniques and EBPs (e.g., family systems theory, structural therapy, etc.). The effects of addiction are far-reaching, and clients' family members and loved ones are also affected by the disorder. By including family members in the treatment process, clinicians provide education about factors that are important to the client's recovery as well as their own recovery. Family members can provide social support to the client, help motivate the client's loved ones to provide social support to the client, help motivate the client to remain in treatment and receive help and support for their own family recovery as well. These services need to be provided by an LPHA-level therapist.
Field-Based Services (FBS)	A method of delivering SUD treatment services to clients outside of Drug Medi-Cal (DMC) Certified facilities and in community settings where clients live, work, learn, and receive other services. FBS aims to improve access to treatment services, enhance client motivation and engagement, and reach underserved populations. Like all DMC-ODS services, FBS is required to be client-centered, individualized, varied in intensity and duration, and based on medical necessity
Group Counseling	In-person or telehealth contact between one (1) or more certified or registered SUD counselors or LPHA, and two (2) or more clients at the same time (with a maximum of 12 clients in the group). Psychosocial issues related to substance use are addressed utilizing relevant best-practice clinical interventions and a focus on peer support.
Homeless <u>defined by HUD</u>	HUD's Four (4) Categories of the Homeless Definition: Literally Homeless: Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (a) has a primary nighttime residence that is a public or private place not meant for human habitation; or (b) is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by Federal, State and local government programs); or (c) is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution. Imminent Risk of Homelessness: An individual or family who will imminently lose their primary nighttime residence, provided that: (a) residence will be lost within 14 days of the date of application for homeless assistance; (b) no subsequent residence has been identified; and (c) the individual or family lacks the resources or support

	networks needed to obtain other permanent housing. <i>(Note: Includes individuals and families who are within 14 days of losing their housing, including housing they own, rent, are sharing with others, or are living in without paying rent.)</i> 3. Homeless Under Other Federal Statutes: Unaccompanied youth under 25 years of age, or families with Category 3 children and youth, who do not otherwise qualify as homeless under this definition, but who: (a) are defined as homeless under the other listed Federal statutes; (b) have not had a lease, ownership interest in permanent housing during the 60 days prior to the homeless assistance application; (c) have experienced persistent instability as measured by two (2) moves or more during the preceding 60 days; and (d) can be expected to continue in such status for an extended period of time due to special needs or barriers. 4. Fleeing/Attempting to Flee DV: Any individual or family who: (a) is fleeing, or is attempting to flee, DV; (b) has no other residence; and (c) lacks the resources or support networks to obtain other permanent housing.
High Utilizer	A high utilizer is a person who is diagnosed with an SUD and meets any of the following criteria: • 3+ ED visits related to SUD within the past 12 months • 3+ inpatient admissions within the past 12 months for physical and/or mental health conditions and co-occurring SUD • Homelessness with SUD (as defined by HUD homelessness definition) • 3+ residential SUD treatment admissions within the past 12 months • 5+ incarcerations with SUD in 12 months
Imminent Danger	Imminent danger has the following three (3) components: 1. A strong probability that certain behaviors will occur (e.g., continued alcohol or drug use or relapse or non-compliance with psychiatric medications). 2. The likelihood that these behaviors will present a significant risk of serious adverse consequences to the individual and/or others (as in a consistent pattern of driving while intoxicated). 3. The likelihood that such adverse events will occur in the very near future Note: In order to constitute “imminent danger,” ALL THREE (3) ELEMENTS need to be present.
Individual Counseling	Clinical contact between an LPHA or counselor and a client that addresses psychosocial issues related to SUDs. SAPC’s required EBPs include MI and CBT. Services may be provided in person, by telephone, or by telehealth.
Intake	Intake is the process of determining that a client meets the medical necessity criteria for care and then admitting a client into an SUD treatment program. It includes the assessment or analysis to determine whether an individual meets the current DSM-5TR criteria for an SUD diagnosis or is at risk for SUD. It also involves using the ASAM Criteria to determine if treatment is medically necessary and identifying the appropriate LOC. Intake for a pharmacological intervention includes a physical examination and laboratory testing necessary for determining and providing appropriate SUD treatment.

Lapse	A brief return to substance use following a sustained period of abstinence, despite the client remaining committed to recovery and demonstrating a willingness to re-engage with the recovery journey.
Licensed Practitioner of the Healing Arts (LPHA)	An LPHA possesses a valid clinical licensure or certification in one (1) of the following professional categories: • Physician (MD or DO) • Nurse Practitioner (NP) • Physician Assistant (PA) • Registered Nurse (RN) • Registered Pharmacist (RP) • Licensed Clinical Psychologist (LCP) • Licensed Clinical Social Worker (LCSW) • Licensed Professional Clinical Counselor (LPCC) • Licensed Marriage and Family Therapist (LMFT) • Licensed Vocational Nurse (LVN) • Licensed Psychiatric Technician (LPT) • Licensed Occupational Therapist (LOT) • Licensed-eligible LPHAs working under the supervision of licensed clinicians All LPHAs need to operate under DHCS's established scope of practice for LPHAs. RNs, LVNs, LPTs, and LOTs may not render diagnoses. As such, cannot finalize ASAM CONTINUUM™ Assessments, nor establish medical necessity.
Medical Necessity	Medical necessity for all SUD treatment provided under a SAPC contract is defined as: Adults (age 21 and over) • To begin service delivery prior to completion of the full assessment: ◦ Services are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain (California WIC § 14059.5(a)); or ◦ For OTPs, a history and physical exams conducted by an LPHA at admission, pursuant to Federal and State regulations, qualify for medical necessity determination. • To fully establish medical necessity: ◦ At least one (1) diagnosis of a substance-related and addictive disorder, with the exception of tobacco-related disorders, from the current edition of the DSM-5-TR. ◦ Appropriate placement in an SUD LOC that is consistent with recommended services and medical necessity based on the current edition of the ASAM Criteria. Youth (age 17 and under) and Young Adults (age 18-20) • At least one (1) diagnosis of a substance-related and addictive disorder, with the exception of tobacco-related disorders, from the current edition of the DSM-5-TR; or • Meet EPSDT criteria to ameliorate or correct a substance misuse-related condition.

	Any qualified provider operating within the scope of their practice, as defined by state law, can provide a screening service to trigger EPSDT coverage and medically necessary SUD treatment for Youth (age 17 and under) and Young Adults (age 18-20). Appropriate placement in an SUD LOC that is consistent with recommended services and medical necessity based on the current edition of the ASAM Criteria.
Medical Psychotherapy	“Medical Psychotherapy” is a counseling service to treat SUDs other than OUD is conducted by the medical director of a s on a one-to-one basis with the client. See Title 9 CCR § 10345 .
Medication Services	Medication Services, including addiction medications, will be discussed and offered as a concurrent treatment option for individuals with an alcohol—and/or opioid-related SUD condition. Staff lawfully authorized to provide such services within their scope of practice and licensure should prescribe or administer addiction medications and assess the side effects and/or impact of these medications. Youth (age 17 and under) are eligible to be treated with addiction medications when these are clinically indicated.
Member	Recipient of Medi-Cal.
Methadone	An opiate agonist medication used to treat OUD.
Motivational Interviewing (MI)	MI focuses on exploring and resolving ambivalence and centers on motivational processes within the individual that facilitate change. The method differs from more “coercive” or externally driven methods for motivating change as it does not impose change (that may be inconsistent with the person's values, beliefs, or wishes) but rather supports change in a manner congruent with the person's values and concerns.
Client Education	The presentation of research-based education on addiction, treatment, recovery, and associated health risks with the goal of minimizing the use of addictive substances, lowering the risk of dependence, and minimizing adverse consequences of substance use. Client Education sessions are defined as in-person, by telephone, or by telehealth contact between up to two (2) registered or certified SUD counselors or LPHAs, and between 2-12 clients at the same time in non-residential settings and between 2-30 clients at the same time in residential settings.
PCNX	ProviderConnect NX also known as PCNX or Sage-PCNX is the provider agency user interface for Sage, SAPC's electronic health record.
Physical Examination	Appropriate medical evaluation needs to be performed prior to initiating treatment services, including physical examinations when deemed necessary.
Provisional LOC	The initial LOC that is determined by the ASAM CO-Triage® Tool. It will be replaced with the actual LOC once the client has received a full ASAM CONTINUUM™ Assessment or Assessment Tool - Youth (Paper Version) found on the SAPC website at the provider agency. The purpose of the provisional LOC is to increase the likelihood that the client is directed to the appropriate provider agency for them the first time.
Recovery Bridge Housing (RBH)	RBH is defined by SAPC as a type of abstinence-focused, peer-supported housing that combines a payment for recovery residences with concurrent treatment in OP, IOP, OTP, or OP-WM settings. RBH is often appropriate for individuals with minimal risk with regard to acute

	intoxication/withdrawal potential, biomedical, and mental health conditions. If there is risk potential, these concerns are to be managed by the treating provider.
Recovery Services	RS will address all needs identified in Dimension 6 of the ASAM Criteria (See Recovery Environment of the ASAM Criteria), and services will be provided in-person, by phone, or via a telehealth modality. RS will include monitoring all six (6) ASAM dimensions. Relapse education and warning sign monitoring will occur throughout the duration of RS. Adults and youth will both be linked to services that will address their psychosocial issues, help them develop self-management skills, and reinforce skills gained during treatment.
Relapse	A prolonged episode of substance use during which the client is not interested or open to a therapeutic intervention.
Sage	Sage is the name for the collective applications that comprise SAPC's electronic health record that includes the SAPC staff user interface as well as the Treatment Provider user interface.
SUD Crisis Intervention	A crisis for DMC-ODS services means an actual relapse or an unforeseen event or circumstance that presents to the member an imminent threat of relapse. Crisis Intervention Services need to focus on alleviating the crisis problem, be limited to stabilizing the member's immediate situation, and be provided at the least intensive LOC that is medically necessary to treat the condition.
Telehealth Services	Telehealth is defined as SUD service that can be delivered between a Certified Peer Support Specialist, a registered or certified SUD counselor, and/or an LPHA and a client via audio and video communications which is 42 CFR Part 2 and HIPAA -compliant and where the SUD counselor/LPHA and client are not required to be at the same location.
Transportation Services	Providing transportation or making arrangements for transportation for members receiving behavioral health residential, inpatient, or ED services. There are two (2) types of transportation in the Medi-Cal program: • NMT for members who do not need medical assistance during transit. • NEMT for when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated.
Treatment Planning	See Care Planning .
Warm Handoff	When a provider agency, care coordinator, counselor, etc. refers a client for additional services related to their treatment, this is not a simple referral but entails going the extra step to ensure that the client feels supported and is not left to their own devices. An example is when a counselor calls another counselor, introduces the client to the counselor, and then sets up a meeting between the client and the new counselor. The client will go into the meeting having already been introduced to the new counselor.

Appendix B. Acronyms Glossary

ACRONYM	TERM
AB	Assembly Bill
ACCBC	Addiction Counselor Certification Board of California
ADA	Americans with Disabilities Act of 1990
AMA	Against Medical Advice
AEVS	Automated Eligibility Verification System
AI	Artificial Intelligence
AI/AN	American Indian and Alaska Native
AIDS	Acquired Immunodeficiency Syndrome
ALP	All Plan Letter
AOD	Alcohol and Other Drugs
APH	Acute Psychiatric Hospital
API	Asian Pacific Islander
APRN	Advanced Practice Nurse
ASAM	American Society of Addiction Medicine
ATC	Alternatives to Custody
AUD	Alcohol Use Disorder
AWD	Alcohol Withdrawal Delirium
AWOL	Absence Without Leave
BAS	Budget Approval System
BBS	California Board of Behavioral Sciences
BFSS	BRIDGE Family Support Specialist
BHIN	Behavioral Health Information Notice (DHCS)
BPC	Business and Professions Code (California)
BRIDGE	Building Relationship, Inspiring Development, and Growing Engagement
CAADE	California Association for Alcohol and Drug Educators
CADTP	California Association of DUI Treatment Programs
CalAIM	California Advancing and Innovating Medi-Cal
CalMHSA	California Mental Health Services Authority
CalOMS	California Outcomes Measurement System
CalSAWS	California Statewide Automated Welfare System
CalWORKs	California Work Opportunity and Responsibility to Kids
CAP	Corrective Action Plan
CARF	Commission on Accreditation of Rehabilitation

CBO	Community-Based Organization
CBT	Cognitive Behavioral Therapy
CCAPP	California Consortium of Addiction Programs and Professionals
CCR	California Code of Regulations
CDPH	California Department of Public Health
CDRH	Chemical Dependency Recovery Hospital
CE	Continuing Education
CENS	Client Engagement and Navigation Services
CEO	Chief Executive Officer
CES	Coordinated Entry System
CEU	Continuing Education Unit
CF	Correctional Facility
CFCI	Care First Community Investment
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CIBHS	California Institute for Behavioral Health Solutions
CIN	Client Index Number
CINA	Clinical Assessment of Narcotic Assessment
CIV	Civil Code (California)
CIWA	Clinical Institute Withdrawal Assessment
CIWA-Ar	Clinical Institute Withdrawal Assessment for Alcohol
CLAS	Culturally and Linguistically Appropriate Services
CM	Contingency Management
CMPSS	Certified Medi-Cal Peer Support Specialists (or Certified Peers)
CMS	Centers for Medicare & Medicaid Services
COD	Co-Occurring Disorder
COIN	Co-Occurring Integrated Care Network
COWS	Clinical Opioid Withdrawal Scale
CPA	Contract Program Auditor
CPT	Current Procedural Terminology
CQI	Continuous Quality Improvement
CRLA	Cultural Responsiveness and Language Assistance
CRRC	Community Reentry and Resource Center
CRS	Change Report Summary
CSW	Children's Social Worker
CTRC	California Telehealth Resource Center

DATAR	Drug and Alcohol Treatment Access Report
DAPO	California Department of Corrections and Rehabilitation, Division of Adult Parole Operations
DCFS	Los Angeles County Department of Children and Family Services
DEA	United States Drug Enforcement Administration
DHCS	California Department of Health Care Services
DHS	Los Angeles County Department of Health Services
DHS-CHS	Los Angeles County Department of Health Services, Correctional Health Services
DHS-HFH	Los Angeles County Department of Health Services, Housing for Health
DHS-ODR	Los Angeles County Department of Health Services, Office of Diversion and Reentry
DJJ	State of California Division of Juvenile Justice
DMC	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal Organized Delivery System
DMH	Los Angeles County Department of Mental Health
DNC	Did Not Complete
DO	Doctor of Osteopathic Medicine
DOJ	California Department of Justice
D.O.O.R.S	Developing Opportunities Offering Reentry Solutions
DPH	Los Angeles County Department of Public Health
DPO	Deputy Probation Officer
DPSS	Los Angeles County Department of Public Social Services
DPSS-CU	Los Angeles County Department of Public Social Services, Centralized Unit
DQR	Data Quality Report
DSM	Diagnostic and Statistical Manual of Mental Disorders
DT	Delirium tremens
DUI	Driving Under the Influence
DV	Domestic Violence
DYD	Los Angeles County Department of Youth Development
EBP	Evidence-Based Practice
ECM	Enhanced Care Management
ED	Emergency department
EHR	Electronic Health Record
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
ER	Emergency room
EV	Eligibility Verification
EW	Eligibility Worker
FAM	Family Code (California)
FBS	Field-Based Services

FDA	United States Food and Drug Administration
FFS	Fee-for-service
FQHC	Federally Qualified Health Center
FY	Fiscal Year
GAIN	Greater Avenues for Independence
GPS	Global Positioning Satellite
GR	General Relief
GSW	GAIN Services Worker
HCPCS	Healthcare Common Procedure Coding System
HHS	U.S. Department of Health & Human Services
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HMIS	Homeless Management Information System
HN	Housing Navigation
HSC	Health and Safety Code (California)
HSH	Los Angeles County Department of Homeless Services and Housing
HSP	Housing Support Plan
HUD	United States Department of Housing and Urban Development
ICD-10	International Classification of Diseases, Tenth Revision
ICRP	In-Custody to Community Referral Program
ICT	Inter-County Transfers
IHCP	Indian Health Care Provider
IH	Interim Housing
IHOP	Interim Housing Outreach Program
IMS	Incidental Medical Services
IN	Information Notice (SAPC)
IOP	Intensive Outpatient
IPV	Intimate Partner Violence
IT	Information Technology
IV	Intravenous
JCOD	Los Angeles County Justice Care and Opportunities Department
JJCPA	Juvenile Justice Crime Prevention Act
LA	Los Angeles
LA-HAT	Los Angeles–Housing Assessment Tool
LAC	Los Angeles County
LAC-Probation	Los Angeles County Probation Department
LACOE	Los Angeles County Office of Education

LACPRS	Los Angeles County Participant Reporting System
LAHSA	Los Angeles Homeless Services Authority
LASD	Los Angeles County Sheriff's Department
LCP	Licensed Clinical Psychologist
LCSW	Licensed Clinical Social Worker
LEAD	Los Angeles Law Enforcement Assisted Diversion
LEP	Limited English Proficiency
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer (“+” represents other identities such as non-binary, asexual, pansexual, two-spirit, and more)
LMFT	Licensed Marriage and Family Therapist
LOC, LOCs	Level of Care, Levels of Care
LOT	Licensed Occupational Therapist
LPCC	Licensed Professional Clinical Counselor
LPHA	Licensed Practitioner of the Healing Arts
LPJH	Los Padrinos Juvenile Hall
LPT	Licensed Psychiatric Technician
LRS	LEADER Replacement System
LVN	Licensed Vocational Nurse
M.A.	Master of Science
M.S.	Master of Arts
MA	Medical Assistant
MAR	Monthly Activity Report
MAT	Medication for Addiction Treatment (<i>also known as Medication Assisted Treatment</i>)
MCP	Managed Care Plan
MD	Doctor of Medicine
MDT	Multi-Disciplinary Team
MEDS	Medi-Cal Eligibility Data System
MEDS ID	Medi-Cal Eligibility Data System Identification Number
MEDSLITE	Medi-Cal Eligibility Data System Lite
MI	Motivational Interviewing
MOTP	Mobile Opioid Treatment Program (<i>also known as Mobile Narcotic Treatment Program</i>)
MOU	Memorandum of Understanding
MSUDRP	Mandatory Substance Use Disorder Recovery Program
MST	Military Sexual Trauma
MSW	Master of Social Work
N3	Non-violent, Non-serious, and Non-sexual
NACA	Network Adequacy Certification Application
NACT	Network Adequacy Certification Tool

NAR	Notice of Appeal Resolution
NARR	National Alliance for Recovery Residences
NCCA	National Commission for Certifying Agencies
NDP	Naloxone Distribution Project (DHCS)
NEMT	Non-emergency medical transportation
NGR	Notice of Complaint/Grievance Resolution
NMT	Non-medical transportation
NOA	Notice of Action
NOABD	Notice of Adverse Benefit Determination
NP	Nurse Practitioner
MPPES	National Plan and Provider Enumeration System
NPI	National Provider Identification Number
NTP	Narcotic Treatment Program
OHC	Other Health Coverage
OMDSO	Office of the Medical Director and Science Officer
OON	Out-of-Network
OP	Outpatient
OP-WM	Outpatient-Withdrawal Management
OTP	Opioid Treatment Program
ODU	Opioid Use Disorder
PA	Physician Assistant
PACT	Parole and Community Team
PATH	Pregnancy/Parenthood, Attitudes, Timing, and How Important
PAUR	Los Angeles County Probation Department, Prospective Authorization and Utilization Review Unit
PAuth	Provider Authorization
PAVE	Provider Application and Validation for Enrollment
PAWWS	Prediction of Alcohol Withdrawal Severity Scale
PCP	Primary Care Provider
PCNX	ProviderConnect NX
PEH	People Experiencing Homelessness
PEN	Penal Code (California)
PES	Psychiatric Emergency Services
PhD	Doctor of Philosophy
PHI	Protected Health Information
PII	Personally Identifiable Information
PIP	Performance Improvement Project
PNA	Provider No Activity

PPW	Pregnant and/or Parenting Women
PSH	Permanent Supportive Housing
PSS	Peer Support Services (also known as Certified Medi-Cal Peer Support Services)
PsyD	Doctor of Psychology
QI	Quality Improvement
QIP	Quality Improvement Project
R95	Reaching the 95%
RBH	Recovery Bridge Housing
RDP	Rapid Diversion Program
RH	Recovery Housing
RI-CM	Recovery Incentives-Contingency Management
RICMS	Reentry Intensive Case Management Services
RN	Registered Nurse
ROI	Release of Information
RP	Registered Pharmacist
RS	Recovery Services (<i>formerly Recovery Support Services or RSS</i>)
RSC	Recovery Support Court (<i>formerly Family Dependency Drug Court or FDDC</i>)
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPC	Substance Abuse Prevention and Control Bureau
SAPC-CCD	SAPC's Contracts and Compliance Division
SAPC-CST	SAPC's Clinical Standards and Training Section
SAPC-FSD	SAPC's Finance Services Division
SAPC-HIM	SAPC's Health Information Management Section
SAPC-HODA	SAPC's Health Outcomes and Data Analytics Division
SAPC-LNC	SAPC Learning and Network Connection
SAPC-SAMS	SAPC's Sage Access Management Section
SAPC-SOC	SAPC's Treatment Systems of Care Division
SAPC-QI	SAPC's Quality Improvement Section
SAPC-UM	SAPC's Utilization Management Section
SAR	Service Authorization Request
SASH	Substance Abuse Service Helpline
SB	Senate Bill
SBAT	Service & Bed Availability Tool
SCL	Service Connections Log
SLN	Sober Living Network
SMART	Specific, Measurable, Attainable, Realistic, and Time-bound
SMHS	Specialty Mental Health Services

SPA	Service Planning Area
SRH	Sexual and Reproductive Health
SSG	Special Services of Groups
SSN	Social Security Number
START-Community	Substance Treatment and Re-Entry Transition – Community
STC	Special Terms and Conditions
STI	Sexually Transmitted Infection
StimUD	Stimulant Use Disorder
SUBG or SUPTRS BG	Substance Use Prevention, Treatment, and Recovery Services Block Grant <i>(formerly known as Substance Abuse Prevention and Treatment Block Grant or SABG)</i>
SUD	Substance Use Disorder
SUD-TIPS	Substance Use Disorder Trauma-Informed Parent Support
SYTF	Secure Youth Treatment Facilities
TB	Tuberculosis
TBI	Traumatic Brain Injury
TDD	Telecommunications Device for the Deaf
TGI	Transgender, Gender Diverse, or Intersex
TIP	Treatment Improvement Protocol
ToT	Training of Trainers
TPS	Treatment Perceptions Survey
TTY	TeleType
TUD	Tobacco Use Disorder
UCC	Urgent Care Center
UCSF	University of California, San Francisco
UM	Utilization Management
VA	Veterans Affairs
VI-SPDAT	Vulnerability Index – Service Prioritization Decision Assistance Tool
WIC	Welfare and Institutions Code (California)
WM	Withdrawal Management
WCRTS	Women and Children’s Residential Treatment Services
WtW	Welfare to Work

Appendix C. Care Coordination References

Care Coordination Scenarios		
Note: Although not an exhaustive list, these scenarios are meant to help provider staff distinguish between the types of services that are and are <u>NOT</u> billable under Care Coordination. The non-billable scenarios listed include activities that <u>should be conducted</u>, when appropriate, but <u>cannot be billed</u> under Care Coordination.		
	Billable	Non-Billable
Connection	With the client present and participating, - Actively helping clients apply for Medi-Cal. - Completing the CES Survey Packet or the Los Angeles Housing Assessment Tool (LA HAT), including the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) for adults, or the Next Step Tool for Youth; and linking clients to housing resources. - Transferring Medi-Cal benefits for clients who have moved from their previous county of residence to LAC. - Linking clients to community resources such as food and clothing assistance.	- Time spent waiting with the client to be seen by a provider (e.g., sitting with a client in the ER waiting room). - Providing transportation for clients to scheduled appointments. Provider staff should arrange transportation for clients to and from appointments and attend scheduled appointments if client consent is given. However, the time spent traveling to and from appointments is non-billable (except for clients in Residential Treatment, which is covered in the day rate and perinatal clients in the DHCS's Substance Use Disorder Perinatal Practice Guidelines (November 2025)).
Coordination	With the client present and participating, - Identifying a referral provider agency by using the SBAT and scheduling an appointment for a Level of Care (LOC) transition (e.g., from IOP or ASAM 2.1 to Low-Intensity Residential or ASAM 3.1, etc.). - Coordinating action plans with mental health providers to ensure clients are provided complementary services.	Documenting Care Coordination activities in Progress Notes, including information regarding recent primary care and specialist visits, ER visits, auxiliary treatment services (e.g., dialysis), and any community resources received.
Communication	With the client present and participating, - Corresponding with justice system partners (ex. Courts, Probation, Jail, etc.) to provide progress report updates as necessary. - Time spent communicating with service providers, county workers, judges, etc., either in-person, by telephone, or by telehealth (e.g., meeting with client and doctor during a primary care visit). - Following up with other agencies regarding scheduled services and/or services received by clients. - Providing written or verbal status reports to health and mental health providers, and county partners (e.g., DCFS, LAC-Probation).	- Entering data into Sage (pre-authorizations, authorizations, Progress Notes, etc.). - Time spent waiting on hold without the client present to arrange the client's connection to a resource (e.g. DPSS) - Attempting, but not successfully contacting service providers either by phone, email, telehealth, or in-person. Provider agencies should only bill for Care Coordination when they successfully communicate with other service providers on the client's behalf.

Care Coordination Checklist

Note: This checklist is a reference tool for use during Care Coordination sessions to ensure that core functions of Care Coordination, and their respective activities, are being performed. This is not meant to be an exhaustive list of Care Coordination activities. This table is intended to offer examples of activities that should be covered in sessions, when applicable, and can be billed as Care Coordination.

Topics		Potential Activities	Performed in session? (Y/N)
Connection	Establishing & Maintaining Benefit	Actively help clients to apply for and maintain health and public benefits (e.g., Medi-Cal, Minor Consent Program, GR, Perinatal, Housing, etc.).	
		Transfer Medi-Cal benefits from the previous county of residence to LA County for clients who have moved.	
	Community Resources	Link clients to community resources and services (e.g., transportation, food and clothing assistance, family planning services, legal assistance, educational services, vocational services, housing, etc.).	
Coordination	Transitions in SUD LOCs	Facilitate necessary transitions in SUD LOCs (e.g., initiating referrals to the next LOC, coordinating with and forwarding necessary documentation to the accepting provider agency, etc.).	
	Health Services	Coordinate care with physical health, community health clinics and providers, and mental health providers to ensure a coordinated approach to whole person health service delivery.	
	Social Services	Coordinate activities with state, County and community (e.g., DPSS, DCFS, LAC-Probation, LA Superior Courts, Housing Providers, etc.) entities.	
Communication	Other Health Providers	Communicate in-person, by telephone or by audio-visual contact with physical health, community health clinics and providers, and mental health providers.	
	Service Partners	Communicate in-person, by telephone or by audio-visual contact with DPSS workers, DCFS social workers, DMH workers, LAC-Probation Officers, Housing Providers, etc.	
	Advocacy	Advocate for clients with health/social service providers, County and community partners, and others in the best interests of clients.	

Appendix D. ICD-10 Clinical Modification Codes Z55-Z65 (Social Determinants of Health-Related Z Codes)

Persons with Potential Health Hazards Related to Socioeconomic and Psychosocial Circumstances

Category	Code	Description
Problems related to education & literacy (8)	Z55.0	Illiteracy and low-level literacy
	Z55.1	Schooling unavailable and unattainable
	Z55.2	Failed school examinations
	Z55.3	Underachievement in school
	Z55.4	Educational maladjustment and discord with teachers and classmates
	Z55.5	Less than a high school diploma
	Z55.8	Other problems related to education and literacy
	Z55.9	Problems related to education and literacy, unspecified
Problems related to employment and unemployment (11)	Z56.0	Unemployment, unspecified
	Z56.1	Change of job
	Z56.2	Threat of job loss
	Z56.3	Stressful work schedule
	Z56.4	Discord with boss and workmates
	Z56.5	Uncongenial work environment
	Z56.6	Other physical and mental strain related to work
	Z56.81	Sexual harassment on the job
	Z56.82	Military deployment status
	Z56.89	Other problems related to employment
	Z56.9	Unspecified problems related to employment
Occupational exposure to risk factors (11)	Z57.0	Occupational exposure to noise
	Z57.1	Occupational exposure to radiation
	Z57.2	Occupational exposure to dust
	Z57.31	Occupational exposure to environmental tobacco smoke
	Z57.39	Occupational exposure to other air contaminants
	Z57.4	Occupational exposure to toxic agents in agriculture
	Z57.5	Occupational exposure to toxic agents in other industries
	Z57.6	Occupational exposure to extreme temperature
	Z57.7	Occupational exposure to vibration
	Z57.8	Occupational exposure to other risk factors
	Z57.9	Occupational exposure to unspecified risk factor
Problems related to	Z58.6	Inadequate drinking-water supply

Category	Code	Description
housing and economic circumstances (17)	Z59.00	Homelessness unspecified
	Z59.01	Sheltered homelessness
	Z59.02	Unsheltered homelessness
	Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
	Z59.2	Discord with neighbors, lodgers and landlord
	Z59.3	Problems related to living in residential institution
	Z59.41	Food insecurity
	Z59.48	Other specified lack of adequate food
	Z59.5	Extreme poverty
	Z59.6	Low income
	Z59.7	Insufficient social insurance and welfare support
	Z59.811	Housing instability, housed, with risk of homelessness
	Z59.812	Housing instability, housed, homelessness in past 12 months
	Z59.819	Housing instability, housed unspecified
	Z59.89	Other problems related to housing and economic circumstances
	Z59.9	Problem related to housing and economic circumstances, unspecified
Problems related to social environment (7)	Z60.0	Problems of adjustment to life transitions (life phase, retirement)
	Z60.2	Problems related to living alone
	Z60.3	Acculturation difficulty (migration, social transplantation)
	Z60.4	Social exclusion and rejection (physical appearance, illness, behavior)
	Z60.5	Target of (perceived) adverse discrimination and persecution
	Z60.8	Other problems related to social environment
	Z60.9	Problem related to social environment, unspecified
Problems related to upbringing (19)	Z62.0	Inadequate parental supervision and control
	Z62.1	Parental overprotection
	Z62.21	Child in welfare custody (non-parental family member, foster care)
	Z62.22	Institutional upbringing (orphanage or group home)
	Z62.29	Other upbringing away from parents
	Z62.3	Hostility towards and scapegoating of child
	Z62.6	Inappropriate (excessive) parental pressure
	Z62.810	Personal history of physical and sexual abuse in childhood
	Z62.811	Personal history of psychological abuse in childhood
	Z62.812	Personal history of neglect in childhood
	Z62.813	Personal history of forced labor or sexual exploitation in childhood
	Z62.819	Personal history of unspecified abuse in childhood

Category	Code	Description
	Z62.820	Parent-biological child conflict
	Z62.821	Parent-adopted child conflict
	Z62.822	Parent-foster child conflict
	Z62.890	Parent-child estrangement NEC
	Z62.891	Sibling rivalry
	Z62.898	Other specified problems related to upbringing
	Z62.9	Problem related to upbringing, unspecified
Other problems related to primary support group, including family circumstances (12)	Z63.0	Problems in relationship with spouse or partner
	Z63.1	Problems in relationship with in-laws
	Z63.31	Absence of family member due to military deployment
	Z63.32	Other absence of family member
	Z63.4	Disappearance/death of family member (assumed death, bereavement)
	Z63.5	Disruption of family by separation and divorce (marital estrangement)
	Z63.6	Dependent relative needing care at home
	Z63.71	Stress on family due to return of family from military deployment
	Z63.72	Alcoholism and drug addiction in family
	Z63.79	Other stressful events affecting family/household (ill/disturbed member)
	Z63.8	Other specified problems related to primary support group (discord or estrangement, inadequate support)
	Z63.9	Problems related to primary support group, unspecified
Problems related to psychosocial circumstances (3)	Z64.0	Problems related to unwanted pregnancy
	Z64.1	Problems related to multiparity
	Z64.4	Discord with counselors
Problems related to other psychosocial circumstances (8)	Z65.0	Conviction in civil and criminal proceedings without imprisonment
	Z65.1	Imprisonment and other incarceration
	Z65.2	Problems related to release from prison
	Z65.3	Problems related to other legal circumstances (arrest, custody, litigation)
	Z65.4	Victim of crime and terrorism
	Z65.5	Exposure to disaster, war and other hostilities
	Z65.0	Conviction in civil and criminal proceedings without imprisonment
	Z65.1	Imprisonment and other incarceration

Appendix E. CENS: Procedure for Additional Co-Location Sites

All negotiations with any entity regarding the possible co-location of CENS staff will be at the direction of SAPC. CENS are to refer all interested parties to SAPC about the possibility of co-locating at a new site, continuing to co-locate at a site, or returning to a site that has been vacated.

CENS providers interested in co-locating at a state, county, city, or community facility need to follow the steps below:

- Complete, sign, and send the Request for CENS co-location Site form to SAPC, along with a brief narrative justifying the request to co-locate. The narrative should include the following information:
 - Name and address of agency/organization requesting a CENS to be co-located at their site (e.g., Probation, Court, etc.)
 - The justification for the co-location (e.g., incarcerated clients unable to go to the CENS Area Office for a screening)
 - Number and level of staff needed and hours of operation (i.e., the number of full-time equivalents (FTE) and days and hours at the co-located site)
 - Expected number of clients to be seen at the site (e.g., per day, per week, per month, etc.)
- Unless otherwise directed by SAPC, execute a Memorandum of Understanding (MOU) or Letter of Agreement with the proposed entity that includes the following information:
 - The host organization contact information, including name, title, phone number and email address.
 - Agreed upon days and times that CENS will be co-located.
 - Detailed description of the roles and responsibilities of the involved entities.
 - Steps taken to assure adherence to de rules and regulations, including 42 CFR Part 2 and HIPAA.
- SAPC reserves the right to approve or deny submitted Requests for CENS Co-Location form at its sole discretion based on the information provided in the narrative and the MOU. SAPC will disallow any services that CENS provides at sites not approved by SAPC.
- Upon approval of the Request for CENS Co-Location Site form and a facility site walk-through by SAPC, the CENS will be notified of the date when services can begin. CENS co-locations will be reviewed as part of the provider agency's annual SAPC audit.
- Should SAPC or CENS determine that a site is no longer viable, notification need to be submitted to the other party at least 30 calendar days in advance of the proposed vacancy date.

Appendix F. SUD Referral and Tracking Form**COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL
CLIENT ENGAGEMENT AND NAVIGATION SERVICES (CENS)****Confidential Client Information****Section 1: Completed by Individual Requesting SUD Screening**

Requestor's Name:		Requestor's E-mail:	
Department/Agency:		Office Phone:	Fax:
Location Name and Address:			
Date of Referral:	Name of Client:		Client's Date of Birth:
Client's Gender: ☐ Male ☐ Female ☐ Transgender (F to M) ☐ Transgender (M to F) ☐ Unknown		Is the Client Pregnant: ☐ Yes ☐ No	Client's phone number:
Client's email:		Case/Program Identifying #:	
Select Program(s) or Population(s) that best fits with the client:	☐ AB 109 ☐ DCFS ☐ Juvenile Probation ☐ General Relief	☐ Mental Health ☐ Family Solutions Center ☐ MAMA's Neighborhood ☐ CalWORKs	☐ Mainstream Services Interim Housing ☐ Homeless Outreach / Encampments ☐ Homeless Outreach / Encampments ☐ Permanent Supportive Housing ☐ Other, specify: _____
Refer the client directly to the CENS counselor at assigned co-location if information is known. Otherwise, you may refer the client to one of the CENS Area Office listed below.			
CENS Providers and Sites			
☐ SPA 1: Tarzana Treatment Centers (661) 726-2630 (Phone) (661) 723-3211 (FAX) ☐ Co-Located Site Specify Facility name and Address: _____	☐ SPA 3: Prototypes (626) 444-0705 (Phone) (626) 444-0710 (FAX) ☐ Co-Located Site Specify Facility Name and Address: _____	☐ SPA 5: Didi Hirsch Mental Health Services (310) 895-2300 (Phone) (310) 895-2353 (FAX) ☐ Co-Located Site Specify Facility Name and Address: _____	☐ SPA 7: Los Angeles Centers for Alcohol and Drug Abuse (562) 273-0462 (Phone) (562-273)-0013 (FAX) ☐ Co-Located Site Specify Facility Name and Address: _____

- | | | | |
|---|---|--|--|
| ☐ SPA 2: San Fernando Valley
Community Mental Health Center
(818) 285-1900 (Phone)
(818) 285-1906 (FAX) | ☐ SPA 4: Homeless Health Care Los
Angeles
(213) 744-0724 (Phone)
(213) 748-2432 (FAX) | ☐ SPA 6: Special Service for Groups
(323) 948-0444 (Phone)
(323) 948-0443 (FAX)
☐ Co-Located Site
Specify Facility Name and Address: | ☐ SPA 8: Behavioral Health Services
(310) 973-2272 (Phone)
(310) 973-7813 (FAX)
☐ Co-Located Site
Specify Facility Name and Address: |
| ☐ Co-Located Site
Specify Facility Name and Address: | ☐ Co-Located Site
Specify Facility name and Address: | | |

I agree to schedule an appointment at one of CENS site and show up to the referred treatment site for SUD assessment and treatment services determined by the CENS counselor.

Signed: _____

Client

Date: _____

Signed: _____

Referral Requestor

Date: _____

Section 2: Completed by CENS counselor

Client has
Medi-Cal:

☐ If yes, Medi-Cal:

☐ If no, Application #: Submitted on:

Client's Sage Member ID Number:

Sage Referral ID Number (auto generated in Sage)

SUD Screening Completed by CENS Counselor:

Date of Screening:

Screened by:

Phone:

CENS Agency:

Email:

For CENS Counselors only - SUD Screening Results

Based on the American Society of Addiction Medicine (ASAM) Triage Tool the CENS Counselor recommends the following Provisional Level of Care (LOC):

SCREENED NEGATIVE OR EARLY INTERVENTION FOR TREATMENT

- ☐ SUD Treatment Not Recommended ☐ ASAM Level 0.5: Early Intervention (Only eligible for Youth and Young Adults)

➔ WAS AT RISK EDUCATION WORKSHOPS PROVIDED?

- ☐ Yes ☐ No

SCREENED POSITIVE FOR OUTPATIENT TREATMENT

- ☐ ASAM Level 0.5: Early Intervention Services only for the 0-18 population that is eligible for EPSDT
- ☐ ASAM Level 1.0: Outpatient Services
- ☐ ASAM Level 2.1: Intensive Outpatient Services
- ☐ ASAM Level 1-OTP: Opioid (Narcotic) Treatment Program
- ☐ ASAM Level 1-WM: Ambulatory WM without Extended On-Site Monitoring

SCREENED POSITIVE FOR RESIDENTIAL TREATMENT

- ☐ ASAM Level 3.1: Low-Intensity Residential Services
- ☐ ASAM Level 3.3: High-Intensity Residential Services, Population-Specific
- ☐ ASAM Level 3.5: High-Intensity Residential Services, Non-Population Specific
- ☐ ASAM Level 3.2-WM: Clinically Managed Residential WM

SCREENED POSITIVE FOR INPATIENT TREATMENT

- ☐ ASAM Level 3.7-WM: Medically Monitored Inpatient WM
- ☐ ASAM Level 4-WM: Medically Managed Intensive Inpatient WM

REFERRED TO OTHER SUPPORT SERVICES

- ☐ Recovery Services
- ☐ Recovery Bridge Housing (requires concurrent enrollment in ASAM 1.0, 2.1, 1-OTP, or 1-WM)
- ☐ Other (Specify): _____

Client Referred to SUD Treatment: ☐ Yes ☐ No ☐ Refused

If Yes, complete the following information:

Name of Treatment Agency: _____

Address: _____

Phone: _____

Contact Person: _____

Email: _____

Appointment Date: _____

Time: _____

If client is referred to SUD treatment, please complete Release of Information (ROI) form

[ROI – In Provider Agency](#); [ROI – Out of Network](#)

The Release of Information (ROI) form has been signed. ☐ Yes ☐ No

Section 3: Treatment Provider Agency Needs to Complete this Section and Return to CENS

Client showed up to appointment: ☐ Yes ☐ No

If no, rescheduled to: _____

Date

Time

If admitted LOC is different than the ASAM CO-Triage® LOC, specify below:

(Specify LOC)

If admitted:

Admission Date: _____

Expected Completion Date: _____

Weekly Treatment Hours: _____

Admission Counselor's Name: _____

Please return this form to the CENS via [Secure] FAX or email upon Admission, No Show, or Rescheduled Appointment.

Comments:

Appendix G: Program Incident Form

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH
 SUBSTANCE ABUSE PREVENTION AND CONTROL
Substance Treatment and Re-entry Transition – Community (START-Community)

START PROGRAM FACILITY	ACTIVITY SITE / LOCATION	DATE	TIME
TYPE OF ACTIVITY			
Client Name: _____ Admit Date: _____ Discharge Date: _____ Client progress to date (program phase, satisfactory progress to date, unsatisfactory progress to date): What happened (objective brief description of incident): When did it happen (time and date)? Who was involved (client, staff name and title, and actual witnesses): Staff Members: How did it happen (if applicable briefly describe cause of incident)? Actions taken (briefly describe steps taken during incident and if applicable steps required to prevent future incidents): Notified: County Program Offices ____ LASD ____ SAPC ____ Follow up (if applicable briefly describe plans for follow up):			
Actions Taken:			
NAME/TITLE/SIGNATURE OF REPORTING STAFF		DATE	

Appendix H. Reportable Incident Reporting Form



SUBSTANCE ABUSE PREVENTION AND CONTROL

Reportable Incident Reporting Form

A reportable event is any unanticipated event resulting in death or serious physical or psychological injury to a client or clients.

CLIENT INFORMATION		
1. Name (Last, First, and Middle):		2. Date of Birth (mm/dd/yyyy):
4. Address:		3. Medi-Cal or MHLA Number:
6. Gender:	7. Preferred Language	5. Phone Number:
8. Race/Ethnicity		Okay to Leave a Message? ☐ Yes ☐ No
PROVIDER AGENCY WHERE INCIDENT OCCURRED		
9. Provider Agency Name:		10. Contact Person:
12. Address:		11. Phone Number:
14. Date of Incident (mm/dd/yyyy):		13. Email Address:
15. Time of Incident:		
16. Reportable Incident Type: ☐ Death – Medical Condition ☐ Death – Suspected Suicide ☐ Death – Other ☐ Suicide Attempt ☐ Client Injured Self (Not Suicide Attempt) ☐ Client Injured another Client, Staff, or Visitor ☐ Medication Error/Medication Event ☐ Alleged Abuse by Staff ☐ Other		



DESCRIPTION OF THE INCIDENT

17. Please describe the nature of the incident. Include any important information about the incident, such as the date, person(s) involved, witnesses, etc. Attach any additional information, as necessary.

18. List any pre-disposing factor(s) or root cause(s) relevant to this incident:

RESPONSE AND FOLLOW UP ACTION

19. Please describe the staff response to the incident. Include a description of intervention(s) applied when dealing with the incident. Attach any additional information, as necessary.

20. List any case reviews, trainings, changes to policies and procedures, or follow up by the Risk Management Committee that were performed or instituted in order to prevent similar events in the future.

21. Reporting Staff Name:**22. Date:**

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to APPLICABLE Welfare and Institutions Code, Civil Code, HIPAA Privacy Standards, and 42 CFR Part 2.

Duplication of this information for further disclosure is prohibited without the prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law.

EXTERNAL SAPC REVIEW *This section will include communication between SAPC and the agency/provider.*

Comments:

Assigned Staff: Reviewed by: _____ Signature: _____ Date: _____

INTERNAL SAPC USE ONLY *This section is reserved for internal SAPC use only.*

Comments:

Assigned Staff: Reviewed by: _____ Signature: _____ Date: _____

Revised: 6/21/2017

Clinical Incident Form Instructions

CLIENT INFORMATION

1. Enter the client's name in the order of last name, first name, and middle name.
2. Enter the client date of birth.
3. Enter the client Medi-Cal number. If the number is not known, leave the space blank.
4. Enter the client address.
5. Enter the client phone number. Check box to indicate if it is okay to leave a message at this phone number.
6. Enter the client gender.
7. Enter the client preferred language.
8. Enter the client race/ethnicity

PROVIDER AGENCY WHERE INCIDENT OCCURRED

9. Enter the provider agency name.
10. Enter the name of the provider agency contact person.
11. Enter the contact person phone number.
12. Enter the provider agency address.
13. Enter the provider agency or the contact person email address.
14. Enter the date of incident.
15. Enter the time of incident.
16. Please describe the incident.
17. List any pre-disposing factor(s) or root cause(s) relevant to this incident.

INCIDENT RESPONSE AND FOLLOW UP ACTION

18. Please describe the staff response to the incident. Include description of intervention(s) applied to when dealing with the incident.
19. List any case reviews, trainings, changes to policies and procedures, or follow up by the Risk Management Committee that were performed or instituted in order to prevent similar events in the future.
20. Enter the name of the reporting staff.
21. Enter the date

EXTERNAL SAPC REVIEW

This section will include communication between SAPC and the agency/provider.

INTERNAL SAPC USE ONLY

This section is reserved for internal SAPC use only.

SUBMIT THE FORM TO:

Fax: (323) 725-2045 Phone: (626) 299-4193

FOR ADDITIONAL SAPC DOCUMENTATION PLEASE SEE

<http://publichealth.lacounty.gov/sapc/NetworkProviders/Forms.htm>

Revised: 6/21/2017

Appendix I. Juvenile Justice SUD Screening Referral Form (For CENS)

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL
CLIENT ENGAGEMENT AND NAVIGATION SERVICES (CENS)

Los Padrinos Juvenile Hall
Juvenile Justice Substance Use Disorder (SUD) Screening Referral Form

Email form to alafferre@lacada.com

If referral is from outside Department of Probation (Probation), please include contact information of person submitting the referral for tracking purposes. Referral outcomes will only be disclosed if the client signs a Release of Information (ROI).

THIS SECTION TO BE COMPLETED BY REFERRAL SOURCE		
Referral Initiated by: ☐ PROBATION ☐ DMH ☐ DHS ☐ DYD ☐ LACOE ☐ COURT ☐ Client/Self-Referral ☐ Other: _____		
Name/Email: _____		
Client Name: _____	Client Date of Birth: ____/____/____	Client PDJ Number: _____
Assigned DPO Name and Email: _____	Client Housing Unit: _____	Client Date of Referral: ____/____/____
Assigned DMH Clinician and Email: _____		
Date Referral Form Submitted to Onsite DPH-SAPC CENS Counselor: ____/____/____	Next Court Date (if applicable): ____/____/____	Release Date (if applicable): ____/____/____

THIS SECTION TO BE COMPLETED BY ONSITE DPH-SAPC CENS COUNSELOR	
ROI Completed? ☐ Yes ☐ No Client Completed Screening? ☐ Yes ☐ No	Date of Screening: ____ / ____ / ____

In-custody SUD Screening Results and Services	
Based on the <i>American Society of Addiction Medicine (ASAM) Screener for Youth and Young Adults</i> (youth = age 17 and under and young adults = ages 18-20) or <i>ASAM CO-Triage® Tool</i> (age 21 and over), the onsite DPH-SAPC CENS Counselor recommends the following service(s):	
SCREENED NEGATIVE ☐ No further SUD needs at this time	SCREENED POSITIVE ☐ Recommend Onsite Early Intervention Services Client Accepted? ☐ Yes ☐ No ☐ Recommend Referral to Community SUD Treatment Provider Client Accepted? ☐ Yes ☐ No
Onsite DPH-SAPC CENS Counselor/Screeners (Name): _____ Agency: _____ Phone No.: _____ Email: _____ Returned form to DPO (Name): _____ Date form returned to DPO: / /	



Post-release/Community SUD Services Follow-up

Date of Initial Contact to SUD Treatment Agency: ____ / ____ / ____

Provisional Level of Care (ASAM CO-Triage® Tool only): _____

Name of SUD Treatment Agency: _____

Address: _____

Contact Person: _____ Phone: _____ Email: _____

Appointment Date: ____ / ____ / ____ Time: _____

Client Referred to Other Support Services:☐ Recovery Services ☐ Recovery Bridge Housing ☐ Other (Specify): _____**Attended post release appointment?** ☐ Yes ☐ No**ADDITIONAL INFORMATION****PROBATION REFERRER**

- | | | | | | |
|---|--------------------------|-----|--------------------------|----|------------------|
| 1) Positive Urinalysis (UA) Result | ☐ | Yes | ☐ | No | If yes, date(s): |
| 2) Found with Substance(s) (Contraband) | ☐ | Yes | ☐ | No | If yes, date(s): |
| 3) Substance Overdose | ☐ | Yes | ☐ | No | If yes, date(s): |

Additional Notes/Comments:**NON-PROBATION REFERRER****Additional Notes/Comments:****DPH-SAPC CENS COUNSELOR****Additional Notes/Comments:**

Revised: 5/30/2024

Appendix J. Juvenile Justice SUD Screening Referral Form (For SYTF)

COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL
EARLY INTERVENTION AND SUD TREATMENT SERVICES

**Secure Youth Treatment Facilities (SYTF)
Juvenile Justice Substance Use Disorder (SUD) Screening Referral Form**

Please email completed form as follows:

Camp Kilpatrick/Dorothy Kirby Center: LVTpatientReferral@phoenixhouseca.org

Barry J. Nidorf Juvenile Hall: vcardona@tarzanatc.org and dneal@tarzanatc.org

If referral is from outside Department of Probation (Probation), please include contact information of person submitting the referral for tracking purposes. Referral outcomes will only be disclosed if the client signs a Release of Information (ROI).

*THIS SECTION TO BE COMPLETED BY PROBATION CASE WORKER		
Referral on Behalf of: ☐ PROBATION ☐ DMH ☐ DHS ☐ DYD ☐ LACOE ☐ Client/Self-Referral ☐ Other: _____		
Name/Email: _____		
Client Name: _____	Client Date of Birth: ____/____/____	Client PDJ Number: _____
Location: Housing Module/Unit/Cottage ☐ Barry J. Nidorf _____ ☐ Camp Kilpatrick _____ ☐ Dorothy Kirby Center _____	Assigned DPO Name and Email: _____ Assigned DMH Clinician Name and Email: _____	Client Date of Referral: ____/____/____
Date Referral Form Submitted to Onsite DPH-SAPC SUD Service Counselor: ____/____/____	Next Court Date (if applicable): ____/____/____	Release Date (if applicable): ____/____/____
THIS SECTION TO BE COMPLETED BY ONSITE DPH-SAPC SUD SERVICE COUNSELOR		
ROI Completed? ☐ Yes ☐ No Client Completed Screening? ☐ Yes ☐ No		Date of Screening: ____/____/____
In-custody SUD Screening Results and Services		
Based on the <i>American Society of Addiction Medicine (ASAM) Screener for Youth and Young Adults</i> (youth = age 17 and under and young adults = ages 18-20) or <i>ASAM CO-Triage® Tool</i> (age 21 and over), the onsite DPH-SAPC SUD Service Counselor recommends the following service(s):		
SCREENED NEGATIVE ☐ No further SUD-related needs at this time		SCREENED POSITIVE ☐ Recommend Onsite Early Intervention or SUD Treatment Services Client Accepted? ☐ Yes ☐ No ☐ Recommend Referral to Community SUD Treatment Provider Client Accepted? ☐ Yes ☐ No
Onsite DPH-SAPC SUD Service Counselor/Screeners (Name): _____		
Agency: _____		
Phone No.: _____ Email: _____		
Returned form to DPO (Name): _____ Date form returned to DPO: ____/____/____		

Post-release/Community SUD Services Follow-up

Date of Initial Contact to Community SUD Service Agency: ____/____/____

Provisional Level of Care (ASAM CO-Triage® Tool only): _____

Name of Community SUD Service Agency: _____

Address: _____

Contact Person: _____ Phone: _____ Email: _____

Appointment Date: ____/____/____ Time: _____

Client Referred to Other Support Services:☐ Recovery Services ☐ Recovery Bridge Housing ☐ Other (Specify): _____**Attended post release appointment?** ☐ Yes ☐ No**ADDITIONAL INFORMATION****PROBATION REFERRER**

1) Positive Urinalysis (UA) Result	☐	Yes	☐	No	If yes, date(s):
2) Found with Substance(s) (Contraband)	☐	Yes	☐	No	If yes, date(s):
3) Substance Overdose	☐	Yes	☐	No	If yes, date(s):

Additional Notes/Comments:**DPH-SAPC CENS COUNSELOR****Additional Notes/Comments:**

Revised: 5/30/2024