Continuity and Care Coordination

El Dorado County
Substance Use Disorder Services
DMC-ODS Quality Assurance Training Series
Wednesday February 21, 2024

Hello everyone. Thanks for coming. We are changing thing up a bit on this training for CEUs and attendance. We will be using a Start code and End code that will be sent out to you with a survey. The link will be emailed and you will need to complete the entire survey to receive Certificates of Attendance. Those of you in CADTP or CCAPP will also be receiving an exam that also must be completed by CADTP or CCAPP counselors/registrants to receive CEUs.

The Start Code is 1182

This presentation will be taped and posted to the EDC SUDS webpage under trainings and the PPT will be sent out later this week.

(Start recording)

Welcome to another El Dorado County Substance Use Disorder Services DMC-ODS Quality Assurance Training Series presentation. Today we will be discussing Continuity and Care Coordination.

CONTINUITY OF CARE & CARE COORDINATION -What does it mean?

El Dorado County, Substance Use Disorder Services and its contracted providers offer care coordination and ensure continuity of care in collaboration with partner organizations and agencies. Continuity of care extends to beneficiaries who receive SUD treatment in the DMC-ODS, as well as those who require care coordination between levels of care within the DMC-ODS, and/or with mental health service providers, hospitals, health care clinics and others.

Under DMC-ODS, beneficiaries will be assessed and have access to a full continuum of SUD services with an emphasis on engaging the beneficiary in the right care, at the right time, with the right provider, utilizing the principles of the American Society of Addiction Medicine (ASAM) Placement Criteria.

Beneficiary's treatment services shall be coordinated across Levels of Care (LOC); from the initial point of contact, first call or in-person visit, first offered appointment, referral, intake/assessment and determination of medical necessity, treatment planning, transition planning, discharge, and recovery support services

Care Coordination Responsibilities

- The individual, at first contact, shall be provided information on how to connect to their designated person or entity
- Care Coordinators work for EDC SUDS and for all EDC DMC ODS Network Providers
- If you are working with beneficiaries, you are also responsible for care coordination

El Dorado County, Substance Use Disorder Services DMC-ODS is responsible for making sure all beneficiaries have an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating services.

The individual, at first contact, shall be provided information on how to connect to their designated person or entity.

Coordination of care for beneficiaries must happen when a beneficiary is receiving care from:

Contracted Network Providers
- ❖Example-Granite Wellness Center

County-Operated Network Providers
- ❖Example-South Lake Tahoe SUDS Community Clinic

Community and social support providers
- ❖ Example-Marshall CARES

Care Coordinators work for EDC SUDS and for all EDC DMC ODS Network Providers.

If you are working with beneficiaries, you are also responsible for care coordination.

Care Coordinator?

We used to

hear Care Coordinator

&

think Case Manager

Not anymore

Care coordination was taught to us that it is an aspect of case management.

Hence, when you heard care coordinator, we were taught to think case manager and when we heard care coordination, we were taught to think case management.

As we move forward, when you here Care Coordinator, think care coordination. Case manager and Case Management is no longer a term to be used in the CalAIM DMC-ODS world we live and work in.

Care Coordination

- Providers work alongside the beneficiary in a person-centered approach
- Providers should discuss care coordination with the beneficiary
- Beneficiaries should be educated about information sharing

Providers are to work alongside the client throughout their health care journey to develop treatment recommendations that support a person-centered approach that is mindful of the need for access to a variety of resources.

It is recommended that providers discuss care coordination with the person in care at the beginning, and throughout treatment.

Included in this discussion is the importance of collaboration between service providers.

Clients are to be educated about information sharing amongst providers, and that the ability to share health information will facilitate improvements to the quality of care they receive by allowing for ease of care coordination among providers.

Care Coordination

- Care Coordination allows for ease of information sharing and increased ability to obtain important information
- Providers must obtain a Release of Information (ROI) when coordinating care with any other providers

When a person in care does not limit care coordination with in their SUD treatment, this allows for ease of information sharing and increased ability to obtain important information in a timely manner.

Providers must have the person in care sign a Release of Information (ROI) to share information when coordinating care with any other providers

Care Coordination Definition

Care Coordination includes the following components

- Coordinating with mental health and medical care providers
- Discharge planning
- Coordinating with ancillary services
- Follow up after linkages

Care Coordination includes the following components:

Coordinating with mental health and medical care providers to monitor and support comorbid health conditions

Discharge planning, including coordination with SUD treatment providers to support transitions between levels of care and to recovery services, referrals to mental health providers and referrals to primary or specialty medical providers

Coordinating with ancillary services including individualized connection, referral and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, child-care, child development, family/marriage education, cultural sources and mutual aid support groups

Care Coordination activities include following up with the person in care and other care providers regarding referrals made to ensure linkage has occurred

Care Coordination Guidance

- Coordination services may be provided by both LPHA & SUD certified / registered Counselors
- Care coordination is to be overseen by an LPHA
- LPHA will document that care coordination services are clinically indicated
- LPHA is to document the need in a progress note at the time of the medical necessity determination

Care coordination services may be provided by both LPHA & SUD certified / registered Counselors operating within their scope of practice throughout treatment whenever care coordination services are clinically indicated.

The provision of care coordination is to be overseen by an LPHA.

The LPHA will document that care coordination services are clinically indicated and will oversee and guide care coordination services.

It is expected that all persons in care will have care coordination needs. Therefore, for each person in care, the LPHA is to document the need / clinical indication for care coordination in a progress note at the time of the medical necessity determination

Beneficiary care

- Takes place
  - Between settings and all levels of care
- With the services
  - That the beneficiary receives from any other managed care organization
  - That the beneficiary receives from community and social support providers

Care coordinators are responsible for beneficiary care. This care takes place:

Between settings and alllevels of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays;

With the services that the beneficiary receives from any other managed care organization and/or through fee-for-service providers; and

With the services that the beneficiary receives from community and social support providers.

Care Coordination Practices

- All Care coordination activities are documented
- A signed Releases of Information (ROI) must be obtained prior to coordinating with other agencies

Care coordination activities, including referrals, are documented in the beneficiary's treatment record.

All contracted and county operated network providers shall obtain signed Releases of Information (ROI) from plan beneficiaries prior to coordinating services with other providers.

Signed ROIs are maintained in the beneficiary's treatment record.

Remember, this is an ethical mandate and cannot be skipped, waived, postponed or forgotten.

Coordination with Mental Health

- Serious Mental Illness (SMI) clients should be referred to El Dorado County Mental Health
- Mild to moderate mental health clients can be referred to either
  - Mountain Valley Health Plan
  - Anthem Blue Cross Partnership Plan
  - Kaiser Permanente

Plan beneficiaries whose mental health symptoms/diagnoses meet the criteria for specialty mental health care receive co-occurring care as appropriate. Those beneficiaries should be referred to El Dorado County Mental Health for an assessment.

For plan beneficiaries with mild to moderate mental health diagnoses, mental health care is provided from one of 3 Medi-Cal managed care plans:
Mountain Valley Health Plan
Anthem Blue Cross Partnership Plan
Kaiser Permanente

EDC DMC ODS network providers shall ensure coordination of care for beneficiaries with co-occurring mental health and SUD conditions

As always, remember the Golden Thread-Integrated SUD/MH care must be documented in the beneficiary's treatment plan

Care coordination includes coordination with multi-discipline team meetings, peer supports, and the utilization of natural supports.

Coordination with Physical Health

- DMC-ODS Provider Contracts shall include:
  - ❖ Written screening and assessment procedures/tools to identify physical health care needs
  - ❖ Written procedures for linking/coordinating plan beneficiaries' physical health services
  - ❖ Written procedures for care coordination with physical health providers, whether internally at a DMC-ODS provider site or externally

In order to coordinate physical health services, EDC DMC-ODS utilizes screening, referral and care coordination activities between EDC DMC-ODS and Mountain Valley Health Plan, Anthem Blue Cross Partnership Plan and Kaiser Permanente . In addition, care coordination services are provided as needed.

DMC-ODS Provider Contracts shall include initial minimum care coordination requirements, goals, and monitoring including but not limited to:

Written screening and assessment procedures/tools to identify physical health care needs (within scope of practice), and to determine primary care provider linkage needs.

Written procedures for linking/coordinating plan beneficiaries' physical health services, including, but not limited to, ensuring the individual has a primary care provider.

Written procedures for care coordination with physical health providers, whether internally at a DMC-ODS provider site or externally, including identifying the position(s) responsible for ensuring care coordination.

Continuity of Care Expectations

- The coordination of services shall be furnished to the beliciaries:
  - ❖ Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays.
  - ❖ With the services the beneficiary receives from any provider or any other managed care organizations.
  - ❖ With the services the beneficiary receives in FFS Medi-Cal.
  - ❖ With the services the beneficiary receives from community and social support providers.

Care Coordinator Point of Contact:

Beneficiaries shall have an ongoing source of care appropriate to his or her needs with a SUD provider designated as primarily responsible for coordinating the services. The beneficiary will be informed on whom and how to contact their designated provider upon linkage with the Care Coordinator. The Care Coordinator's contact information shall be made available to beneficiaries as part of the intake and linkage process.

The coordination of services shall be furnished to the beneficiaries:

Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays.

With the services the beneficiary receives from any provider or any other managed care organizations.

With the services the beneficiary receives in FFS Medi-Cal.

With the services the beneficiary receives from community and social support providers.

Access to Care

- Access points
  - EDC DMC-ODS 24-hour Toll Free Access Phone Line
  - SUDS Office Phone Line
  - Walk-in at Placerville and South LAKE TAHOE SUDS offices
  - Referrals to SUDS
  - Contracted Providers

Beneficiaries shall access care through the following access points:

EDC DMC-ODS 24-hour Toll Free Access Phone Line

EDC Behavioral Health SUDS Office Phone Line

Walk-In to EDC Behavioral Health SUDS Locations

Referrals received by EDC Behavioral Health SUDS

Walk-In to Contract Provider Outpatient Clinic Locations

Access to Care

- At every Access point
  - ❖ Beneficiaries shall be triaged for risk including suicidality, homelessness, emergency physical health needs, and detoxification services
  - ❖ Beneficiaries shall be referred and linked to the appropriate ASAM level of care (LOC)

At every access point in El Dorado County, beneficiaries shall be triaged for risk (suicidality, homelessness, emergency physical health needs, and detoxification services) and will be advised of the benefits to which they are entitled under the DMC-ODS waiver. Initial screenings shall be completed using a universal screening tool based on the ASAM dimensions (Brief ASAM Tool or other SUDS-approved Brief ASAM Screening Tool) by trained screening staff.

Upon screening, the beneficiary shall be referred and linked to the appropriate ASAM level of care (LOC) to ensure engagement in services. Placement considerations include findings from the screening, geographic accessibility, threshold language needs and the beneficiaries' preferences.

The beneficiary shall be referred to DMC-ODS network providers for an intake appointment for the following services:

Outpatient, Intensive Outpatient

Narcotic Treatment Program Services

Outpatient or Residential Withdrawal Management Services

Residential Treatment Services

Recovery Services

Case Management Services

Access to Care

- Each beneficiary's privacy shall be protected under
  - **45 C.F.R.Parts 160 and 164 subparts A and E**
  - **42 C.F.R.Part 2**

In the process of coordinating care, each beneficiary's privacy shall be protected in accordance with the privacy requirements in 45 C.F.R.Parts 160 and 164 subparts A and E and 42 C.F.R.Part 2,to the extent that they are applicable.

One exception-DMC-ODS and its' subcontracted providers may share with DHCS or other managed care organizations serving the beneficiary the results of any identification and assessment of the beneficiary's needs to prevent duplication of those activities.

At this point some of you may be asking, what does 45 C.F.R.Parts 160 and 164 subparts A and E and 42 C.F.R.Part 2 have to do with care coordination. Well let’s find out shall we.

45 C.F.R. Parts 160 and 164

- The HIPAA Privacy Rule
  - ❖ Establishes national standards to protect individuals' medical records and other personal health information
  - ❖ Applies to health plans, health care clearinghouses, and those health care providers
  - ❖ Requires appropriate safeguards to protect the privacy of personal health information
  - ❖ Sets limits and conditions on the uses and disclosures
  - ❖ Gives patients rights over their health information

45 C.F.R.Parts 160 and 164-The HIPAA Privacy Rule

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

42 CFR Part 2

- Confidentiality of Substance Use Disorder Patient Records
  - ❖ Applies to any individual or entity that is federally assisted
  - ❖ Most drug and alcohol treatment programs are federally assisted
  - ❖ Restricts the disclosure and use of alcohol and drug patient records
  - ❖ Applies to any information that “would identify a patient as an alcohol or drug abuser …”
  - ❖ Requires patient consent for disclosures

42 CFR Part 2-CONFIDENTIALITY OF SUBSTANCE USE DISORDER PATIENT RECORDS

42 CFR Part 2 applies to any individual or entity that is federally assisted and holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment (42 CFR § 2.11). Most drug and alcohol treatment programs are federally assisted. The regulations restrict the disclosure and use of alcohol and drug patient records which are maintained in connection with the performance of any federally assisted alcohol and drug abuse program (42 CFR § 2.3(a)). The restrictions apply to any information disclosed by a covered program that “would identify a patient as an alcohol or drug abuser …” (42 CFR §2.12(a) (1)). With limited exceptions, 42 CFR Part 2 requires patient consent for disclosures of protected health information even for the purposes of treatment, payment, or health care operations. Consent for disclosure must be in writing.

42 CFR Part 2

- The final rule includes the following modifications to Part 2:
  - Permits use and disclosure of Part 2 records based on a single patient consent given once for all future uses and disclosures for treatment, payment, and health care operations.
  - Permits redisclosure of Part 2 records by HIPAA covered entities and business associates in accordance with the HIPAA Privacy Rule, with certain exceptions.
  - Provides new rights for patients under Part 2 to obtain an accounting of disclosures and to request restrictions on certain disclosures, as also granted by the HIPAA Privacy Rule.

On Thursday, February 8, 2024 the Final Rule to Implement the Bipartisan CARES Act Legislation was implemented. Specifically, the final rule increases coordination among providers treating patients for SUDs, strengthens confidentiality protections through civil enforcement, and enhances integration of behavioral health information with other medical records to improve patient health outcomes.

The was informed by the bipartisan Coronavirus Aid, Relief, and Economic Security Act (CARES Act) that, among other things, required HHS to bring the Part 2 program into closer alignment with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy, Breach Notification, and Enforcement Rules.

42 CFR Part 2

- The final rule includes the following modifications to Part 2:
  - Expands prohibitions on the use and disclosure of Part 2 records in civil, criminal, administrative, and legislative proceedings.
  - Provides HHS enforcement authority, including the potential imposition of civil money penalties for violations of Part 2.
  - Outlines new breach notification requirements applying to Part 2 records.

We will likely provide a further training specifically to the final rule for 42 CFR Part 2 in the future.

Special Health Care Needs

- The Problem List or service plan shall include
  - Beneficiary participation, and in consultation with any providers
  - Developed by a person trained in person-centered planning using a person-centered process
  - A goal or goals of appropriate treatment for the illness

Beneficiaries having special health care needs shall be assessed to identify any ongoing special conditions of the beneficiary that may require a course of treatment or regular monitoring. The assessment shall indicate such on the Problem List and shall ensure linkage to the appropriate providers.

The Problem List or service plan shall include:

Beneficiary participation, and in consultation with any providers caring for the beneficiary;

Developed by a person trained in person-centered planning using a person-centered process and plan as defined in 42 CFR §441.301(c)(1);

A goal or goals(s) that the beneficiary obtains appropriate treatment for the illness.

Special Health Care Needs

- The Problem List or service plan shall be:
  - A key tool for treatment teams
  - Should be kept up to date to accurately communicate a person's needs and to support care coordination.
  - Updated on an ongoing basis to reflect the current presentation

The Problem List or service plan shall be:

A key tool for treatment teams

Should be kept up to date to accurately communicate a person's needs and to support care coordianation; and

Updated on an ongoing basis to reflect the current presentation

For beneficiaries with special health care needs determined through assessment to need a course of treatment or regular care monitoring, the provider shall ensure beneficiaries have access to a specialist as appropriate for the beneficiary's condition and identified needs through referral to a managed care plan, primary care provider, or Federally Qualified Health Center.

Care Coordination Procedures

- Emphasis on engaging the beneficiary:
  - ❖ In the right care
  - ❖ At the right time
  - ❖ With the right provider

Plan beneficiaries will be assessed and have access to a full continuum of SUD services with an emphasis on engaging the beneficiary in the right care, at the right time, with the right provider, utilizing the principles of the American Society of Addition Medicine (ASAM) Placement Criteria.

Beneficiaries shall be linked to care through known treatment providers.

Beneficiary's treatment services shall be coordinated across the Levels of Care (LOC) by following the continuity of care procedures.

Screening

- Via EDC DMC-ODS 24/7 access line
- "No wrong door" approach
- Shall be conducted upon first contact

Initial Screening

Screening via EDC DMC-ODS 24/7 access line:

Beneficiaries will be able to access SUD services through any contact within DMC-ODS, local managed care plans, community health clinics or other health/human services providers.

The 24/7 toll-free access line will be provided to any beneficiary seeking or identified as needing any level of SUD services. Using this "no wrong door" approach will ensure that beneficiaries will be directed to the point of access for SUD services immediately upon identification of need.

Community based SUD treatment providers will be another point of access where screening and referral can occur. Initial screenings of each beneficiary's needs shall be conducted upon first contact.

Screening

Procedures for Screening via EDC DMC-ODS 24/7 access line

- Determine individual's Medi-Cal eligibility
- Conduct screenings for SUD and MH services
- For Housed beneficiaries:
  - Schedule appointment within 30 days for a full ASAM criteria assessment
- For Homeless beneficiaries or beneficiaries under 21 years old:
  - Schedule appointment within 60 days for a full ASAM criteria assessment

Procedures for Screening via EDC DMC-ODS 24/7 access line

Determine individual's Medi-Cal eligibility; base data will be collected for entry into the EHR.

Conduct screenings for SUD and MH services, if needed, using approved scripts and brief screening instrument based on ASAM criteria and approved MH screening tool

If MH screening indicates further assessment for SMI is indicated, refer individual to MHP Access Team and document in beneficiary file

Schedule appointment **within 30 days** for a full bio-psychosocial assessment with ASAM criteria assessment with SUDS staff for housed beneficiaries.

Schedule appointment **within 60 days** for a full bio-psychosocial assessment with ASAM criteria assessment with SUDS staff for Homeless beneficiaries or beneficiaries under 21 years old.

Determine whether the individual should be referred directly to DMC ODS outpatient or intensive outpatient services. Contact network provider to obtain an appointment for beneficiary. Beneficiaries **mus**t receive an appointment **within 10 business days** for Outpatient Services and **within 3 business days** for Opioid Treatment Programing

Screening

- El Dorado SUDS Urgent Condition
  - ❖ The brief screening must rule out the need for emergency interventions
  - ❖ Emergencies shall be immediately referred for services at the most appropriate local hospital
  - ❖ Urgent Conditions that do not require hospitalization are screened using in-person assessments within 48 hours.

NOTE:

El Dorado SUDS Urgent Condition

Urgent condition is a situation that without immediate intervention is highly likely to result in an immediate emergency condition (as defined by 22 CCR § 51056, 9 CCR § 1810.253) and/or highly likely to risk the life and limb of the beneficiary and others. Such situations include, but are not limited to, actively using pregnant beneficiaries, beneficiaries known to be actively driving or operating heavy equipment under the influence, and those in an active sexually or physically abusive situation.

At the time of first contact, each beneficiary's needs will be triaged to identify the presence of an urgent condition. Once a network provider is made aware of an urgent condition, it must be addressed.

The brief screening must rule out the need for emergency interventions. Emergencies shall be immediately referred for services at the most appropriate local hospital. Urgent Conditions requiring immediate attention but that do not require hospitalization are screened for ASAM Levels of Care, 3.1, 3.5, or 3.2-WM using in-person assessments within 48 hours.

Screening

Screening via SUD Network Provider

- Beneficiaries will be able to access services at outpatient provider program during business hours
- 24/7 toll-free access line will be available on the contract provider voicemail and posted on the front door of the provider facility

Screening via SUD Network Provider

Beneficiaries will be able to access SUD services by calling or by walk-in request for services at the Plan contract outpatient provider program during business hours.

The 24/7 toll-free access line will be available on the contract provider voicemail and posted on the front door of the provider facility for times provider is closed.

Verify Medi-Cal eligibility

In instances when the individual requests services from the SUDS outpatient contract provider without a scheduled appointment, a qualified staff beneficiary will conduct the initial brief assessment, if available. If no qualified staff person is available, the individual will be given an appointment to return for a face-to-face appointment, at the earliest time available, for the individual to complete a full assessment and screening for MH needs. The next available appointment will be offered. Beneficiaries **must** receive an appointment **within 10 business days** for Outpatient Services and **within 3 business days** for Opioid Treatment Programing

If the network provider's full assessment determines that the individual does not meet medical necessity and that the individual is not entitled to any DMC-ODS services, refer matter to EDC DMC ODS for review and issuance of eligibility notice (NOABD) and appeal rights information to individual as appropriate.

Screening

Screening via SUD Network Provider

- Determine appropriate ASAM level of care
- Initiate Service Authorization Request
- If the network provider does not offer the identified level of care, offer referrals for the appropriate care level

Procedures for screening via SUDS Network Provider

Following the full assessment, determine appropriate ASAM level of care

Initiate Service Authorization Request to EDC DMC ODS for residential levels of care including residential withdrawal management.

If the network provider does not offer the identified level of care, the network provider will offer referrals to the individual for the appropriate care level and documents the referral.

If MH screening indicates further assessment for SMI is indicated, refer individual to County MH Dept. and document in beneficiary file

In instances where the network provider is unable to begin service delivery within the required 10 day time period due to non-budget related capacity issues, interim services shall be offered. In addition, the network provider must offer referrals to other network providers, when available, to ensure timely access to services.

Referral Process

To Outpatient (OP)--Intensive Outpatient (IOT)--Opioid/Narcotic Treatment Program (OTP/NTP)

- Beneficiaries will be provided a list of SUD network providers
- Appointment within 10 business days for Outpatient Services
- Appointment and within 3 business days for Opioid Treatment Programing

To Outpatient (ODF)/Intensive Outpatient (IOT)/Opioid/Narcotic Treatment Program (OTP/NTP)

Beneficiaries will be provided a list of SUD network providers to contact for treatment. County DMC-ODS Access staff will contact the SUD network provider of the beneficiary's choice to schedule an intake appointment.

Beneficiaries **must** receive an appointment **within 10 business days** for Outpatient Services and **within 3 business days** for Opioid Treatment Programing

Access line staff will provide appointment information to the beneficiary.

Access line staff will forward screening information to the chosen network provider.

SUD network providers will schedule a full intake/assessment with ASAM **within 10 business days** for Outpatient Services and **within 3 business days** for Opioid Treatment Programing of receipt of referral.

Referrals to primary care, mental health and other agencies will be provided as needed to beneficiaries requesting SUD services. These referrals will be noted in the EHR

Intake and Placement

Intake Assessment and ASAM Level of Care Determination Procedure

- ODS Staff or a SUD Network Provider will meet with the beneficiary and complete the full assessment
- Qualified staff will conduct the initial assessment
  - If no qualified staff person is available, the beneficiary will be given an appointment to return for a face-to-face appointment, at the earliest time available

Intake Assessment and ASAM Level of Care Determination Procedure

The selected agency from the initial contact and brief screening (either ODS Staff or a SUD Network Provider) will meet with the beneficiary and complete the full assessment to provide additional information for determining the diagnosis, medical necessity, and appropriate ASAM level of care.

In instances when the beneficiary requests services from the treatment SUD Network Provider without a scheduled appointment, a qualified staff will conduct the initial assessment, if available.

If no qualified staff person is available, the beneficiary will be given an appointment to return for a face-to-face appointment, at the earliest time available, for the beneficiary to complete a full assessment. An appointment must be made **within 10 business days** for outpatient treatment and **within 3 business days** for Opioid Treatment Program .

The assessment will be conducted by a Licensed Practitioner of the Healing Arts (LPHA), or certified /registered Drug and Alcohol Counselor. Services are available in English and Spanish.

The assessment, diagnosis, and medical necessity will be clearly documented in the beneficiary's electronic health record (EHR) and/or medical record. For adults, the diagnosis will include at least one DSM Substance-Related and Addictive Disorder (excluding Tobacco Related and/or non-Substance-related disorders). For beneficiaries under the age of 21, the diagnosis may also include an assessed risk for developing a SUD. Assessments will be conducted by a Licensed Practitioner of the Healing Arts (LPHA) or a certified /registered Drug and Alcohol Counselor.

Intake and Placement

Intake Assessment and ASAM Level of Care Determination Procedure

- Medical necessity will be determined for all beneficiaries
- Medical necessity will be determined by a licensed LPHA, licensed physician, or Medical Director
- If beneficiary does not meet medical necessity, the beneficiary is not entitled to any DMC-ODS treatment

Intake Assessment and ASAM Level of Care Determination Procedure

Medical necessity will be determined for all beneficiaries entering the DMC-ODS. The beneficiary must be diagnosed with a DSM/ICD 10 Substance Related Disorder by a licensed LPHA, licensed physician, or Medical Director. DMC Title 22 requires that all SUD Network Providers include documentation of medical necessity in the beneficiary's file.

If the assessment determines that the beneficiary does not meet medical necessity and that the beneficiary is not entitled to any DMC-ODS substance use disorder treatment services then a written Notice of Action (NOABD) will be issued in accordance with 42 CFR 438.404

Outpatient Level of Care Placement Procedure

If the assessment takes place at an Outpatient Provider facility

- If services other than outpatient services are indicated
  - Full ASAM to ODS Staff and request service authorization
- If the does not offer the identified level of care
  - Refer the beneficiary to another Network Provider that offers the indicated ASAM level of care or
  - Link the beneficiary to the ODS Staff
- Document the referral and the outcome of the linkage

The SUD Network Provider will determine the appropriate level of care. If services other than outpatient services are indicated, the SUD Network Provider will provide a copy of the full ASAM to ODS Staff and request service authorization.

If the SUD Network Provider does not offer the identified level of care, the SUD Network Provider will immediately refer the beneficiary to another DMC-ODS SUD Network Provider that offers the indicated ASAM level of care, or link the beneficiary to the ODS Staff, for linkage to the appropriate care.

The SUD Network Provider and the ODS staff will document the referral and the outcome of the linkage to the appropriate level of care.

DMC-ODS SUD Network Providers will provide an appointment within 10 business days for outpatient services and within 3 business days for opioid treatment programs. In instances where the SUD Network Provider is unable to begin service delivery within the required 10 day time period due to non-budget related capacity issues, interim services will be offered. In addition, the SUD Network Provider will make referrals to other SUD Network Providers, when available, to ensure timely access to services.

Residential Level of Care Placement Procedure

- Access line screening indicates withdrawal management, residential, or inpatient services beneficiary will be assigned to county ODS staff
- When screening by the Network Provider indicates withdrawal management, residential, or inpatient services provider will initiate the request for treatment authorization
- ODS Staff will complete the full assessment or review the provider treatment authorization request and determine/verify and document diagnosis and medical necessity

When higher levels of care (such as withdrawal management, residential, or inpatient services) are identified by the county Access line screening beneficiary will be assigned to county ODS staff.

When higher levels of care are indicated by the SUD Network Provider full assessment, provider will initiate the request for authorization with ODS staff.

ODS Staff will complete the full assessment or review the provider treatment authorization request and determine/verify and document diagnosis and medical necessity for the appropriate level of care.

Residential Level of Care Placement Procedure

- For provider submitted treatment authorizations requests one of the following response to the requesting provider within 24 hours
  - Approved
  - Pending – Requesting additional information
  - Denial
    - This time frame of 24 hours is for original treatment authorization requests only.
- If marked Pending, provider will have 24 hours to respond to county requests for additional information

On the rare occasion when a EDC DMC ODS Network Provider generates an original Treatment Authorization request:

For provider submitted treatment authorizations requests ODS staff will provide one of the following response to the requesting provider within 24 hours.

Approved
Pending – Requesting additional information
Denial

This time frame of 24 hours is for original treatment authorization requests only.

SUD Network Provider will have 24 hours to respond to county requests for additional information for requests in a Pending status.

ODS Staff will **securely** send the selected SUD Network Provider information regarding the beneficiary, including the completed assessment and ASAM, the treatment authorization, and confirmation of the appointment time and date.

If an authorization request is denied, a written Notice of Action (NOABD) will be sent to the beneficiary notifying them of the authorization decision. ODS Staff will also refer the beneficiary to the appropriate ASAM Level of Care.

If the beneficiary's selected SUD Network Provider is not available within 10 business days, linkage with other SUD Network Providers will be offered.

If the beneficiary's medical necessity demonstrates additional services are needed, a one-time extension of up to 30 days on an annual basis may be authorized. Perinatal and criminal justice beneficiaries may receive a longer length of stay, based upon medical necessity.

Medical Necessity

- Encompasses all six ASAM dimensions
- Takes into consideration severity of the various dimensions within the assessment
- OP—IOP beneficiaries re-assessed for reauthorization of medical necessity between 5th and 6th month
- NTP beneficiaries re-assessed for reauthorization of medical necessity between 11th and 12th month

Medical necessity encompasses all six ASAM dimensions and takes into consideration the extent and biopsychosocial severity of the various dimensions within the full ASAM assessment. Medical necessity must not be restricted to acute care and narrow medical concerns.

Beneficiaries receiving Outpatient and Intensive Outpatient services will be re-assessed for reauthorization of medical necessity between 5th and 6th month

Beneficiaries receiving NTP services which require annual reauthorization will be re-assessed for reauthorization of medical necessity between 11th and 12th month .

Transition to Other Levels of Care

- Network Provider will make a referral to the appropriate level of treatment if it is determined that beneficiary needs an increase or decrease in level of care
- Placement transitions occur within 5-10 business days
- Provider will then follow the ASAM Residential Level of Care Placement Procedure if a beneficiary requires residential treatment

When it is determined that a beneficiary is in need of an increase or decrease in level of care, the SUD Network Provider will make a referral to the appropriate level of treatment.

Placement transitions to other levels of care will occur within 5-10 business days from the date of reassessment.

The exception to this will be when a beneficiary requires residential treatment. Provider will then follow the ASAM Residential Level of Care Placement Procedure.

Care Coordination

Care Coordination services include

- Comprehensive assessment and periodic reassessment
- Care level transitions
- Problem List building and amending
- Progress Monitoring
- Linkages

Care Coordination is defined as a service to assist beneficiaries in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.

Care Coordination services include:
Comprehensive assessment and periodic reassessment of individual needs to determine the need for the continuation of Care Coordination services;

Transition to a higher or lower level of substance use disorder (SUD) care;

Development and periodic revision of a beneficiary Problem List that includes service activities;

Communication, coordination, referral, and related activities;

Monitoring service delivery to ensure beneficiary access to service and the service delivery system;

Monitoring the beneficiary’s progress;

Patient advocacy, linkages to physical and mental health care, transportation, and retention in primary care services; and,

Care Coordination shall be consistent with and shall not violate confidentiality of alcohol or drug patients as set forth in 42 CFR Part 2, and California law.

Care Coordination

- ODS Staff will provide Care Coordination services directly
  - When necessary ODS Staff will authorize Providers to provide Care Coordination services
- Care Coordinators will be responsible for
  - Initial placement
  - Transitions to different levels of care
  - Collaboration on Discharge Planning
  - Support
  - Linkages to ancillary support services

ODS Staff will both provide Care Coordination services directly, and when necessary, will authorize SUD Network Providers to provide Care Coordination services to beneficiaries.

High utilizers of service beneficiaries at risk of unsuccessful transitions to other levels of care will be assigned an ODS Staff Care Coordinator upon completion of full assessment.

Care Coordinators will be responsible for assisting the beneficiary with initial placement, transitions to different levels of care, and collaborate with the provider to ensure effective discharge planning.

Care Coordinators will also provide support in scheduling intake appointments and linking beneficiaries to ancillary support services.

Coordination with Out of Network Providers

- EDC DMC ODS shall make the determination DMC services are not available through the EDC DMC ODS
- Out-of-Network Services may be authorized
  - ❖ When plan beneficiary is out of county and develops an urgent condition
  - ❖ When there are no providers contracting with EDC DMC ODS reasonably available
  - ❖ When EDC DMC ODS determines that services cannot be provided through EDC DMC ODS's network of contract providers

There may be instances where beneficiary services must be obtained by providers that are not contracted providers to the EDC DMC ODS plan. EDC DMC ODS provides medically necessary DMC services when identified services are not available internally from EDC DMC ODS resources a provider contracting with the plan.

EDC DMC ODS shall make the determination whether medically necessary DMC services are not available through the EDC DMC ODS plan or a provider contracting with the plan.

EDC DMC ODS may authorize Out-of-Network Services under the following circumstances:

When plan beneficiary is out of county and develops an urgent condition and no providers contracting with the EDC DMC ODS are reasonably available based on EDC DMC ODS's evaluation of the needs of the beneficiary, especially in terms of timeliness of service.

When there are no providers contracting with EDC DMC ODS reasonably available to the beneficiary based on the EDC DMC ODS's evaluation of the needs of the beneficiary, the geographic availability of providers.

When EDC DMC ODS determines that services cannot be provided through the EDC DMC ODS or the EDC DMC ODS's network of contract providers

Coordination with Out of Network Providers

- EDC DMC ODS shall only authorize out-of-network services
  - ❖ That would be considered a covered service if it were provided by EDC DMC ODS
  - ❖ That would be considered a covered service if it were provided by contracted provider
  - ❖ For as long as EDC DMC ODS is unable to provide the identified services

EDC DMC ODS shall only authorize out-of-network services that would be considered a covered service if it were provided by EDC DMC ODS or a contracted provider and for as long as EDC DMC ODS is unable to provide the identified services.

EDC DMC ODS requires out-of-network providers coordinate authorization and payment with the EDC DMC ODS. The cost for services provided out of network shall be no greater than if the services were furnished by EDC DMC ODS contract provider.

Out of Network Approval Procedure

- Medically necessary services that are not available through EDC DMC ODS or contracted provider have been identified
- SUDS QA/UR Supervisor shall review the treatment request
  - ❖ If the service is available, the request for an Out-of-Network Service shall be denied.
  - ❖ If the service is not available, the request for an Out-of-Network Service shall be approved
- The SUDS QA/UR Supervisor shall coordinate authorization and payment

The beneficiary's treating provider shall identify in writing the medically necessary services that are not available through EDC DMC ODS or contracted provider.

The written request shall be forwarded to the SUDS QA/UR Supervisor by the treating provider.

The SUDS QA/UR Supervisor shall review the treatment request to determine if the requested services are available through the EDC DMC ODS or contracted providers.

Questions?

El Dorado County
Substance Use Disorder Services

Quality Assurance Training Coordinator
Dennis Wade
dennis.wade@edcgov.us

Quality Assurance Supervisor
Shaun O'Malley
shaun.omalley@edcgov.us

Here is our contact information if you have any questions regarding Continuity and Care Coordination. Shaun or I will be more than happy to assist you.

(End Recording)

Please remember-We will be using a Start code and End code that will be sent out to you with a survey. The link will be emailed, and you will need to complete the entire survey to receive CEUs or Certificates of attendance. Those of you in CADTP or CCAPP will also be receiving an exam that also must be completed by CADTP and CCAPP counselors/registrants to receive CEUs.

End code 7349

Our next training will take place Tuesday March 12, 2024, at 1:00 pm or Thursday March 14, 2024, at10:00 am. The topic is the Practice Guidelines.

This is a Mandatory Training for all Network Providers.

Thanks for coming and have a wonderful day.