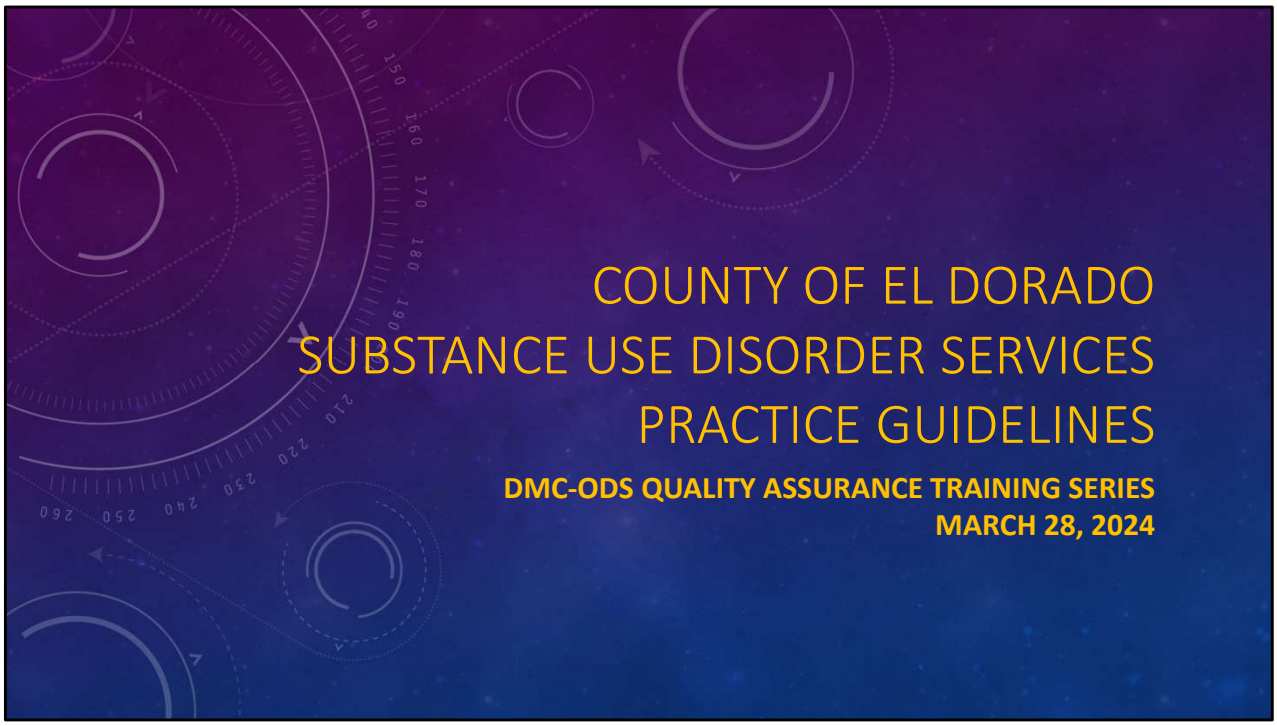


Welcome to another EDC DMC-ODS Quality Assurance Training series presentation. Today topic is The El Dorado County Practice Guidelines.

El Dorado County Drug Medi-Cal Organized Delivery System (DMC-ODS) is a managed care plan
Authorized by the California Department of Health Care Services (DHCS)
Implemented to create a more organized and comprehensive approach to providing substance use disorder (SUD) treatment services
Organized under 42 Code Federal Regulations Section 438.2 as a Prepaid Inpatient Health Plan.
In coordination with the Center for Medicare & Medicaid Services of the U.S. Department of Health and Human Services
The El Dorado County Health and Human Services Agency (HSAA) is authorized by the El Dorado County Board of Supervisors to administer the plan under an intergovernmental agreement with DHCS.

TREATMENT PRACTICE GUIDELINES

- The El Dorado County Practice Guidelines represent a combination of local, State and Federal regulations, standards and guidelines
- Contracted and County-operated providers are expected to adhere to all applicable regulations, standards, guidelines, policies and practices

These guidelines are to be disseminated to all providers and, upon request, to beneficiaries and potential beneficiaries.

These guidelines are available through the online provider portal, and will be made available during training, technical assistance and via email.

OVERVIEW OF REGULATIONS

- El Dorado County are held to varying, and at times overlapping, regulations depending on, but not limited to, the service modality, activities being performed and funding source
- El Dorado County (EDC) DMC-ODS will operate according to the regulations set forth by the Federal Government, the State of California, as well as its own provisions outlined in specific provider contracts

No one set of regulations addresses all components of the provision of Substance Use Services and at times differences in regulatory language may create multiple interpretations on how regulations may apply. Whenever questions regarding regulation interpretation arise, the more stringent regulation applicable shall apply as this is how El Dorado County QA/UR and the Department of Health Care Services will evaluate providers.

El Dorado County and its SUD network must abide by the 42 Code of Federal Regulations (CFR) Part 438 managed care requirements.

All providers are required by contract to establish policies and procedures regarding confidentiality and must ensure compliance with Title 42, Chapter I, Subchapter A, Part 2 of the Code of Federal Regulations, Part 2 (42 CFR Part 2), the Health Insurance Portability and Accountability Act (HIPAA) standards, and California State law regarding confidentiality for information disclosure of alcohol and drug use, and other medical records.

HIPAA Provides data privacy and security provisions for safeguarding medical information and Should not be used as barriers to providing coordinated and integrated care

REQUIRED STANDARDS AND GUIDELINES

- Providers in El Dorado County's DMC-ODS are required to obtain and maintain the following, as applicable:
  - Drug Medi-Cal Certification
  - SUD Licensing (NTP, Residential)
  - DHCS ASAM Designation

Standards and Guidelines include the following:

- Drug/Medi-Cal Certification Standards
- Re-Certification Events
- Facility Licensing Standards
- ASAM Level of Care Designation
- Minimum Quality Drug Treatment Standards for DMC
- Minimum Quality Drug Treatment Standards for SUBG
- California Code of Regulations (CCR) Title 9 Counselor Certification
- Culturally and Linguistically Appropriate Services (CLAS) Standards
- Perinatal Guidelines
- Adolescent Guidelines

ADOLESCENT BEST PRACTICES

- All Youth providers shall follow the updated DHCS Adolescent Substance Use Disorder Best Practices Guidelines in developing and implementing adolescent treatment programs.

Adolescents have psychological, developmental, and emotional strengths and needs that are distinct from those of adults. Adolescents are individuals 12 through 17 years of age.

Adolescents need programs that address their developmental issues, provide comprehensive and integrated services, involve families, and allow adolescents to remain in the most appropriate, but least restrictive setting.

DMC-ODS REQUIREMENTS 2022-2026

- Beginning in 2022, the Centers for Medicare and Medicaid Services (CMS) approved a set of updates that now govern DMC-ODS services
- Aligns the DMC-ODS program requirements with the CalAIM behavioral health initiatives that are effective July 2022

The policies are outlined in BHIN 22-005, BHIN 22-011, BHIN 22-013, BHIN 22-019, and BHIN 22-026 and the new policy updates in BHIN 23-001 that replaces the 1115 Special Terms and Conditions that were used to describe the DMC-ODS program for the years 2015-2021. In accordance with W&I Code section 14184.102(d).

BENEFICIARY ELIGIBILITY AND ENROLLMENT

- It is the responsibility of each DMC-ODS SUDS provider to conduct a verification/determination of each beneficiary's Medi-Cal eligibility and county of residence as part of program acceptance.
- Medi-Cal eligibility verification must be performed prior to rendering service

Providers shall verify the Medi-Cal eligibility of each beneficiary for each month of service prior to billing for Drug/Medi-Cal services to that beneficiary for that month.

For additional information, please refer to the DHCS DMC Billing Manual.

Medi-Cal beneficiaries of all ages whose county of responsibility is El Dorado County are able to receive DMC-ODS services consistent with the following access criteria, assessment, and level of care determination criteria.

EPSDT

- Section 1905(r) of the Social Security Act
- Section 1905(a) of the Social Security Act
- BHIN 22-003

In accordance with the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate under Section 1905(r) of the Social Security Act, all Counties, irrespective of their participation in the DMC-ODS program, shall ensure that all beneficiaries under age 21 receive all applicable SUD services needed to correct or ameliorate health conditions that are coverable under Section 1905(a) of the Social Security Act. Nothing in the DMC- ODS limits or modifies the scope of the EPSDT mandate. DMC-ODS counties are responsible for the provision of SUD services pursuant to the EPSDT mandate. Counties should refer to BHIN 22-003 regarding Medi-Cal SUD treatment services for beneficiaries under age 21 for further compliance with EPSDT requirements. Please note that the access criteria for beneficiaries under 21 is different and more flexible than the access criteria for adults accessing DMC-ODS services, to meet the EPSDT mandate and the intent for prevention and early intervention of SUD conditions.

TELEHEALTH CONSENT

- Telehealth is not a distinct service, but an allowable mechanism to provide clinical services

It is a tool for the benefit of the beneficiary not the practitioner.

Providers that offer telehealth services to Medi-Cal beneficiaries must meet all applicable Medi-Cal licensure and program enrollment requirements.

For more information on Telehealth requirements please review BHIN 23-018 for a complete rendering of Telehealth requirements

CONSENT PROCESS

- Providers are required to obtain verbal or written consent for the use of telehealth
  - DHCS has created model verbal and written consent language, which can be found on the DHCS website
    - Link to DHCS website on Page 13 of the Practice Guidelines

Providers must explain the following to beneficiaries:

- The beneficiary has a right to access covered services in person.
- Use of telehealth is voluntary and consent for the use of telehealth can be withdrawn at any time without affecting the beneficiary's ability to access Medi-Cal covered services in the future.
- Non-medical transportation benefits are available for in-person visits.
- Any potential limitations or risks related to receiving covered services through telehealth as compared to an in-person visit, if applicable.

Providers must also document the beneficiary's verbal or written consent to receive covered services via telehealth prior to the initial delivery of the services. The beneficiary's consent must be documented in their medical record and made available to DHCS and/or El Dorado County Quality Assurance upon request.

A provider may utilize a general consent agreement to meet this documentation requirement if that general consent agreement:

- Specifically mentions the use of telehealth delivery of covered services;
- Includes the information described above;
- Is completed prior to initial delivery of services; and
- Is included in the beneficiary record.

AMERICAN SOCIETY OF ADDICTION MEDICINE CRITERIA (ASAM)

- Benefits offered through the DMC-ODS are modeled after the ASAM criteria

Regular review of the beneficiary's appropriate placement in the correct Level of Care is required to assure fidelity to ASAM

The review of all 6 dimensions is documented at admission and discharge using the ASAM and should be included in the beneficiary's file.

This review is to be clearly documented in the progress notes and should identify any increase or decrease in problem severity and risk rating for each ASAM Dimension.

The ASAM must be completed whenever there is a change in condition.

Beneficiary placement and level of care determinations shall ensure that beneficiaries are able to receive care in the least intensive level of care that is clinically appropriate to treat their condition.

DOCUMENTATION REQUIREMENTS

- Practice Guidelines were developed to be used in conjunction with the CalMHSA documentation guides and El Dorado County Documentation Companion Guide

Guides include:

- Doc guide for AOD counselors
- Doc guide for LPHA
- EDC Doc Companion Guide

DESCRIPTION OF COVERED SERVICES

- Services available to beneficiaries' have been updated to reflect descriptions in BHIN 23-001.

Service Levels include all of the following:

- Individual Counseling
- Group Counseling
- Crisis Intervention Counseling
- Care Coordination
- Clinician Consultation
- Screening, Brief Intervention, Referral to Treatment and Early Intervention Services (ASAM Level 0.5)
- Outpatient Treatment Services (ASAM Level 1)
- Intensive Outpatient Treatment Services (ASAM Level 2.1)
- Residential Treatment and Inpatient Services (ASAM Levels 3.1 – 4.0)
- Narcotic Treatment Services
- Withdrawal Management Services
- Recovery Services
- Medication-Assisted Treatment within All Levels of Care

DESCRIPTION OF COVERED SERVICES

- Services available to beneficiaries' have been updated to reflect descriptions in BHIN 23-001.

Please note the following:

- Clinician Consultation replaces and expands the previous "Physician Consultation" service referred to in the Section 1115 STCs that were used to describe the DMC-ODS program during the years 2015-2021. Clinician Consultation is not a direct service provided to DMC-ODS beneficiaries. For more information, please refer to BHIN 23-001.
- Early intervention services are covered DMC-ODS services for beneficiaries under the age of 21. For more information, please refer to BHIN 23-001 or the most updated version of DHCS Billing Manual.
- For more information on residential treatment services including applicable laws and requirements please refer to BHIN 23-001.
- While most DMC-ODS providers are expected to adopt problem lists as described in BHIN 22-019, treatment plans continue to be required for some services in accordance with federal requirements.
- As noted in BHIN 22-019, NTPs are required by Federal law to create treatment plans for their beneficiaries. NTP requirements for documentation are not impacted by BHIN 22-019 and NTPs must continue to comply with federal and state regulations regarding treatment plans and documentation.
- All information on WM services can be found on BHIN 23-001
- For more information on Recovery Services please refer to BHIN 23-001 and BHIN 22-005.
- For more information on DMC-ODS MAT Policy please refer to BHIN 23-0001

EVIDENCE BASED PRACTICES (EBP) COMPLIANCE

- As a requirement of El Dorado DMC-ODS, each provider must implement—and assess fidelity to—at least two of the following Evidenced Based Practices per modality

Evidenced Based Practices include:

- Motivational Interviewing
- Cognitive-Behavioral Therapy
- Relapse Prevention
- Trauma-Informed Treatment
- Psycho-Education

Programs should have an EBP treatment fidelity plan

SPECIAL TOPICS

- The Practice Guidelines detail requirements for providers when handling sensitive and/or special topic including:
  -Suicide Protocols
  -Threats of Violence
  -Unusual Incident Reports

Suicide Protocol-Counselors must complete the Suicide Potential Protocol threat assessment and Safety Plan when a beneficiary presents with a risk of self-harm
Threats of Violence-The counselor must use reasonable efforts to inform the victim and contact law enforcement. Please review the Tarasoff Statute
Child Abuse and Elder Abuse-Please refer to CCR Title 11, Article 1:§901 for child abuse guidelines and CCR § 15630 for guidelines
Incident reports-Providers are required to complete and send an Unusual Incident Report to Quality Assurance staff securely at sudsqualityassurance@edcgov.us.
Indian Health Care-Providers-American Indian and Alaska Native individuals who are eligible for Medicaid and reside in counties that have opted into the DMC-ODS can also receive DMC-ODS services through Indian Health Care Providers (IHCPs). Please refer to BHIN 22-053 for additional guidance.
Intersection with the Criminal Justice System-El Dorado DMC-ODS and its providers shall ensure that beneficiaries may receive recovery services immediately after incarceration regardless of whether or not they received SUD treatment during incarceration.

TREATMENT PERCEPTIONS SURVEY (TPS)

- TPS surveys are administered by the county and all contract providers provide the survey to beneficiaries during survey period
- Surveys give beneficiaries a voice in improving our services

The TPS is required to fulfill the county External Quality Review Organization (EQRO) requirement related to having a valid client survey.

The data may also be used by counties (and service providers) to evaluate and improve the quality of care and client experience.

TPS surveys are administered by the county and all contract providers provide the survey to beneficiaries during survey period.
Surveys are important because they help us see how we are doing, but through the beneficiary's eyes.

DELIVERY OF INDIVIDUALIZED AND QUALITY CARE COORDINATION SERVICES

- EDC Drug Medi-Cal ODS plan beneficiaries must have an ongoing source of care

This includes a person or entity formally designated as primarily responsible for coordinating services

Care Coordination Procedures-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.

Coordination with Mental Health-Plan beneficiaries whose mental health symptoms/diagnoses meet the criteria for specialty mental health care receive co-occurring care as appropriate

Coordination with Physical Health -In order to coordinate physical health services, EDC DMC-ODS utilizes screening, referral and care coordination activities outlined in the MOU between EDC DMC-ODS and Anthem, CA Health and Wellness and Kaiser Permanente.

DELIVERY OF INDIVIDUALIZED AND QUALITY CARE COORDINATION SERVICES

- Continuity of Care Expectations
  - Care Coordinator Point of Contact
  - The coordination of services shall be furnished to the beneficiaries several ways

Care Coordinator Point of Contact:

- Beneficiaries shall have an ongoing source of care appropriate to their 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 coordinators 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 other managed care organizations.
- With the services the beneficiary receives in FFS Medicaid.
- With the services the beneficiary receives from community and social support providers.

DELIVERY OF INDIVIDUALIZED AND QUALITY CARE COORDINATION SERVICES

- Access to Care
  - Beneficiaries shall access care through the multiple access points

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 WM Facilities, NTP's, and Outpatient Clinic locations

Timely access data—including date of initial contact, date of first offered appointment and date of scheduled assessment—shall be documented within three (3) business days of the service.

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.

DELIVERY OF INDIVIDUALIZED AND QUALITY CARE COORDINATION SERVICES

- Access to Care
  - 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 WM Facilities, NTP's, and Outpatient Clinic locations

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
- Residential Withdrawal Management Services
- Residential Treatment Services
- Recovery Services
- Care Coordination Services

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

SPECIAL HEALTH CARE NEEDS

- Beneficiaries having special health care needs shall be assessed to identify any ongoing special conditions

The assessment shall indicate such in the Problem List and shall ensure linkage to the appropriate providers.

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.

ACCESS TO SERVICES

- Initial Assessment and Services Provided During the Assessment Process

Covered and clinically appropriate DMC-ODS services (except for residential treatment services) are Medi-Cal reimbursable for up to 30 days following the first visit whether or not a DSM diagnosis for Substance-Related and Addictive Disorders is established.

Covered and clinically appropriate DMC-ODS services (except for residential treatment services) are Medi-Cal reimbursable for up to 60 days if the beneficiary is under age 21, or if a provider documents that the client is experiencing homelessness

If a beneficiary withdraws from treatment prior to establishing a DSM diagnosis for Substance-Related and Addictive Disorders, and later returns, the 30-day time period starts over.

DMC-ODS ACCESS CRITERIA FOR BENEFICIARIES AFTER ASSESSMENT

- To qualify for DMC-ODS services after the initial assessment process

Beneficiaries 21 years of age and older must meet one of the following criteria:

- Have at least one diagnosis from DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, OR
- Have had at least one diagnosis from the 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, determined by substance use history.

Beneficiaries under age 21 qualify to receive all medically necessary DMC-ODS services as required pursuant to Section 1396d(r) of Title 42 of the United States Code

EL DORADO COUNTY DMC-ODS ACCESS PROCESSES

- Screening
  - Screening via EDC DMC-ODS 24/7 access line
  - Screening via SUD Network Provider

- 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.

EL DORADO COUNTY DMC-ODS ACCESS PROCESSES

- 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.

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

EL DORADO COUNTY DMC-ODS ACCESS PROCESSES

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

1. 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.
2. Beneficiaries must receive an appointment within 10 business days for Outpatient Services and within 3 business days for Opioid Treatment Programing
3. Access line staff will provide appointment information to the beneficiary.
4. Access line staff will forward screening information to the chosen network provider.
5. 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

EL DORADO COUNTY DMC-ODS ACCESS PROCESSES

- Intake and Placement
  - EDC DMC-ODS has developed an Intake Assessment and ASAM Level of Care Determination Procedure

The selected agency from the initial contact and brief screening will meet with the beneficiary and complete the full assessment
A 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, **within 10 business days** for outpatient treatment and **within 3 business days** for Opioid Treatment Program
The assessment will be conducted by a LPHA or certified /registered Drug and Alcohol Counselor
The assessment, diagnosis, and medical necessity will be clearly documented in the beneficiary's electronic health record (EHR) and/or medical record
Medical necessity will be determined for all beneficiaries entering the DMC-ODS
Once the assessment process is complete, the diagnosis, placement recommendations, and information about treatment services will be authorized and discussed during a face-to-face meeting with the beneficiary by an LPHA

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 Adverse Beneficiary Determination (NOABD) will be issued in accordance with 42 CFR 438.404.

EL DORADO COUNTY DMC-ODS ACCESS PROCESSES

- Contract Provider Authorization Process
  - ODS staff will provide responses to the requesting provider within 24 hours.

- For provider submitted treatment authorizations requests ODS staff will provide one of the following responses to the requesting provider within 24 hours.
  - Approved
  - Pending – Requesting additional information
  - Denied

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

- If an authorization request is denied, a written Notice of Action 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.

EL DORADO COUNTY DMC-ODS ACCESS PROCESSES

- Extension Request Authorization Process
  - The provider will submit the Extension Request Packet Seven (7) business days prior to expiration of the previous authorization

- Seven (7) business days prior to expiration of the previous authorization, the provider will submit the Extension Request Packet, which includes the following:
  - Treatment Extension Request form
  - Verification of EDC Medi-Cal benefits
  - Current Problem List
  - Documentation of current moderate or severe level substance use disorder
  - Continuing care ASAM assessment and LOC recommendation with LPHA signature
  - Document describing what medically necessary services the beneficiary requires that cannot be provided at an outpatient or intensive outpatient level
  - Document describing goals that have not yet been met and a timeline for expected implementation and completion of the goals that have not yet been met.

Extension Request – Late Request Form required if request is not submitted before seven (7) business days prior to expiration of previous authorization.

The QA/UR Clinician will review the extension authorization request and make a re-authorization determination within three (3) business days.

CONTINUING SERVICES ASSESSMENTS

- Reassessments no longer occur at specific timeframes, but rather shall occur every time there is a change in condition.

Examples of a change of condition could include:

Need for a higher level of care

Need for a lower level of care

Physical Health issues

Mental Health issues

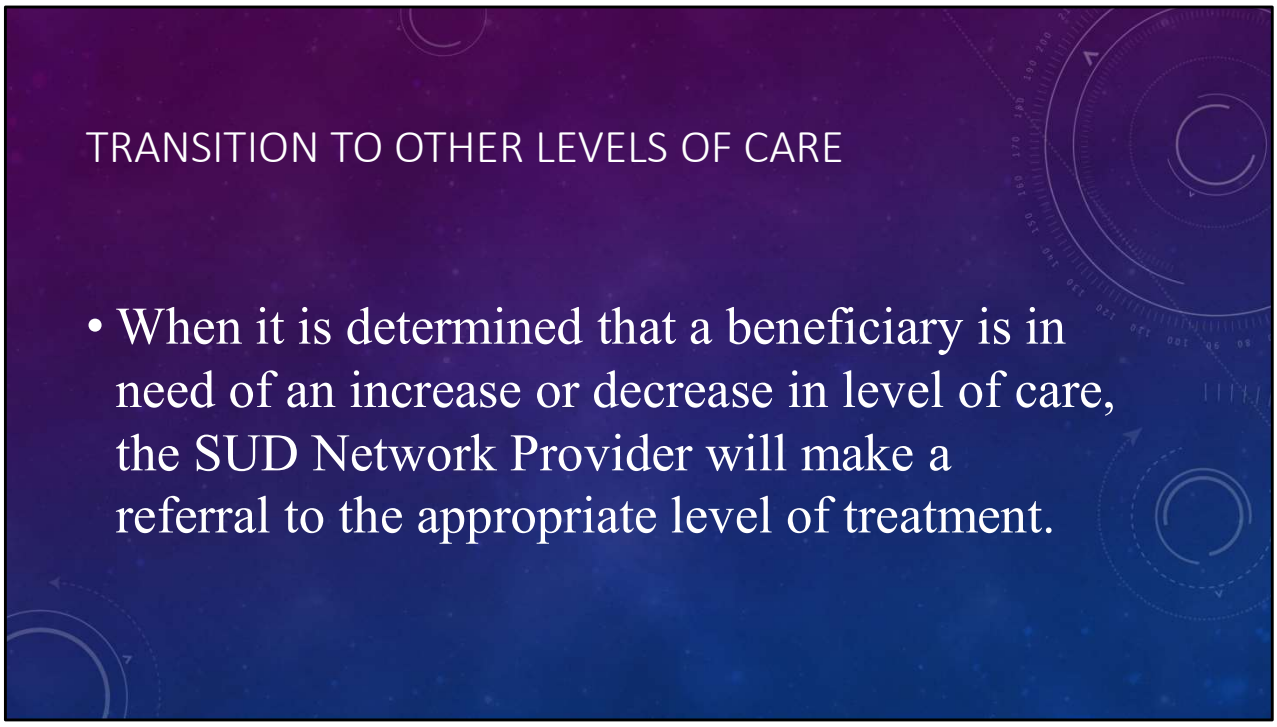
Beneficiaries shall still be re-assessed for reauthorization of medical necessity no sooner than 5 months and no longer than 6 months (except for NTP services which require annual reauthorization).

MEDICAL NECESSITY OF SERVICES

- DMC-ODS services must be medically necessary.

Pursuant to W&I Code section 14059.5(a),.

- For individuals 21 years of age or older, a service is “medically necessary” or a “medical necessity” when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
- For individuals under 21 years of age, a service is “medically necessary” or a “medical necessity” if the service is necessary to correct or ameliorate screened health conditions.



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.

COORDINATION WITH OUT OF NETWORK PROVIDERS

- EDC DMC ODS provides medically necessary DMC services when identified services are not available internally from EDC DMC ODS resources

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 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.

STAFFING REGULATIONS AND REQUIREMENTS

- Training information and Procedure
  - Designed to meet the requirements of state and federal law

The purpose of this procedure is to meet the requirements of state and federal law regarding the education and ongoing training requirements of El Dorado County Behavioral Health-Alcohol and Drug Program (DMC-ODS-SUDS) staff and contract providers of substance use disorder (SUD) services.

STAFFING REGULATIONS AND REQUIREMENTS

- Training Requirements
  - DMC-ODS-SUDS require that SUD staff and providers complete specific training

- DMC-ODS-SUDS require that SUD staff and providers complete specific training upon hire/contract execution, and at least annually thereafter.
- Non-licensed staff shall receive appropriate onsite orientation and training prior to performing assigned duties. Licensed and/or administrative staff shall supervise non-licensed staff.
- Licensed staff is required to have appropriate experience and any necessary training at the time of hiring, relevant to their scope of practice.
- Providers shall maintain provider staff's training documentation in personnel files at provider site.

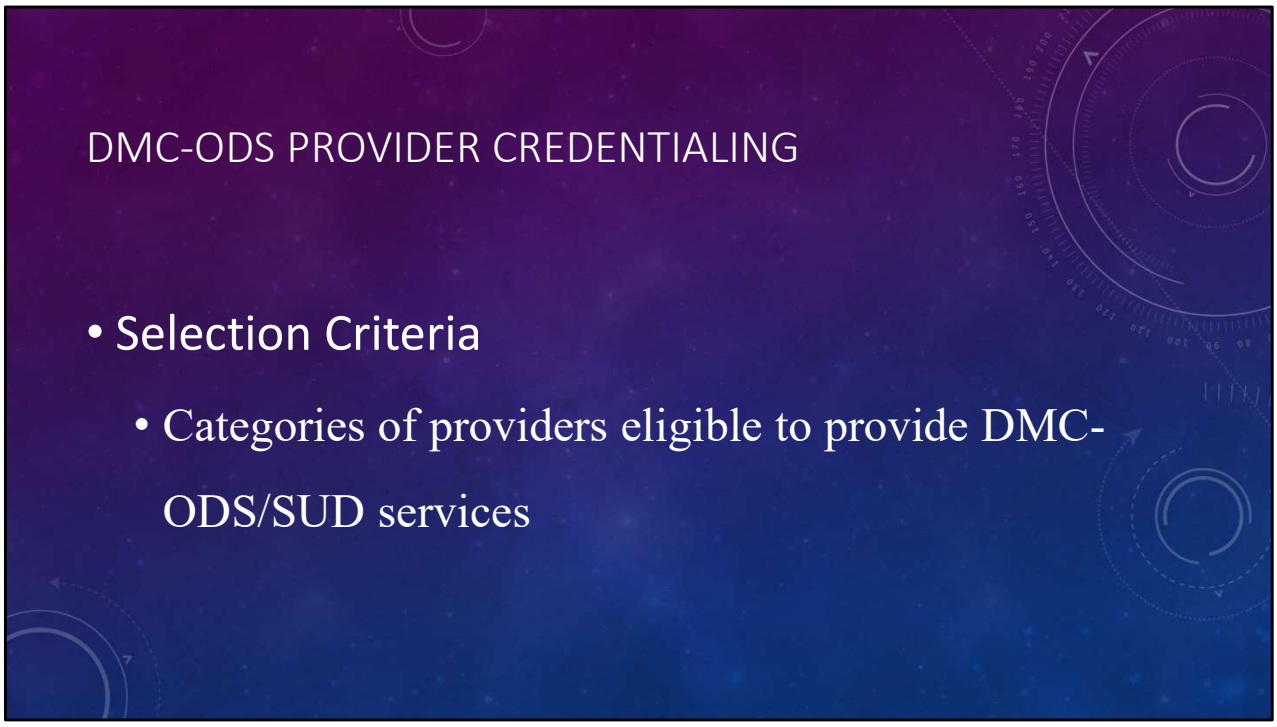
STAFFING REGULATIONS AND REQUIREMENTS

- Training Plan
  - Training curricula and a complete reading of the training plan can be found on El Dorado DMC-ODS website

- DMC-ODS-SUDS maintain a written plan, updated annually, that outlines the training requirements of staff and providers.
- The Training Plan lists the types of training that staff and providers are required to complete
- The Training Plan may also indicate when a specific training offers CEUs.

DMC-ODS PROVIDER CREDENTIALING

- Process is based on El Dorado County BH Policy number BH-134.



The following categories of providers are eligible to provide DMC-ODS/SUD services through DMC-ODS:

- SUD Peer Counselors (delivering peer-to-peer substance abuse assistance services as a component of recovery services)
- Registered and certified SUD counselors
- Licensed Practitioners of the Healing Arts (LPHAs)

DMC-ODS PROVIDER CREDENTIALING

- Credentialing-defined as the recognition of professional or technical competence.

The credentialing process may include registration, certification, licensure, and/or professional association membership.

Credentialing ensures that providers are licensed and certified as required by state and federal law.

DMC-ODS PROVIDER CREDENTIALING

- Signed Attestation
  - For all network providers who deliver covered services

For all network providers who deliver covered services, each provider must submit a signed and dated statement, attesting to the following:

a. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation;
b. A history of loss of license or felony conviction;
c. A history of loss or limitation of privileges or disciplinary activity;
d. A lack of present illegal drug use; and
e. The application's accuracy and completeness.

The attestation also includes assurance that the provider will complete annual training in the following areas:

a. Cultural Competency
b. HIPAA, 42 CFR Part 2, privacy, confidentiality, and security standards
c. Law and Ethics
d. Compliance

DMC-ODS PROVIDER CREDENTIALING

- 3 Year Recredentialing
  - Retention Process

DHCS requires DMC-ODS to verify and document at a minimum every three (3) years that each network provider that delivers covered services continues to possess valid credentials

DMC-ODS requires that each provider submits any updated information needed to complete the re-credentialing process, as well as a new signed attestation, including compliance with the annual training requirements

QUESTIONS

Thank you all for attending.

End code 1063

Please feel free to contact Shaun or myself with any questions. If you have not received a copy of the Practice Guidelines, let me know and I will email them out to you right away. Certificates of attendance will be issued to all attendees in the next few days.