



SUPPORT



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EXCELLENCE

# DMC-ODS Contractor Meeting

## May 14, 2025



# Agenda

- Welcome and Introductions
- Provider Updates/Announcements
- County Updates/Announcements
- ASAM – 4<sup>th</sup> Edition Training: Jeffrey DeVido, MD, MTS

# Updates and Announcements

- **Provider Updates**
- **State and Federal Funding**
- **May is Mental Health Month: [Calendar of Events](#)**
- **HCAI – [Medi-Cal Behavioral Health Student Loan Repayment Program](#) (BH-CONNECT: Application opens 7/1)**
- **SB 525 (Healthcare Minimum Wage):** Beginning 10/16/24, health care workers are eligible to receive the higher minimum wage if they (1) work for certain “health care facilities” that are covered in the new law and (2) provide health care services or support the provision of health care. Details on eligibility can be found in the [FAQs](#)
- **CalMHSA – Updated [DMC-ODS Clinical Documentation Guides](#)**



# Medi-Cal Share of Cost and OHC

- If a client has a Medi-Cal Share of Cost or Other Health Coverage (OHC)
  - Work with Client to Complete [Financial Responsibility Form](#) (jotform) → It routes to HHS Billing, who will update the UMDAP report in SmartCare and invoice the client either lower of Share of Cost or UMDAP
  - Complete the 270/271 to ensure Medi-Cal eligibility/coverage is current
  - Note: An FRF needs to be completed annually (or if circumstances change)



# FY 2025-26 Contract Renewal

## What's New?

- DMC-ODS Provider Rate Increase (3.09%)
- DMC-ODS Provider Eligibility for Earning Incentives
- Exhibit I – Reflects Updated AOD Certification Standards
- Exhibit M – Business Associate Agreement
- New Form for Signature – Use of Generative AI

## Contract Renewal Documents

- Submit Scopes of Work, Budgets and Insurance to Contract Managers by **6/9/25**
- E-sign applicable forms (Jot Form) by **6/9/25**
- You do not need to submit Policies & Procedures if submitted and no changes since Self-Audit/Site Visit processes



# FY 2025-26 DMC-ODS Incentives

## Potential Incentive Totals

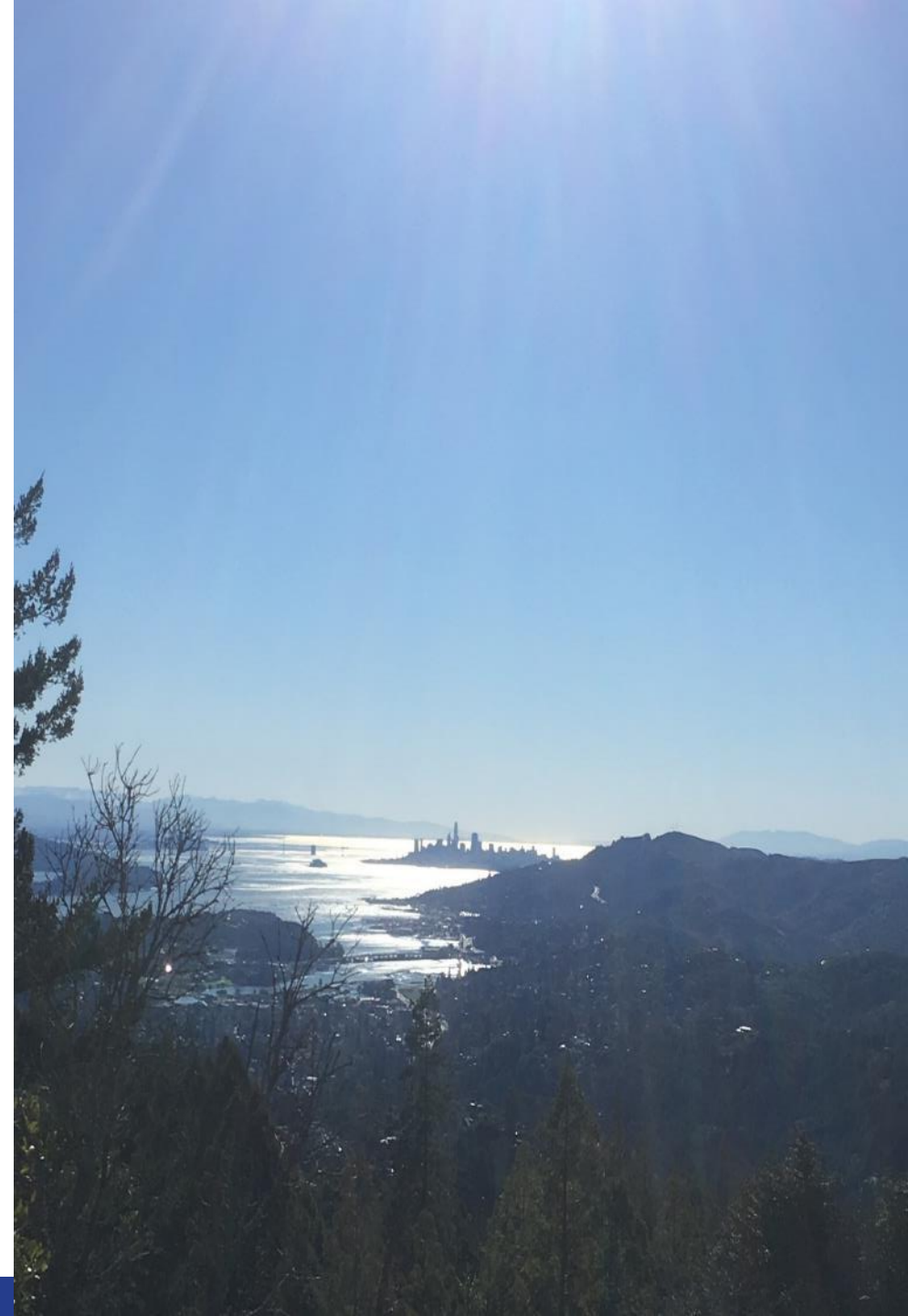
- Based on completed claims through Q3 and total available funding

Potential Incentive	
Completed Claims through FY 24-25 Q3	Maximum Incentive Total per Contract
\$50k - \$200k	\$ 5,000.00
\$200k - \$400k	\$ 10,000.00
\$400k - \$600k	\$ 15,000.00
\$600k - \$800k	\$ 20,000.00
\$800k - \$1M	\$ 25,000.00
\$1M +	\$ 35,000.00

## Care Coordination Incentive Metrics – Select One

- Care Coordination Claims by Client
- Transitions between levels of care within 14 days

*\*Note: Specific metrics, targets and criteria to be discussed at June Provider meeting*



# *The ASAM Criteria 4th Edition: Implications for Substance Use Treatment in California*

**Jeffrey DeVido, M.D., M.T.S., FAPA, DFASAM**

**Chief, Addiction Services—Marin County, CA, Department of Health and Human Services; Division of Behavioral Health and Recovery Services**

**Behavioral Health Clinical Director, Partnership HealthPlan of CA**

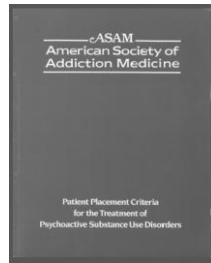
**Assistant Clinical Professor—Volunteer; Dept of Psychiatry and Behavioral Sciences; Weill Institute for Neurosciences and University of California, San Francisco**

## Disclaimer

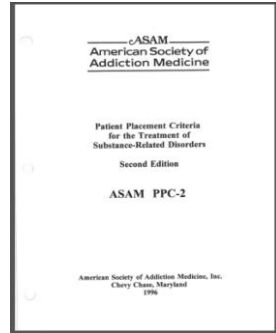
The ASAM Criteria standards do not purport to set a medical or legal standard of care and may not encompass all levels of service options that may be available in a changing healthcare field. Therefore, The ASAM Criteria as presented and discussed may not be wholly relevant to all levels and modalities of care—such as forensic treatment facilities, custodial care providers, and addiction treatment programs that address concomitant developmental disability disorders, among others—nor to external judgments—such as those made by legal or regulatory entities concerning the appropriateness of patient admission into various levels of care. **The ASAM Criteria is designed to serve as a resource for general, mental health, and addiction treatment clinicians and counselors but is not intended to substitute for their independent clinical judgment based on the particular facts and circumstances presented by individual patients.**

# History of The ASAM Criteria

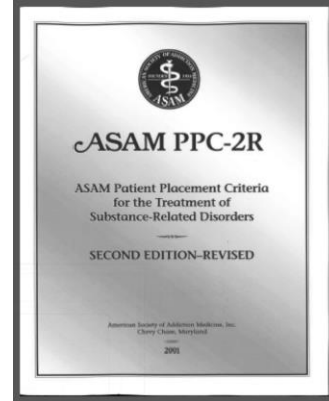
1991



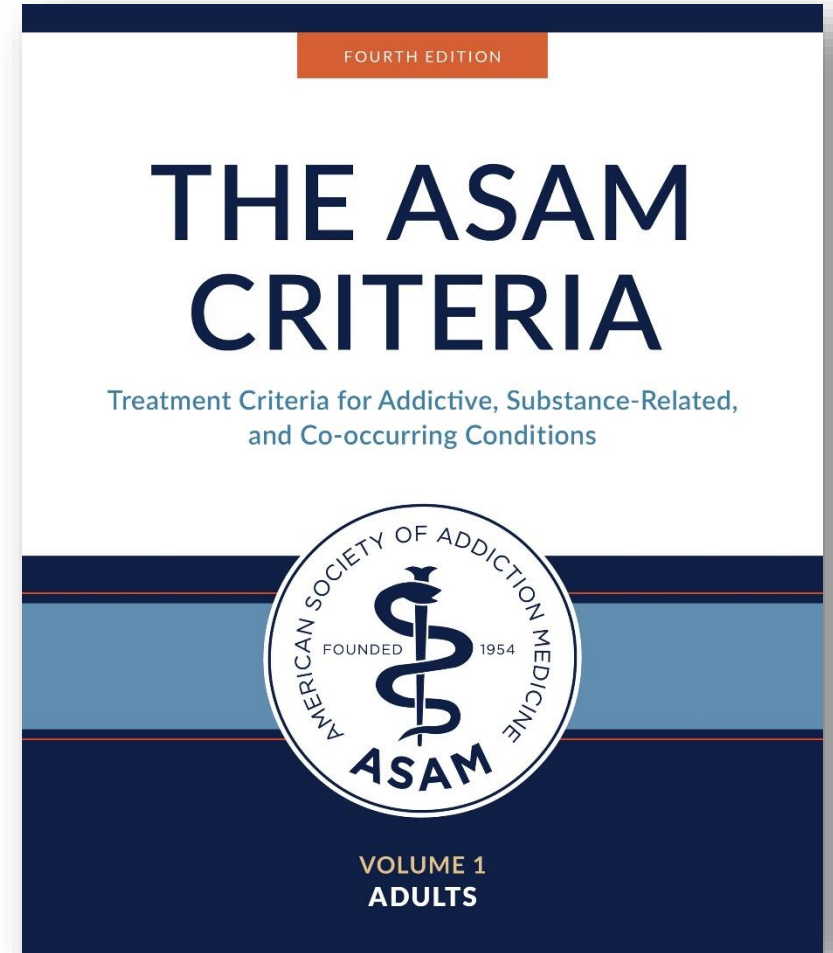
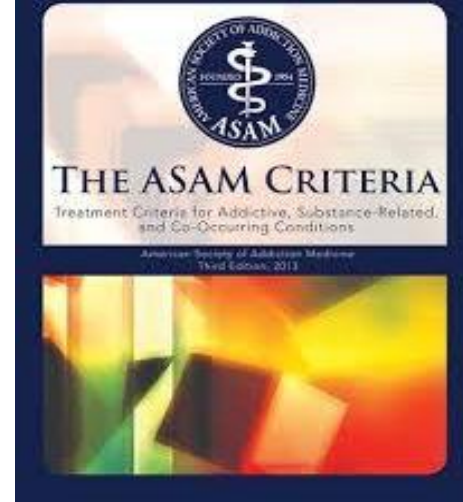
1996



2001



2013



## The Problem...

- ASAM criteria aim to provide a common language and approach for how we assess biopsychosocial circumstances and determine the care that is appropriate for each patient, and define the services that should be available at each level of care.
- We have a history in SU treatment to tend to describe ourselves in a “Program-centric” manner
  - i.e., “I run a 28 day program...”
- Question: what is the right amount of care for a patient?
  - It depends!! When we admit people to care, it is based on their needs at the time, and then assess what ongoing care is needed

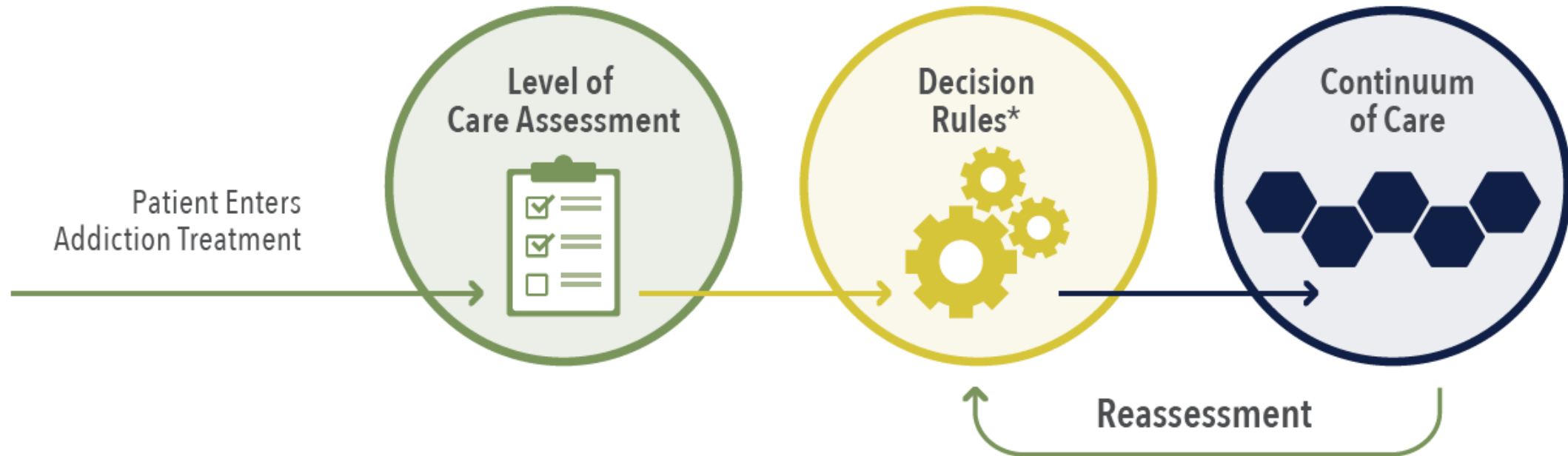
## The ASAM Criteria

- The criteria provide a consistent way to:
  - assess patients' biopsychosocial circumstances to identify the appropriate level of care
  - develop comprehensive, individualized, and patient-centered treatment plans
  - define the services that should be available at each level of care
- Promote individualized and holistic treatment planning
- Guide clinicians and care managers in making objective decisions about patient admission, continuing care, and movement along the continuum of care.

## Principles of *The ASAM Criteria*

- Admission into treatment is based on patient needs, not arbitrary prerequisites
- Multidimensional assessment addresses the broad biological, psychological, social, and cultural factors that contribute to addiction and recovery
- Treatment plans are individualized based on patient needs and preferences
- Care is interdisciplinary, evidence-based, patient-centered, and delivered from a place of empathy
- Co-occurring conditions are an expectation, not an exception
- Patients move along the continuum of care based on their progress, not predetermined lengths of stay
- Informed consent and shared decision-making accompany treatment decisions

# Core Components of The ASAM Criteria



\* Decision rules include the Dimensional Admission Criteria and the transition and continued service criteria.

# Goals of the Fourth Edition



Update the standards to reflect the current state of science and practice



Promote a chronic care model that supports seamless movement along the care continuum



Facilitate patient-centered, holistic, integrated care



Improve clarity and simplify where possible to support more effective implementations.

## MAJOR CHANGES IN FOURTH EDITION

- Update the dimensions
  - Incorporate more attention to SDOH
  - Readiness to change integrated throughout
  - Defining subdimensions
- Integrate MAT throughout
- Update continuum of care
  - 0.5; 3.2; 3.3 → all gone
  - 3.7 is residential!
  - Recovery services throughout
  - 1.0 = long term monitoring
- Integrate mental health, biomedical, medication, cognitive impairment throughout

## MAJOR CHANGES IN FOURTH EDITION

- Recovery residences
- Subdimensional risk ratings in each dimension
- Introduction of concept of dimensional drivers
- Harm reduction as a component of individualized care

# Access to Addiction Medications



- Dimension 1 updated to include “Addiction Medication Needs” to support delivery of the standard of care for SUD treatment
- All medically managed levels of care able to initiate all FDA-approved medications for SUD
- All patients should have a physical exam within a reasonable time that assesses addiction medication needs
- All clinically managed levels of care able to support continuation of any FDA-approved medication

# NEW METHODOLOGY



## ASAM Criteria 4<sup>th</sup> Edition Development Process

18 Writing  
Committees

Structured  
Evidence Review

Review 3<sup>rd</sup>  
Edition  
standards

Draft standards  
and decision  
rules

Voting Panel  
rating and  
reconciliation

Public comment  
period and  
reconciliation

Board and  
Council Review  
and Approval

Narrative  
Chapter Field  
Reviews

# ASSESSMENT STANDARDS

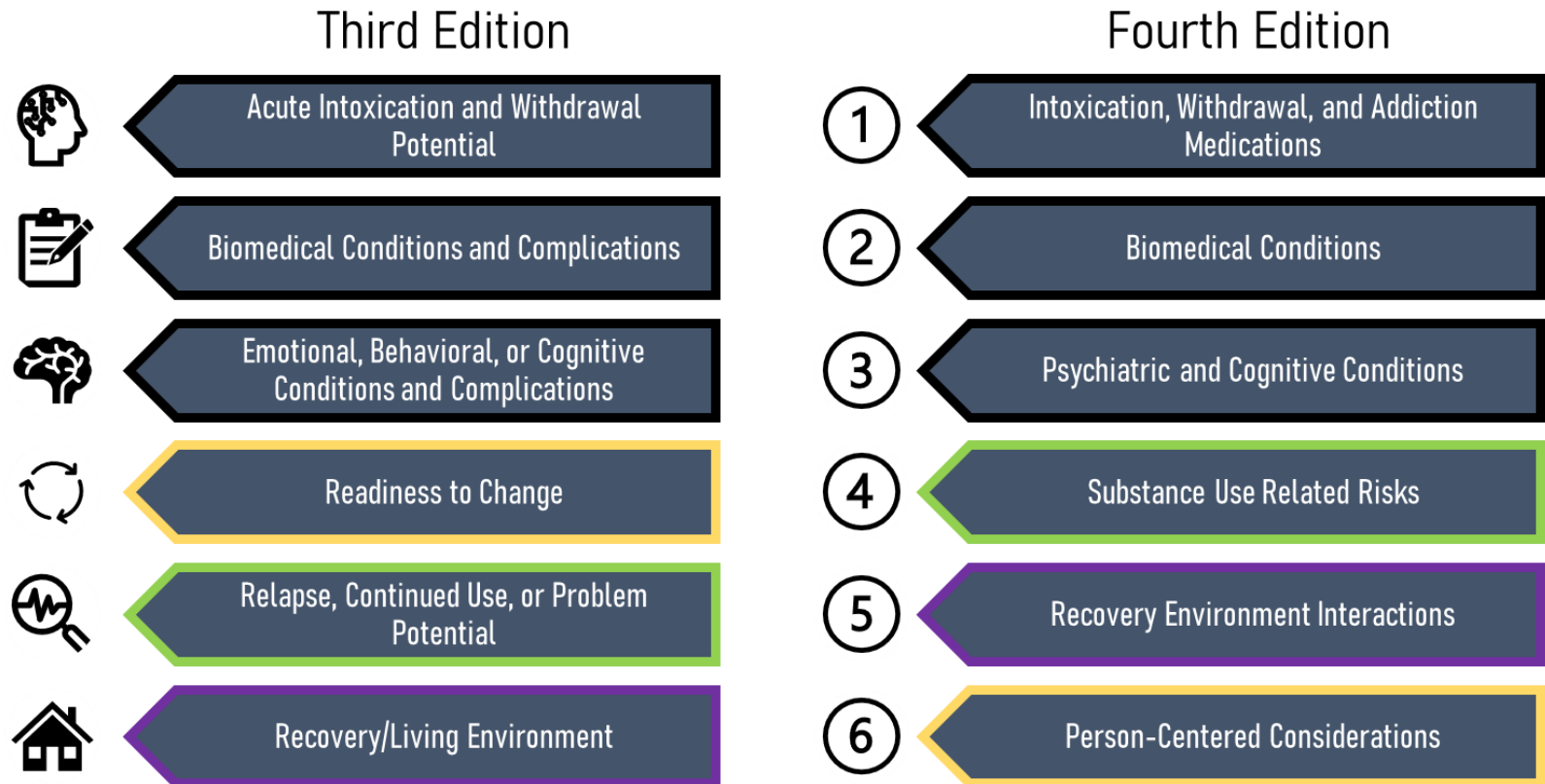


## ASAM Criteria Assessment

- The 4th Edition describes separate standards for:
  - The ASAM Criteria Level of Care Assessment that is used to determine the recommended level of care
  - The ASAM Criteria Treatment Planning Assessment
  - Both assessments are multidimensional and consider the patient's full biological, psychological, and sociocultural context

# Reordering the dimensions

- Since readiness to change does not independently contribute to initial treatment recommendations the dimensions will be adjusted
- Readiness considered across all dimensions.
- New Dimension 6 focuses on patient preferences, barriers to care, and need for motivational enhancement



## Fourth Edition

1 Intoxication, Withdrawal, and Addiction Medications

2 Biomedical Conditions

3 Psychiatric and Cognitive Conditions

4 Substance Use-Related Risks

5 Recovery Environment Interactions

**NEW**

6 Person-Centered Considerations

# Assessment Dimensions

# Subdimensions

## **Dimension 1 – Intoxication, Withdrawal, and Addiction Medications**

- **Intoxication and associated risks**
- **Withdrawal and associated risks**
- **Addiction medication needs**

## **Dimension 2 – Biomedical Conditions**

- **Physical health concerns**
- **Pregnancy-related concerns**
- Sleep problems

## **Dimension 3 – Psychiatric and Cognitive Conditions**

- **Active psychiatric concerns**
- **Persistent Disability**
- Cognitive Functioning
- Trauma exposure and related needs
- Psychiatric and cognitive history

## **Dimension 4 – Substance Use Related Risks**

- **Likelihood of risky substance use**
- **Likelihood of risky SUD-related behaviors**

## **Dimension 5 – Recovery Environment Interactions**

- **Ability to function in current environment**
- **Safety in current environment**
- **Support in current environment**
- Cultural perceptions of substance use

## **Dimension 6 – Person-Centered Considerations**

- Patient preferences
- Barriers to care
- Need for motivational enhancement

# 1

## Dimension 1

- Intoxication, Withdrawal, and Addiction Medications
  - Intoxication and Associated Risks
  - Withdrawal and Associated Risks
  - Addiction Medication Needs

### Medical Management

- Medications (and related education)
- Nursing care
- Medical monitoring/follow ups

### Clinical Services and Supports

- Motivational interventions
- Treatment plan/medication adherence
- Behavioral interventions
- Psychoeducation
- Overdose prevention

## 2

- Biomedical Conditions
  - Physical health concerns
  - Pregnancy-related concerns
  - Sleep problems

## Dimension 2

### Medical Management

- Medications (and related education)
- Monitoring/follow ups
- Anticipated duration of medically managed care

### Referrals for External Care

- Care coordination
- Patient navigation

### Clinical Services and Supports

- Goals related to physical health
- Treatment plan/medication adherence
- Psychosocial services
- Motivational interventions

# 3

## Dimension 3

- Psychiatric and Cognitive Conditions
  - Active psychiatric symptoms
  - Persistent disability
  - Cognitive functioning
  - Trauma-related needs
  - Psychiatric and cognitive history

### Medical Management

- Medications (and related education)
- Monitoring/follow ups
- Anticipated duration of medically managed care

### Referrals for External Care

- Care coordination

### Clinical Services and Supports

- Goals related to mental and cognitive health
- Treatment plan/medication adherence
- Psychosocial services
- Integrated treatment plans
- Motivational interventions

# 4

## Dimension 4

- Substance use-related risks
  - Likelihood of engaging in risky substance use
  - Likelihood of engaging in risky SUD-related behaviors

### Clinical Services and Supports

- Individual goals
- Building skills and insight
- External factors that influence recovery
- Adherence to treatment plan
- Motivational interventions

### Harm Reduction Strategies

### Recovery Support Services

- Peer support

# 5

## Dimension 5

- Recovery Environment Interactions
  - Ability to function effectively in current environment
  - Safety in current environment
  - Support in current environment
  - Cultural perceptions of substance use and addiction

### Clinical Services and Supports

- Establishing safe living environment
- Insight
- Skills of daily living
- Building a support network
- Motivational interventions
- Family/support system interventions
- Case management

### Recovery Support Services

- Peer support
- Educational services (eg, job training, financial literacy, parenting skills)
- Social services navigation



## Dimension 6

- Person-Centered Considerations
  - Barriers to care
  - Patient preferences
  - Need for motivational enhancement

### Clinical Services and Supports

- Motivational interventions
- Coordination with external agencies (eg, criminal justice, child protective services)

### Recovery Support Services

- Services addressing SDOH
- Social services navigation
- Peer support

# CONTINUUM OF CARE



# The ASAM Criteria Continuum of Care for Adult Addiction Treatment

Level 4:  
Inpatient

4 Medically Managed Inpatient  
4 Psych

Level 3:  
Residential

3.1 Clinically Managed Low-Intensity Residential

3.5 Clinically Managed High-Intensity Residential  
3.5 COE

3.7 Medically Managed Residential  
3.7 BIO 3.7 COE

Level 2:  
IOP/HIOP

2.1 Intensive Outpatient (IOP)

2.5 High-Intensity Outpatient (HIOP)  
2.5 COE

2.7 Medically Managed Intensive Outpatient  
2.7 COE

Level 1:  
Outpatient

1.0 Long-Term Remission Monitoring

1.5 Outpatient Therapy  
1.5 COE

1.7 Medically Managed Outpatient  
1.7 COE

Recovery Residence

RR Recovery Residence

# Notable Level of Care changes



Removing Level 0.5. Early intervention and prevention are addressed in a new chapter.



Removing Level 3.3. Reflecting that cognitive deficits should be addressed in all levels of care.



Level 3.2 WM services integrated into Level 3.5.



Recovery support service expectations at each level of care.



Expectation that all levels of care be co-occurring capable at minimum.



Adding harm reduction as a component of individualized care.

## Continuity Along the Continuum



Prevent sharp drop-offs in clinical care



Structured services 7 days per week in Level 3.1 and 3.5



Aligning clinical service standards.

## Access to Addiction Medications



- Dimension 1 updated to include “Addiction Medication Needs” to support delivery of the standard of care for SUD treatment
- All medically managed levels of care able to initiate all FDA-approved medications for SUD
- All patients should have a physical exam within a reasonable time that assesses addiction medication needs
- All clinically managed levels of care able to support continuation of any FDA-approved medication

## Expansion of Level 1

- Level 1.0 – Long-Term Remission Monitoring
  - Recovery management checkups
  - Rapid reengagement in care when needed
- Level 1.5 – Outpatient Therapy
  - Less than 9 hours per week of psychosocial services
- Level 1.7 – Medically Managed Outpatient
  - Encompasses Level 1-WM from 3rd edition
  - Incorporates low threshold medication initiation
  - Able to provide psychosocial services equivalent to Level 1.5

## Updated Continuum of Care

- Reframing early intervention and prevention
  - Includes chapter but no longer uses Level 0.5 nomenclature
- Treatment of cognitive impairments
  - Eliminates third edition Level 3.3
  - Includes chapter addressing treatment of individuals with cognitive impairments across the continuum
- Updating Level 3.7 to reflect residential care

## Supporting Comprehensive Care

- Integrating withdrawal management and biomedical care in the continuum of care
  - Level 1.7: Medically Managed Outpatient Treatment
  - Level 2.7: Medically Managed Intensive Outpatient Treatment
  - Level 3.7: Medically Managed Residential
    - Level 3.7 BIO has advanced biomedical capabilities including intravenous (IV) fluids and medications, as well as advanced wound care
  - Level 4: Medically Managed Inpatient

## Integrating Co-Occurring Capability

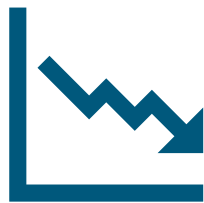
- All programs should be co-occurring capable at minimum
  - Program services designed with expectation that most patients have co-occurring conditions
  - Ability to manage mild to moderate acuity, instability, and/or functional impairment.
  - At least one staff member qualified to assess and triage mental health conditions
  - Integrated treatment plans
  - Coordination with external mental health providers as needed
  - Program content that addresses co-occurring conditions

## Recovery Services

- Recovery service expectations at each LOC
- Dimensional Admission Criteria consider the need for recovery residence support
- Algorithm may recommend an outpatient level of care plus a recovery residence
- New chapter on Integrating Recovery Support Services (Chapter 15)

## Continuity Along the Continuum

- Prevent sharp drop-offs in clinical care
- Structured services 7 days per week in Level 3.1 and 3.5
- Aligning clinical service standards
  - Aligning 2.1 and 3.1: 9-19 hours of clinical services per week
  - Aligning 2.5 and 3.5: 20 plus hours of clinical services per week



Prevent sharp drop-offs in  
clinical care



Structured services 7 days  
per week in Level 3.1 and  
3.5



Aligning clinical  
service standards.

# Chronic Care Model

- Integration of long term remission monitoring (Level 1.0)
- Emphasis on recovery services (RSS)
  - Assessment of RSS needs
  - RSS service standards for each level of care
- Encouraging formal affiliations across levels of care to support seamless transitions

# The ASAM Criteria Continuum of Care for Adult Addiction Treatment

## Clinically Managed Care

Level 4:  
Inpatient

4 Medically Managed Inpatient  
4 Psych

Level 3:  
Residential

3.1 Clinically Managed Low-Intensity Residential

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3.5 COE

3.7 Medically Managed Residential  
3.7 BIO 3.7 COE

Level 2:  
IOP/HIOP

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2.7 Medically Managed Intensive Outpatient  
2.7 COE

Level 1:  
Outpatient

1.0 Long-Term Remission Monitoring

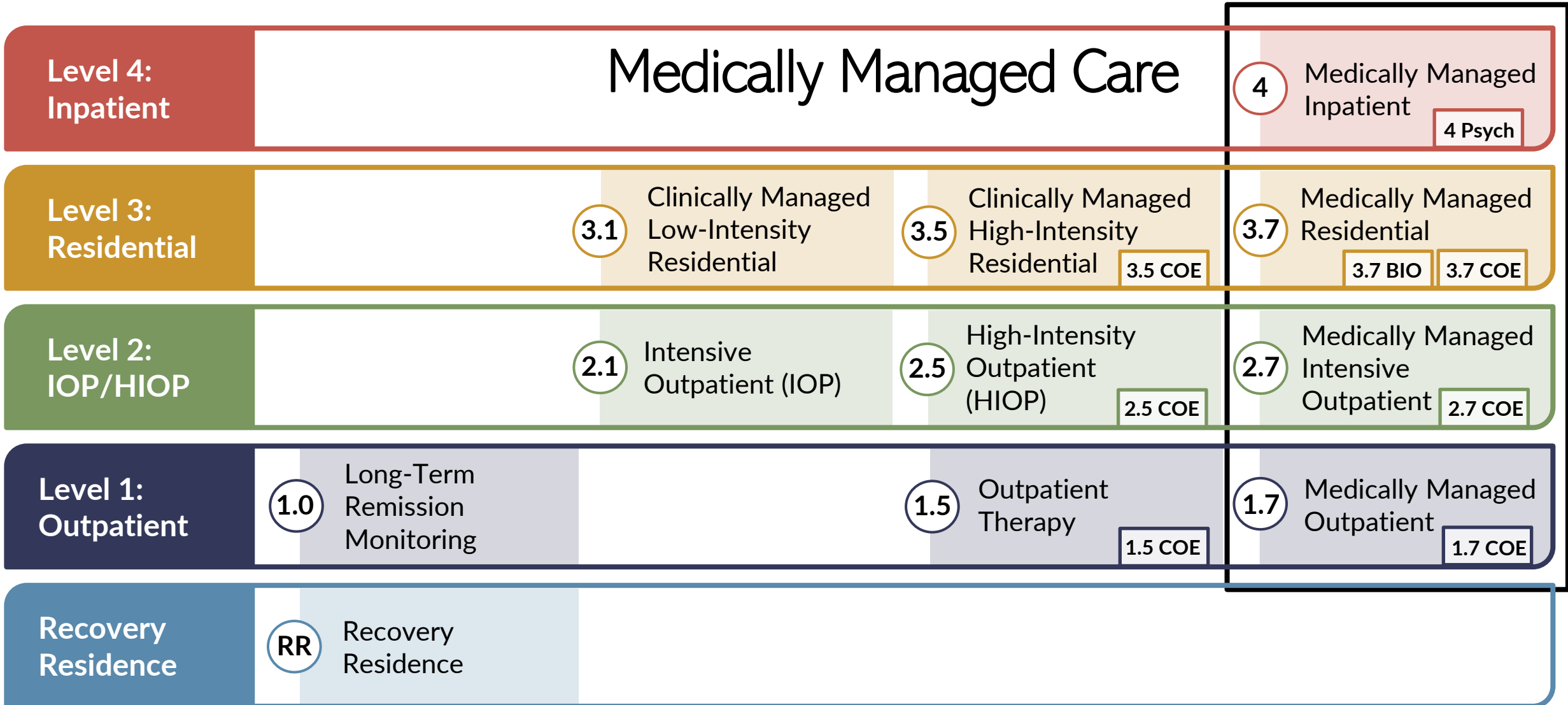
1.5 Outpatient Therapy  
1.5 COE

1.7 Medically Managed Outpatient  
1.7 COE

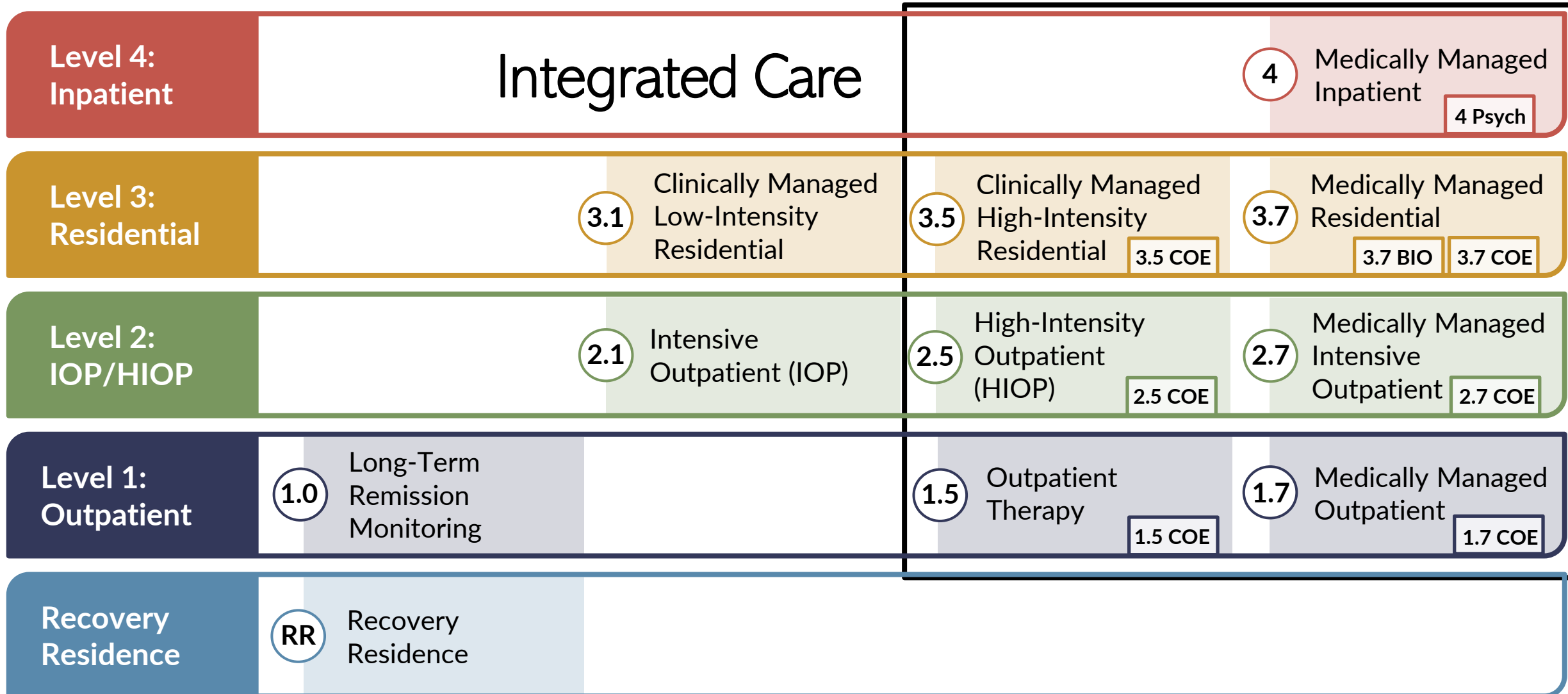
Recovery Residence

RR Recovery Residence

# The ASAM Criteria Continuum of Care for Adult Addiction Treatment

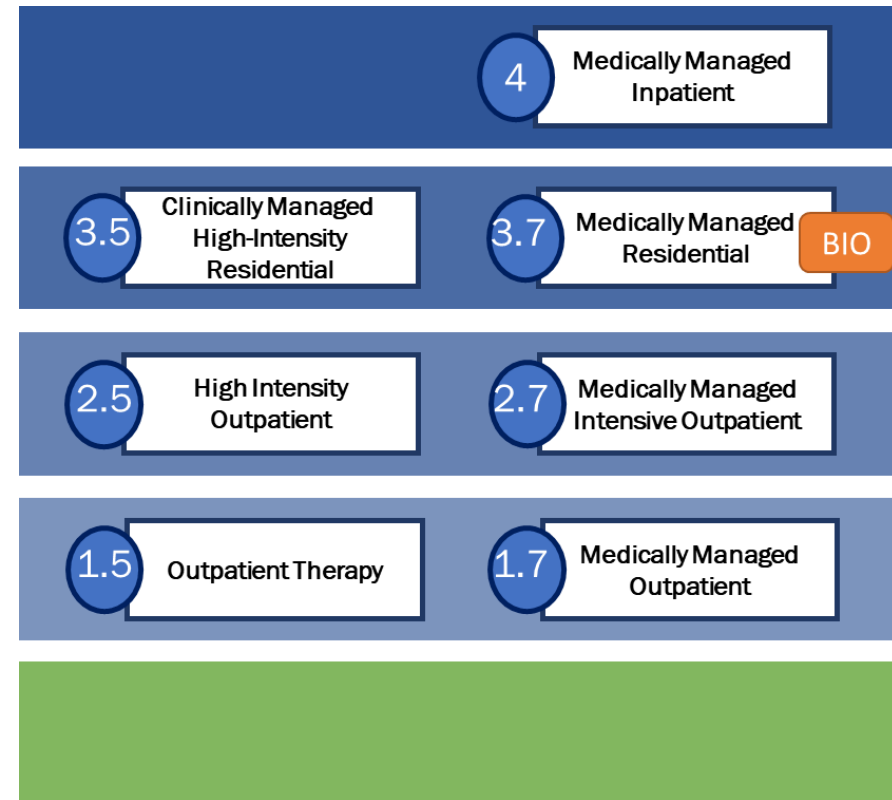


# The ASAM Criteria Continuum of Care for Adult Addiction Treatment



## Integration of Care

- Withdrawal management and biomedical services integrated into the main continuum
- All programs expected to be co-occurring capable



Co-occurring enhanced care (COE) Standards  
Defined for x.5, x.7, and Level 4



All programs should  
be co-occurring  
capable at minimum

## Integrating Co-occurring Capability

- Program services designed with expectation that most patients have co-occurring conditions
- Ability to manage mild to moderate acuity, instability, and/or functional impairment.
- At least one staff member qualified to assess and triage mental health conditions
- Integrated treatment plans
- Coordination with external mental health providers as needed
- Program content that addresses co-occurring conditions

# The ASAM Criteria Continuum of Care for Adult Addiction Treatment

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2.5 COE

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2.7 COE

Level 1:  
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1.0 Long-Term Remission Monitoring

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1.5 COE

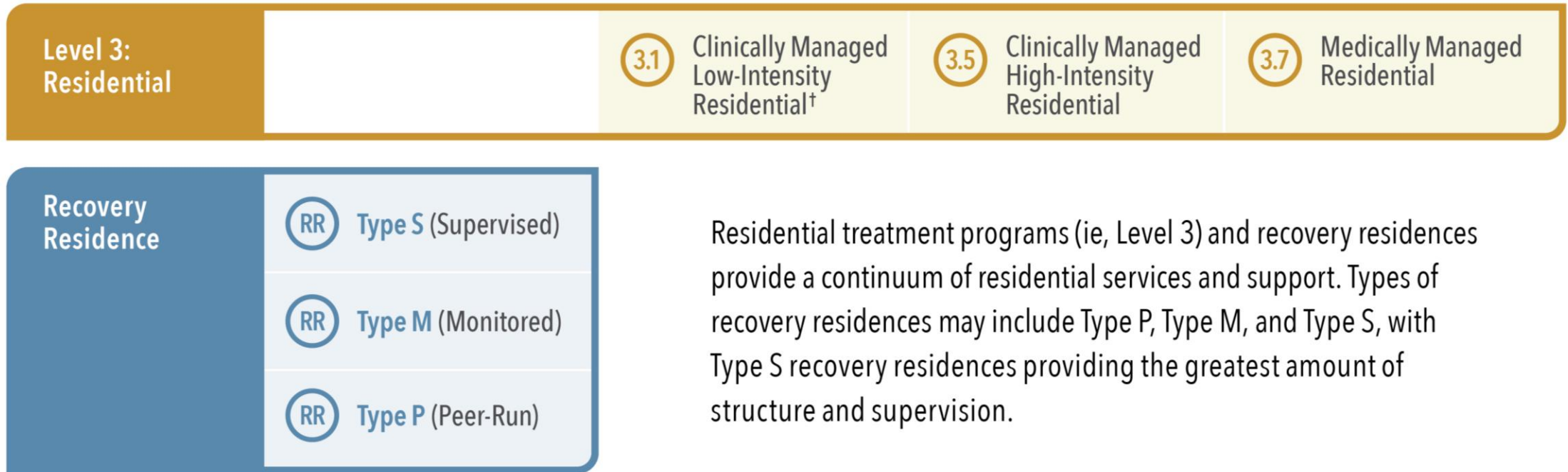
1.7 Medically Managed Outpatient  
1.7 COE

Recovery Residence

RR Recovery Residence

Chronic Care Model

## Residential Treatment and Recovery Residence Continuum of Care\*



Residential treatment programs (ie, Level 3) and recovery residences provide a continuum of residential services and support. Types of recovery residences may include Type P, Type M, and Type S, with Type S recovery residences providing the greatest amount of structure and supervision.

\* Developed in coordination with the National Alliance for Recovery Residences (NARR).

† NARR Type C (Clinical) programs are equivalent to *The ASAM Criteria* Level 3.1 that applies the social model.

# Service Characteristic Standards



# Service Characteristic Standards



Setting



Support Systems



Services



Staff



Assessment and  
Treatment Planning



Documentation

# Clinically Managed Outpatient

	<b>1.0</b>	<b>1.5</b>	<b>2.1</b>	<b>2.5</b>
	<b>Long-term Remission Monitoring</b>	<b>Outpatient Therapy</b>	<b>Intensive Outpatient Treatment</b>	<b>High-intensity Outpatient Treatment</b>
<b>Medical Director</b>	Not typically on-site	Not typically on-site	Not typically on-site	Yes
<b>Nursing</b>	Not typically on-site	Not typically on-site	Not typically on-site	Variable <sup>†</sup>
<b>Program Director</b>	Variable <sup>‡</sup>	Yes	Yes	Yes
<b>Allied Health Staff</b>	Variable	Variable	Typically available	Typically available
<b>Physical exam</b>	Verify a physical exam in the last year or refer	Within 1 month of treatment initiation	Within 14 days of admission <sup>§</sup>	Within 7 days of admission
<b>Nursing Assessment</b>	Not typical	Not typical	Not typical	Not typical
<b>Clinical Services</b>	Recovery and remission management services	Direct psychosocial services	Direct psychosocial services Therapeutic milieu	Direct psychosocial services Therapeutic milieu
<b>Clinical Service Hours</b>	Quarterly services at minimum	<9 h/wk	9-19 h/wk	≥20 h/wk
<b>Recovery Support Services (RSS)</b>	Recovery management checkups and other RSS*	Yes*	Yes*	Yes*

\* Directly or through formally affiliated provider

# Residential Levels Overview

	<b>3.1</b>	<b>3.5</b>
	<b>Clinically Managed Low-intensity Residential Treatment</b>	<b>Clinically Managed High-intensity Residential Treatment</b>
<b>Supervision</b>	Patients may leave independently during the day with appropriate accountability checks	24-h supervision
<b>Medical Director</b>	Not typical	Yes
<b>Physicians and Advanced Practice Providers</b>	Not typical	Available to review admission decisions.
<b>Nursing</b>	Not typical	Variable <sup>†</sup>
<b>Program Director</b>	Yes	Yes
<b>Allied Health Staff</b>	On-site and alert 24 h/d	On-site and alert 24 h/d
<b>Physical Exam</b>	Within 14 days of admission <sup>‡</sup>	Within 72 hours of admission
<b>Nursing Assessment</b>	Not typical	Not typical
<b>Clinical Services</b>	<ul style="list-style-type: none"> <li>• Direct psychosocial services</li> <li>• Therapeutic milieu</li> </ul>	<ul style="list-style-type: none"> <li>• Direct psychosocial services</li> <li>• High-intensity therapeutic milieu</li> </ul>
<b>Hours of Clinical Services</b>	9-19 h/wk, available 7 d/wk	≥20 h/wk, available 7 d/wk
<b>Recovery Support Services</b>	Yes*	Yes*

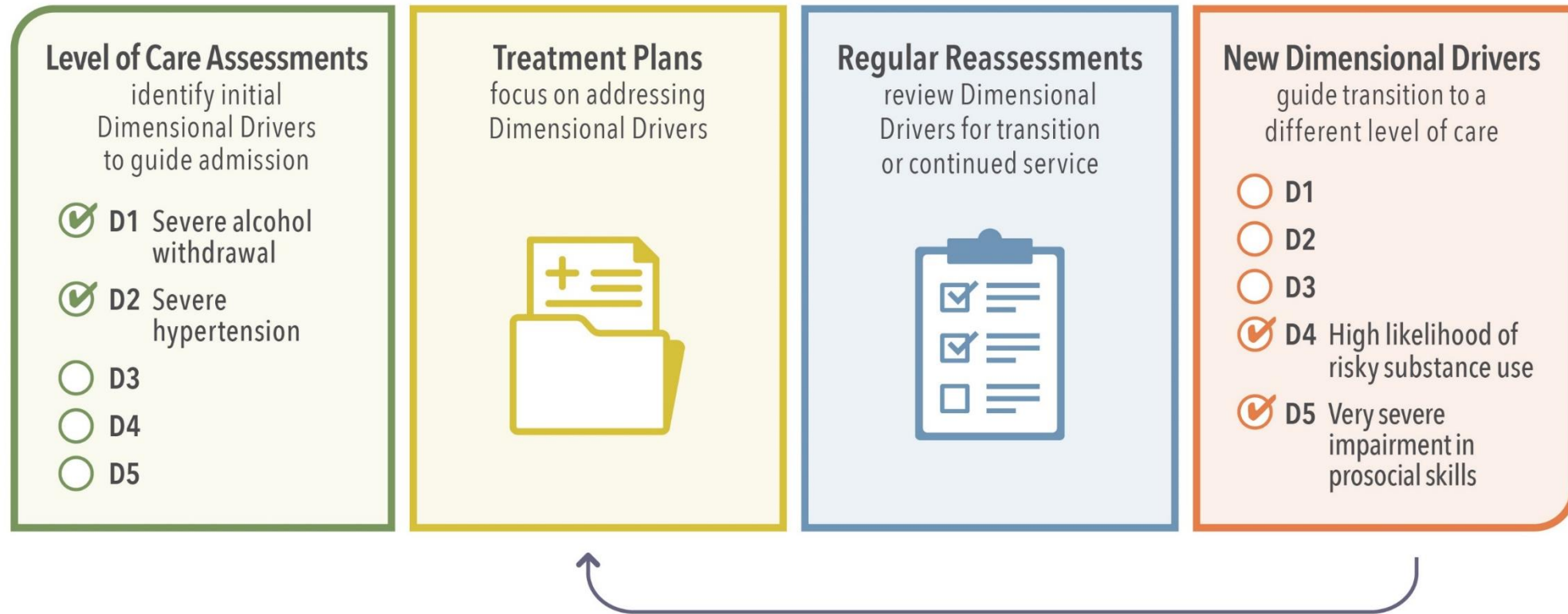
\* Directly or through formally affiliated provider

# Medically Managed Overview

	1.7	2.7	3.7	4
	Medically Managed Outpatient Treatment	Medically Managed Intensive Outpatient	Medically Managed Residential Treatment	Medically Managed Inpatient Treatment
<b>Supervision</b>	N/A	N/A	24-h supervision	24-h supervision
<b>Medical Director</b>	Yes†	Yes	Yes	Yes
<b>Physicians and Advanced Practice Providers</b>	Available by appointment	Available on-site or via telehealth during program hours	Available on-site or via telehealth 24/7	Typically available on-site 24/7
<b>Nursing</b>	Variable	Yes	Available 24/7	Available 24/7
<b>Program Director</b>	Not typical	Yes	Yes	Variable
<b>Allied Health Staff</b>	Variable	Typically available	Typically available	Typically available
<b>Physical Exam</b>	Typically at initial assessment	Within 24-48 hours of initial assessment	Within 24 hours of admission	Within 24 hours of admission
<b>Nursing Assessment</b>	Variable	At admission	At Admission	At Admission
<b>Clinical Services</b>	<ul style="list-style-type: none"> <li>• Direct withdrawal management and biomedical services</li> <li>• Management of common psychiatric disorders</li> <li>• Psychosocial services*</li> </ul>	<ul style="list-style-type: none"> <li>• Direct withdrawal management and biomedical services, with extended nurse monitoring</li> <li>• Management of common psychiatric disorders</li> <li>• Psychosocial services*</li> </ul>	<ul style="list-style-type: none"> <li>• Direct withdrawal management and biomedical services</li> <li>• Management of common psychiatric disorders</li> <li>• Psychosocial services (direct or through formal affiliation)</li> </ul>	<ul style="list-style-type: none"> <li>• Direct withdrawal management and biomedical services (ICU available)</li> <li>• Psychiatric services</li> <li>• Psychosocial services (direct or through formal affiliation)</li> </ul>
<b>Clinical Service Hours</b>	<9 h/wk	≥20 h/wk	≥20 h/wk	Variable
<b>Recovery Services</b>	Yes*	Yes*	Yes*	Yes*

† may be the responsible physician in an independent practice; \* Directly or through formally affiliated provider

## The ASAM Criteria Dimensional Drivers\*



\* The Dimensional Drivers presented in this figure are illustrative; Dimensional Drivers should be individualized to each patient.

**Dimensional Drivers** are the concerns that drive the recommendation for a specific level of care for an individual. They are concerns that cannot be safely and effectively managed in a less intensive level of care.

DEVELOPING A PLAN OF CARE  
also known as  
TREATMENT PLANNING



## Developing and Evolving *Plans of Care*



- Occurs soon after admission
  - May be delayed if the patient is too acutely ill to participate
- Collaborative process between clinicians and patients
  - May include family and support systems
- Focused on Dimensional drivers and patient priorities

# Treatment Planning Principles

Individualized

Patient centered

Unconditional positive regard

Meet patients where they are

- Build upon patient strengths
- Respect autonomy and values
- Get patient buy in

## Multidisciplinary process

Treatment planning should be led by patient's primary clinician

Dimensions 1 or 2 concerns that require medical care should be led by a medical professional

Dimension 3 concerns that require psychiatric services should be led by a mental health professional



# Treatment Planning Process

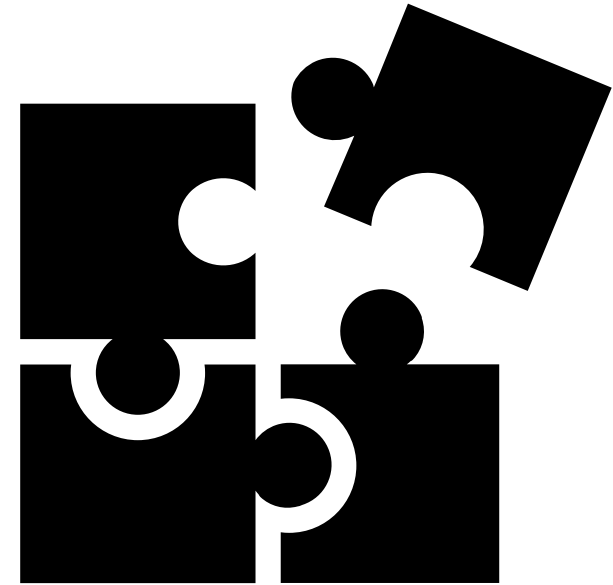
- Integrates motivational interviewing to expand patient insight
- When identifying goals, objectives and action items, consider
  - Patient strengths
  - Need for motivational and harm reduction strategies
  - Availability of services and anticipated wait times
  - Care coordination needs
  - Past successes and challenges

## Plans of Care

- How will success be measured
- Contingency plans in case instability arises
- Safety planning
- Transition planning (beginning at admission)
  - Continuity of care
  - Dimension 5 or 6 concerns that may impact transition to a less intensive level

## Care Coordination

- The treatment plan should be well coordinated with external providers
  - shared understanding of treatment plan goals
  - incorporate relevant services
    - Appointment reminders
    - Relevant psychoeducation
    - Motivational interventions
    - Adherence monitoring



## Other Changes



## **New Content**

- Treatment Planning (Chapter 9)
- Telehealth and Other Health Technologies (Chapter 13)
- Integrating Recovery Support Services (Chapter 15)
- Integrating Trauma-Sensitive Practices, Culturally Humble Care, and Social Determinants of Health (Chapter 16)
- Addressing Pain (Chapter 18)
- Addressing Cognitive Impairment (Chapter 19)

## Additional Volumes

Adolescent  
and Transition  
Age Youth

Correctional  
Settings and  
Reentry

Behavioral  
Addictions

# Implementation Tools

- Updating implementation tools
  - Training courses
  - ASAM Criteria software
  - Level of Care Certification program with CARF
  - ASAM Criteria Interview Assessment guide
- Developing new implementation tools
  - Standard medical necessity and continued service forms
  - Treatment planning template



## Questions?

Jeffrey DeVido, M.D., M.T.S., FAPA, DFASAM  
[Jeffrey.devido@marincounty.gov](mailto:Jeffrey.devido@marincounty.gov)

Interested in more? Come to:

- ASAM Annual Meeting  
(Denver in April 2025!)  
<http://www.asam.org>

- CSAM Annual Meeting  
(Anaheim Aug 2025!)  
<http://csam-asam.org>

- AAAP Annual Meeting  
(San Francisco Nov 2025!)  
<http://www.aaap.org>

# Discussions/Questions



**“The opposite of addiction is not sobriety; the opposite of addiction is **connection.**”**

*- Johann Hari*



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# RESOURCE SLIDES

*Please share with applicable staff*

# Immigration-Related Resources

- [Marin Immigrant Rights and Justice Workgroup](#)
- [Immigrant Legal Resource Center](#)
- [Red Card](#) (*Available in multiple languages*)
- Marin Rapid Response Network (Report ICE Activity): 415-991-4545
- You Tube Video: [Know Your Rights](#)



# County Updates and Announcements

- **Service Entry and Billing Submission**

- Ensure all services in SmartCare have been moved from Scheduled and Show status each month with submission of billing.
- All services should be in Complete, Cancel, No Show or Error **status**.
- Use the Services (My Office) List page and filter the All Service Statuses dropdown by Scheduled and Show to review outstanding services.
- Services with Warnings or Errors will remain in Show status until the errors are resolved.



Services (3551)

All Services	Scheduled	Include Do Not Complete	All Programs	Financial Assignment...	Apply Filter
All Locations	All Procedure Codes	All Clinicians	All Service Entry Staff	All Service Areas	
Service Id	Entered From	Entered To	DOS From 07/01/2023	DOS To 06/30/2024	
<input type="checkbox"/> Include Services created from Claims	<input type="checkbox"/> Only include Services with Add On Codes	<input type="checkbox"/> Only show Non-Billable Services	<input checked="" type="checkbox"/> Show Only Active Clients		

# County Updates and Announcements



## Payer Plan Entry and Maintenance

- All services must have an active payer plan on the date-of-service.
  - Non Medi-Cal services also require an additional payer plan that is appropriate for the service.
- All payer plans must have an ID number.
  - For Marin County, SB678, AB109, ADC, etc. add the client's account number.
- All payer plans should have a “Start Date” of the first of the month that services were rendered.

# County Updates and Announcements

- **Payer Plan Entry and Maintenance (cont.)**
  - Enter payer plans only once in the coverage screen
    - If the payer is already present in the “Client Plans” (top) box, use the “start/end dates” and “Service Area” fields to “Add” the payer to the “Plan Time Spans” (bottom) box.

Coverage (4) i

**Client Plans**    Notes

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**Client Plans**

Plan Name	△	Insured Id	Co-Pay	Start Date	End Date	COB	Service Area	
<u>Marin County</u>				<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	DMC	<b>Add</b>
<u>Medi-Cal DMC</u>				<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	DMC	<b>Add</b>
<del><u>Medi-Cal DMC</u></del>				<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	DMC	<del><b>Add</b></del>
<u>Medi-Cal MH</u>				<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	MH	<b>Add</b>

# Resource Reminder: Medi-Cal Eligibility Re-determinations

## Who:

- Public Assistance (PA) Contact for SUD Providers: **Peter Funk** ([peter.funk@marincounty.gov](mailto:peter.funk@marincounty.gov))

## What:

To assist with continuous Medi-Cal coverage given return to regular Medi-Cal rules, this pilot was developed to provide a direct point of contact in PA for SUD Providers to inquire about Medi-Cal, including:

- Ascertaining eligibility status (active, denied, discontinued, pending)
- Troubleshooting Intercounty Transfer issues
- Troubleshooting Managed Care and access to care issues
- Receiving change reports for Medi-Cal eligibility, including but not limited to redetermination paperwork
- Navigating and remedying discontinuances and Medi-Cal restorations

## How:

- For PA and SUD to discuss, the client will need to **complete the *Authorization for Release of Protected Health Information to Third Parties (DHCS 6247)* and return it to the Peter.** It can be emailed, mailed, dropped off, faxed, or completed by phone by the client with Peter.
- *Note: Peter aims to respond within 48 hours and please encrypt emails.*

# SmartCare Electronic Health Record Updates and Tips

- How to Run Real Time Eligibility (270/271) Screen - 2023 CalMHSA

- Tip: If the client is not showing, you can either do an Inquiry or go back to the previous method used to check Medi-Cal eligibility.
- Reminder: Ensure you click “Update Coverage”
- Reminder: The End Date is the date of eligibility being searched for (e.g. first day of month)
- Reminder: Please verify that you are double checking the Plan Time Span start date. We are seeing more MCAL start dates of 2032 or 204. Ideally, most clients should have their MCAL start date be 7/1/23.
  - If you notice an incorrect start date, changing the end date of eligibility to 7/1/23 will solve
- Reminder: If client’s insured ID is blank, use the SSN for that field to run eligibility

The screenshot displays the 'Coverage' section in SmartCare. It features two main tabs: 'Client Plans' and 'Notes'. The 'Client Plans' tab is active, showing a table with columns for Plan Name, Insured Id, Co-Pay, Start Date, End Date, COB, and Service Area. The table lists four plans: Marin County, Medi-Cal DMC, Medi-Cal MH, and SABG. Below the table, there are filters for 'Show Current Plans Only' (checked) and 'Maximize Time Spans'. The 'Plan Time Spans' section shows a list of plans for the date 07/01/2023 - No End Date, with a 'Change COB Order...' button and 'Set End Date' buttons for each plan.

*\*The plan for SUD is Medi-Cal DMC. Please ensure that is at the bottom - the top will have both Medi-Cal DMC and Medi-Cal MH*

# SmartCare Electronic Health Record Updates and Tips

- For Marin County Payor Plans (Non-Medi-Cal): Please make sure the Plan is at the top and bottom (this will happen automatically for Medi-Cal when clicking “Update Coverage”)
  - *Note: The “Marin County” Plan should only be added to the DMC service area.*
- Reminder: Coverage plans are not specific to the program – they are specific to the client. As such, if they are Medi-Cal eligible, DMC should be listed as a payor, even if the service is not Medi-Cal eligible, as the client may access DMC-eligible services elsewhere.
- Tip: If the County of Responsibility is not Marin, though the eligibility shows County of Residence is Marin, then the Medi-Cal Plan will need to be added every month. Note: You can use the 270/271 for this.

# SmartCare Electronic Health Record Updates and Tips

- Reminder: **Interpreter Services** (All Providers)
  - If needed, click the box – **AND** – complete the Custom Fields
- **New:** The **CA ASAM** will now pull any responses from a CA ASAM completed for the same client in the last 180 days (EXCEPT for the LoC and Risk choices for each dimension)

The screenshot displays the 'Service Detail' tab of the SmartCare EHR system. It includes the following sections:

- Service Detail:** Contains fields for 'Documentation Time' (with a 'Days' label), 'Evidence Based Practices' (a dropdown menu), and 'Transportation Service' (set to 'No').
- Authorization(s):** Includes checkboxes for 'Override Charge Amount', 'Override Errors', and 'Interpreter Services Needed'. There are also 'Overridden By' fields.
- Warnings / Errors:** A table with columns 'Date', 'Error Type', 'Error Message', and 'Next Step'. The table is currently empty, displaying 'No data to display'.
- Custom Fields:** A section titled 'Interpreter Service' containing:
  - 'Interpreter has been scheduled' with radio buttons for 'Yes' and 'No'.
  - 'Language' with a dropdown menu.
  - 'Interpreter Agency Scheduled' with a text input field.

# Reminder: DMC Timely Access to Services

- Links to Instructions:
  - **For Non-OTP:** <https://2023.calmhsa.org/how-to-complete-the-dmc-outpatient-timeliness-record/>
  - **For OTP:** <https://2023.calmhsa.org/how-to-complete-the-dmc-opioid-timeliness-record/>
- This is required for State Reporting and important for assessing access to care and for continuous quality improvement
- There is a “flag” set-up in SmartCare to prompt staff to complete this form at enrollment
- **Implementation:**
  - For Outpatient and OTP LOCs: Use for all new admissions for January 1, 2024 forward (no change from guidance issued on 1/10/2024)
  - For Residential and Residential WM: Use for all new admissions for January 22, 2024 forward (updated guidance issued 1/18/2024)
  - You do not need to enter data retroactively from the above noted timeframes at this point

## SmartCare - CalOMS


- Issue: The FSN number is required to ensure that the CalOMS Discharge information is accurately transcribed to State reporting. The FSN numbers did not get transferred during the initial client data conversions – and only started to populate in SmartCare around 8/10/23. This is a known issue with CalMHSA.
- Action: If an FSN number does NOT auto populate on the CalOMS Discharge Data:
  - Step #1: Complete the CalOMS Discharge Data as thoroughly as possible and save as draft.
  - Step #2: Submit a BHRS EHR Support Ticket with the name of the client, program and type of update (e.g. Discharge, Annual Update) and they will look up and enter it in SmartCare.

# SmartCare Updates & Tips

- **Health Questionnaire**
  - FYI: CalMHSA added a scanned document type for this document
- **SmartCare – Addresses**
  - If the beneficiary does not have an address, enter “20 North San Pedro Road, San Rafael, CA 94903”
  - No address will trigger a DMC denial (even if services shows as Completed)
- **New Users and Staff Updates** (e.g. role change, updated certification/ licensure dates, etc.)
  - Link to: [Staff User Access Form](#) (can be found at [www.marinbhhs.org/providers](http://www.marinbhhs.org/providers))

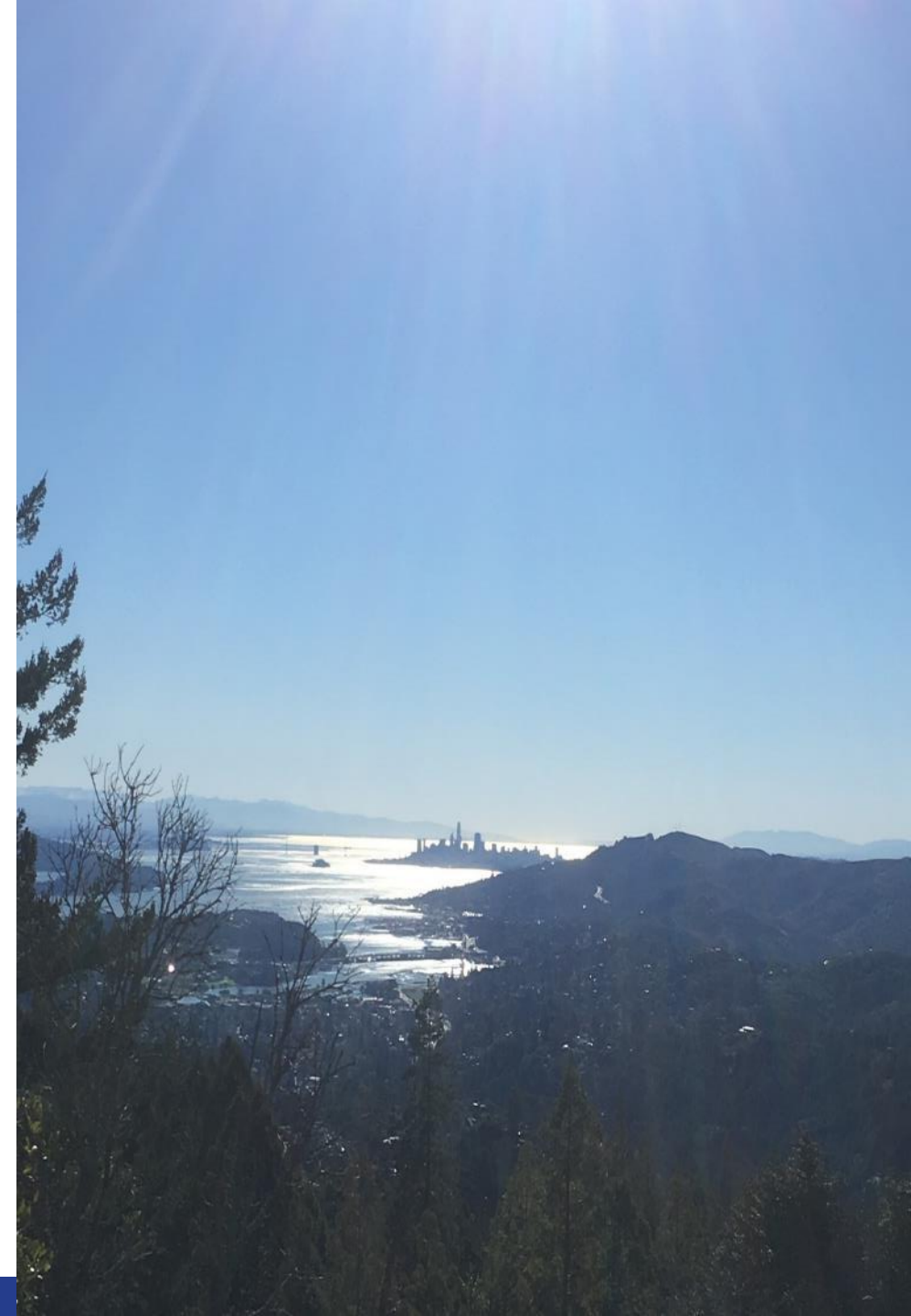
## SmartCare - Seeking Help

### CalMHSA Support:

- Navigating the EHR (Procedures & Workflows)
  - Use the “**Walk Me**” function by clicking the question mark icons  in the upper and lower right corners wherever you see it displayed.
  - Review Training Videos & Guides on the CalMHSA website: <https://2023.calmhsa.org/>

### For additional support

- [Live Chat is available and preferred - 2023 CalMHSA Site](#)
- [EHR@calmhsa.org](mailto:EHR@calmhsa.org) or by phone at (833) 686-6801
  - \* *This help is available from 7am – 7pm PST*
  - Additional help with procedures and workflows
  - Troubleshoot system related errors
  - Report system issues (glitches, bugs, etc.)



## SmartCare - Seeking Help

### Marin County BHRS EHR Support Team:

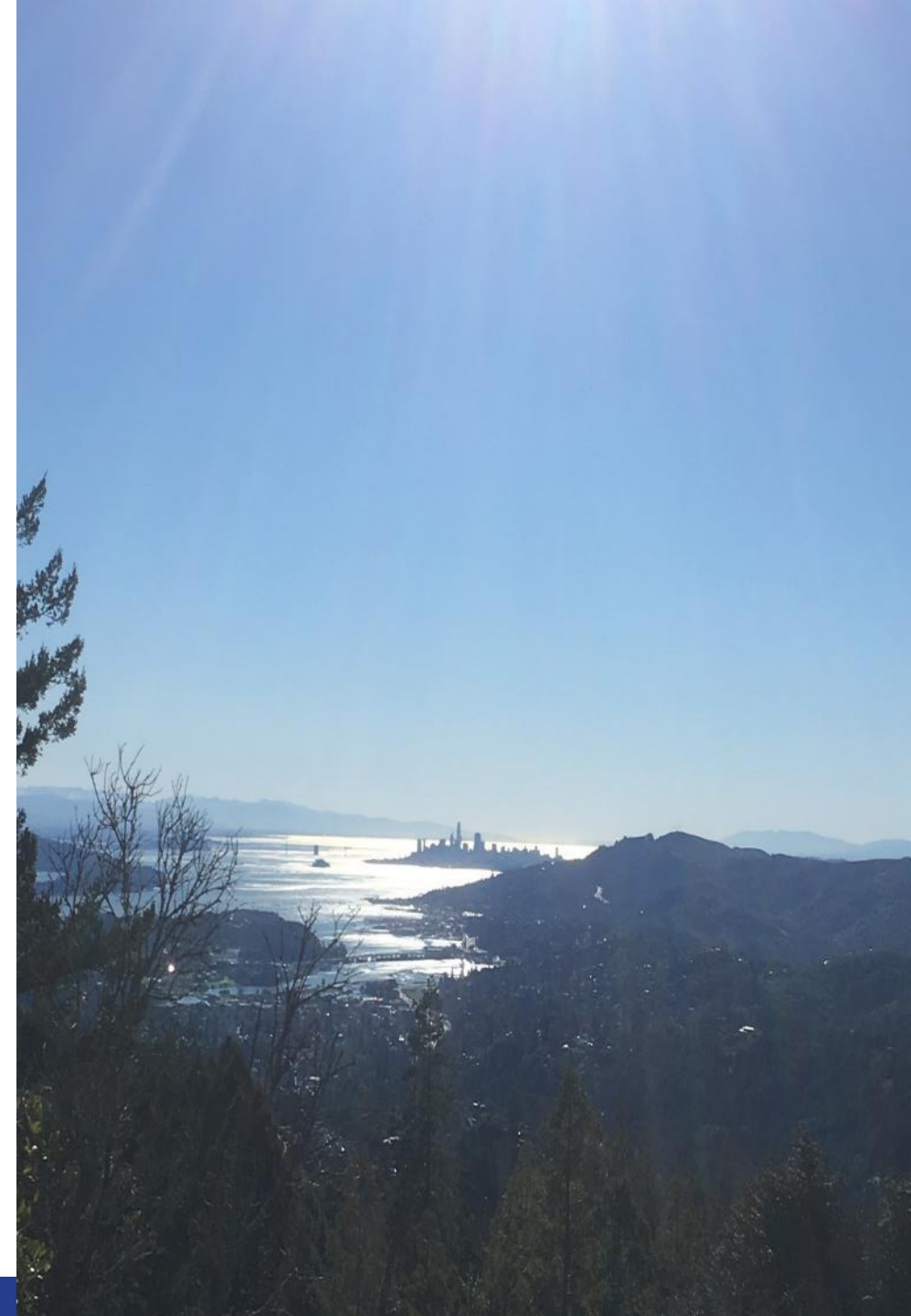
Use the [Marin BHRS EHR Support Request](#) /ticketing system to submit all new inquiries. The BHRS EHR support email should be used to respond to additional EHR requests to previously submitted tickets.

*Response time in/up to 3 days*

- Can't log in/locked out of account.
- There are missing programs, procedure codes or other options from drop downs.
- Can't add a problem to the problem list.
- Error messages that have to do with permissions.

### Submitting a Support Request:

- Please provide the specific screens that you were on and the buttons that you clicked that led to the error and the exact error message so the EHR team can troubleshoot.
- If the inquiry is client related, please provide the client account number, DOS or other service-related info to research and recreate the issue.
- Examples:
  - *Please add the following services/programs for the providers below: Provider First/Last, Comprehensive Community Support or add counseling to program A*
  - *Services have rate errors: Client ID #555xxxx for DOS 7/1/2023 has a rate error*



## SmartCare - Seeking Help

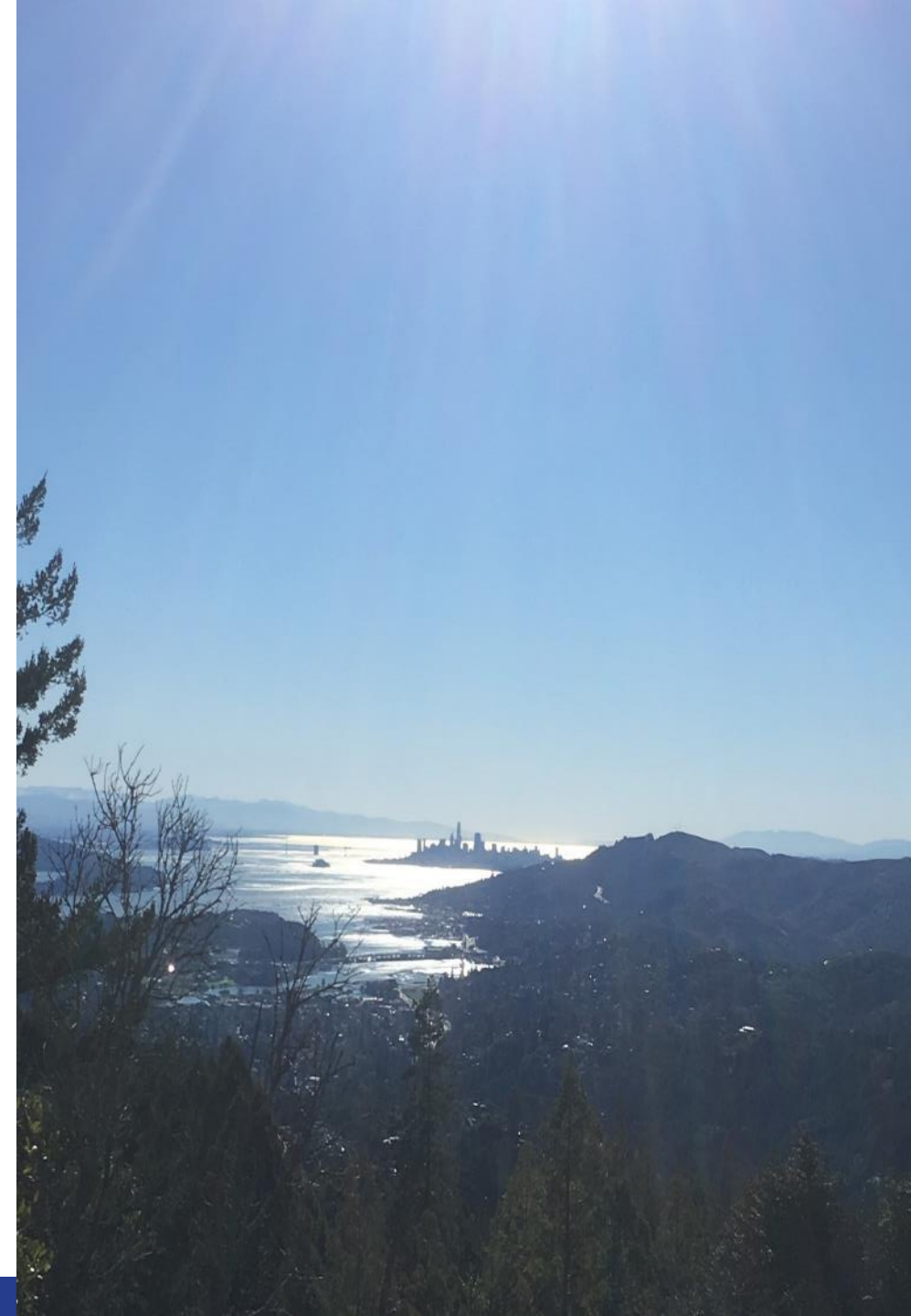
### Ongoing Clinical Support:

[BHRSQM@MarinCounty.org](mailto:BHRSQM@MarinCounty.org)

- BHRS Quality Management provides clinical support for services and required documents, etc.

### Contract Manager Support:

- Policy questions
  - CPT codes in contract
  - Which procedure codes to pick
- Billing questions
  - *Note: currently we do not have billing functionality and we anticipate possibly 3-6 months for submission. In the interim, we have plans for how to pay contractors and payment will not be delayed.*
- Barrier to time sensitive work (contact Contract Manager in addition to above resources)
- Notify them of reoccurring issues to keep them in the loop so they can provide support.



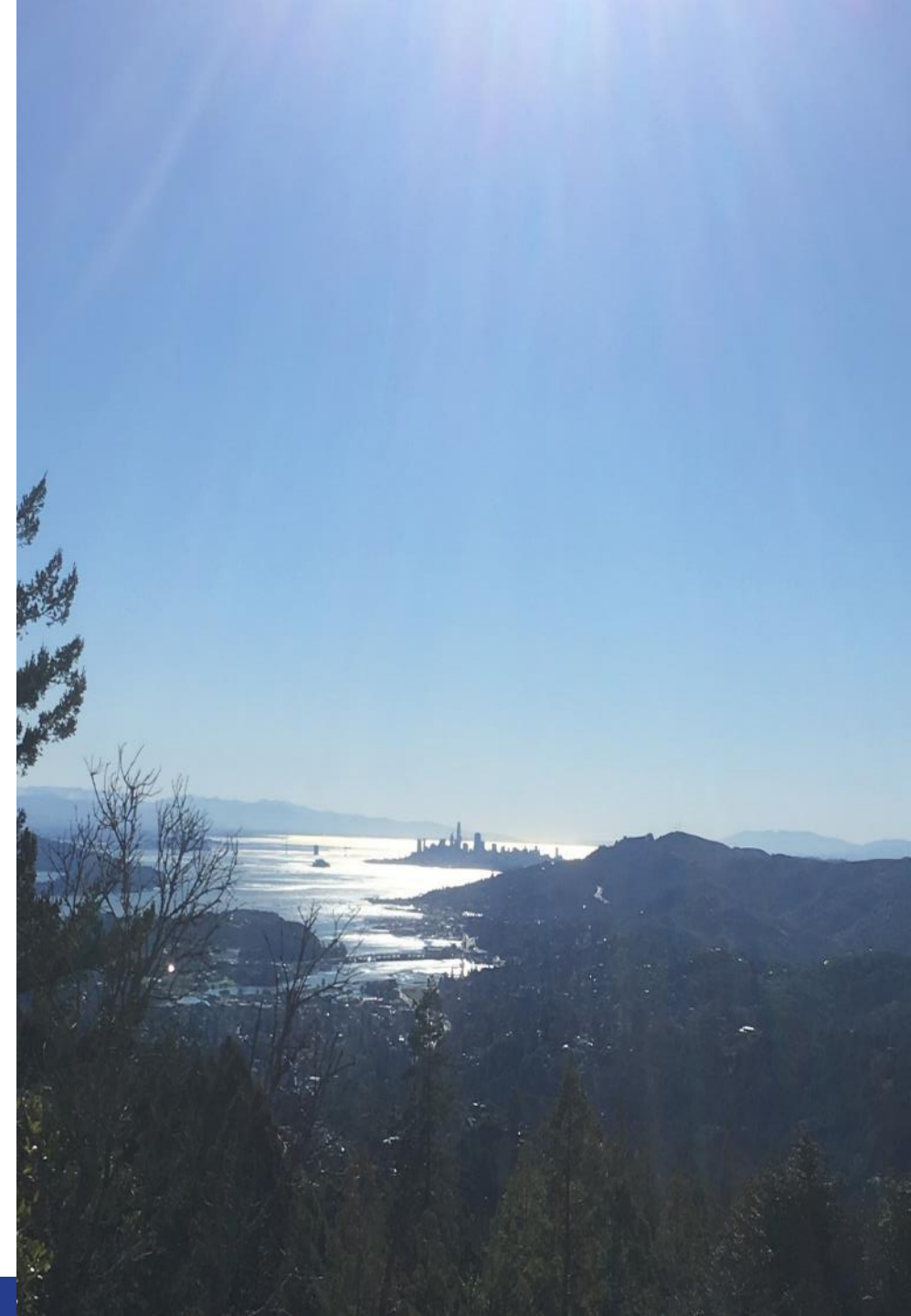
## SmartCare - Seeking Help

### EHR Support Resources:

- Please route inquiries to the resources provided on previous slides
- If you are unsure where to route your inquiry and are unable to find the answer to your question on the CalMHSA website/chat, please submit a ticket to BHRS EHR Support and they will coordinate with your Contract Manager and others as needed.
  - *Example: I know how to enter this service, but for this client and DOS, I am receiving this error that I haven't seen before and don't know how to resolve.*

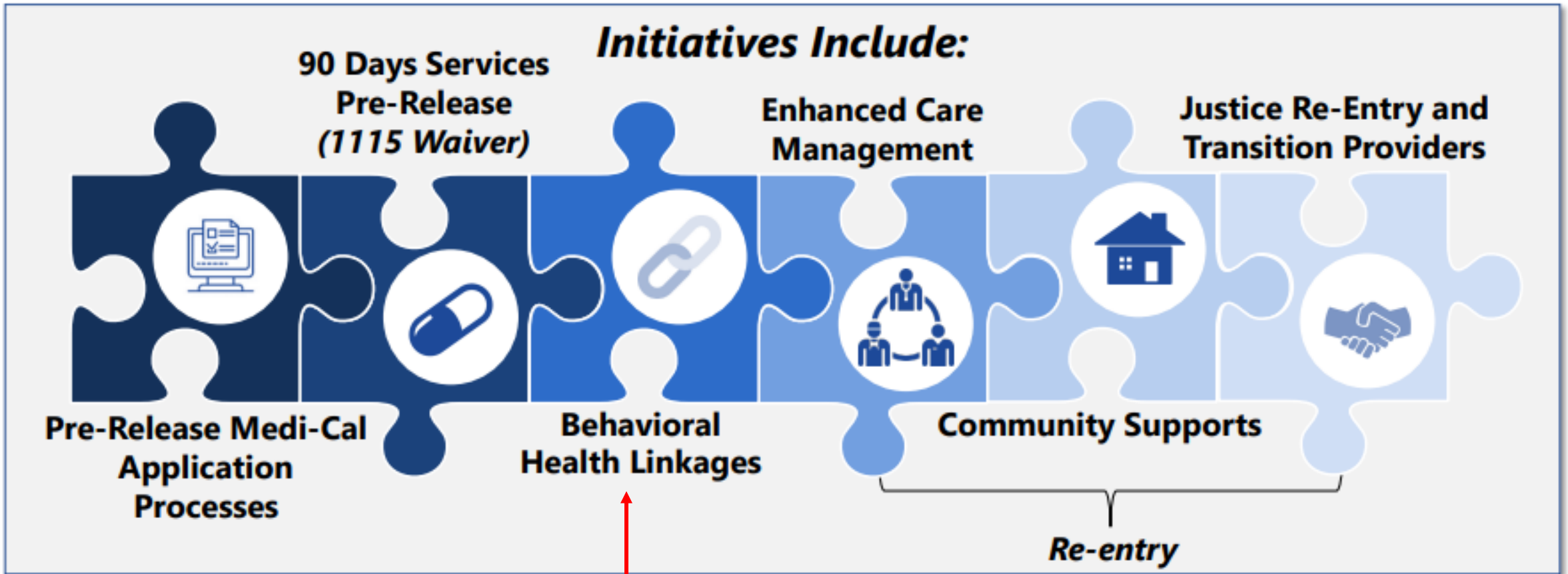
### SUD Office Hours:

- We have resumed [SUD Office Hours](#) on the 2<sup>nd</sup> Wednesday of the month from 1:00-2:00 pm
- Please be prepared to share examples including screenshots, background information and specific clients, services or other details to assist in resolution during Office Hours.



# What is CalAIM Justice Involved?

CalAIM justice-involved initiatives support justice-involved individuals by providing key services pre-release, enrolling them in Medi-Cal coverage, and connecting them with behavioral health, social services, and other providers that can support their re-entry.



# BHRS Responsibilities for Behavioral Health Links Pre & Post-Release

- Data Sharing With Managed Care Plans (Kaiser and Partnership HealthPlan) & Correctional Facilities (CFs)
- Participating in Re-entry Planning & Warm Handoff with ECM if requested
- Participating in Professional-to-Professional Clinical Handoff 14 days prior to release
- Follow-up services Post-Release
- Behavioral Health Links Go Live: 10/1/2024
- Resources: CalAIM Justice Involved (JI) [Fact Sheet](#); CalAIM JI [Policy and Operations Guide](#)



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*Health, Well-being & Safety*

