Quality Assurance (QA) in

Drug Medi-Cal Organized Delivery System

(DMC-ODS)

Programs

Presented by:

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TRAINING OBJECTIVES

Training Goal:

Development of Quality Improvement Plans, as a component of a County’s DMC-ODS Implementation Plan, that complies with State Department of Health Care Services (DHCS) Terms and Conditions.

Training Objectives:

Participants with adequate pre-training familiarity with the fundamentals of administrative accountability in public services will be able to:

1. Identify key terminology related to Quality Assurance (QA), as used in the California Department of Health Care Services (DHCS) Special Terms and Conditions (STC’s).
2. Understand and describe the relationship between federal, state and county Quality Assurance requirements for DMC-ODS services.
3. Identify required components of a Quality Assurance Plan as a component of a County’s overall DMC-ODS Implementation Plan.
4. Identify issues for Phase B and Phase C training sessions.
DHCS SPECIAL TERMS AND CONDITIONS

SECTION 156 Regarding QA Issues

DMC-ODS county oversight, monitoring and reporting.

The intergovernmental agreement with the state and counties that opt into the waiver must require counties to have a Quality Improvement Plan (QIP) that includes the county’s plan to monitor the service delivery, capacity as evidenced by a description of the current number, types and geographic distribution of substance use disorder services.

For counties that have an integrated mental health and substance use disorders department, this QIP may be combined with the Mental Health Plan (MHP) Quality Improvement Plan.

(a). The county shall have a QI Committee to review the quality of substance use disorder services provided to the beneficiary. For counties with an integrated mental health and substance use disorders department, the county may use the same committee with the Substance Use Disorder (SUD) participation as required in the MHP contract.

b. The QA committee shall recommend policy decisions; review and evaluate the results of QI activities; institute needed QI actions, ensure follow-up of QI process and document QI committee minutes regarding decisions and actions taken. The monitoring of accessibility of services outlined in the QIP will at a minimum include:

i. Timeliness of first initial contact to face to face appointment
ii. Timeliness of services of the first dose of Narcotic Treatment Program
iii. Access to afterhours care
iv. Responsiveness of the beneficiary access line
v. Strategies to reduce avoidable hospitalizations
vi. Coordination of physical and mental health services with waiver services at the provider level
vii. Assessment of the beneficiaries’ experiences
viii. Telephone access line and services in English as well as in the prevalent non-English languages.
c. Each county’s QI Committee should review the following data at a minimum on a quarterly basis since External Quality Review (EQR) site reviews will begin after county implementation. These data elements will be incorporated into the EQRO protocol.

i. Number of days to first DMC-ODS service at appropriate level of care after referral
ii. Existence of a 24/7 telephone access line with English and with prevalent non-English language(s)
iii. Access to DMC-ODS services with translation services in English and the prevalent non-English language(s)
iv. Number, percentage of denied authorization requests and time period of authorization requests approved or denied.

d. Counties will have a Utilization Management (UM) Program assuring that beneficiaries have access to substance use disorder services; medical necessity has been established and the beneficiary is at the appropriate American Society of Addiction Medicine (ASAM) level of care and that the interventions are appropriate for the diagnosis and level of care. Counties shall have a documented system for collecting, maintaining and evaluating accessibility to care and waiting list information, including tracking the number of days to first DMC-ODS service at an appropriate level of care following initial request or referral for all DMC-ODS services.

e. Counties will provide the necessary data and information required in order to comply with evaluation required by the DMC-ODS.
County Implementation Plan

The county implementation plan will be used by the Department of Health Care Services (DHCS) and the Center for Medicaid and Medicare Services (CMS) to assess the county’s readiness to implement the DMC-ODS Waiver. The implementation plan will also demonstrate how the county will have the capacity, access and network adequacy required for DMC-ODS implementation. The information contained in this plan draw upon the Special Terms and Conditions and the appropriate Code of Federal Regulations (CFR) 438 requirements. DHCS and CMS will review and render an approval or denial of the county’s participation in the Waiver based upon the initial and follow-up information provided by the counties.

Table of Contents

- Part I Plan Questions
  - This part is a series of questions regarding the county’s DMC-ODS program

- Part II Plan Description: Narrative Description of the County’s Plan
  - In this part, the county describes its DMC-ODS program based on guidelines provided by DHCS.
PART I - PLAN QUESTIONS

This part is a series of questions that summarize the county’s DMC-ODS plan.

1. Identify the county agencies and other entities involved in developing the county plan. (Check all that apply) Input from stakeholders in the development of the county implementation plan is required; however, all stakeholders listed are not required to participate.
   - County Behavioral Health Agency
   - County Substance Use Disorder Agency
   - Providers of drug/alcohol treatment services in the community
   - Representatives of drug/alcohol treatment associations in the community
   - Physical Health Care Providers
   - Medi-Cal Managed Care Plans
   - Federally Qualified Health Centers (FQHCs)
   - Clients/Client Advocate Groups
   - County Executive Office
   - County Public Health
   - County Social Services
   - Foster Care Agencies
   - Law Enforcement
   - Court
   - Probation Department
   - Education
   - Recovery support service providers (including recovery residences)
   - Health Information technology stakeholders
Other (specify) _______________________________________

2. How was community input collected?
   - Community meetings
   - County advisory groups
   - Focus groups
   - Other method(s) Explain Briefly ____________________________

3. Specify how often entities and impacted community parties will meet during the implementation of this plan to continue on-going coordination of services and activities.
   - Monthly
   - Bi-Monthly
   - Quarterly
   - Other ____________________________

Review Note: One box must be checked.

4. Prior to any meetings to discuss development of this implementation plan, did representatives from Substance Use Disorders (SUD), Mental Health (MH), and Physical Health (PH) all meet regularly on other topics, or has preparation for the waiver (see definition of waiver below) been the catalyst for these new meetings?

(Note: waiver definition- California’s 1115 waiver renewal called Medi-Cal 2020 was approved by the Centers for Medicare and Medicaid Services on December 3015, effective January 1, 2016.)

   - SUD, MH, and PH representatives in our county have been holding regular meetings to discuss other topics prior to waiver discussions.
   - There were previously some meetings, but they have increased in frequency or intensity as a result of the waiver.
   - There were no regular meetings previously. Waiver planning has been the catalyst for new planning meetings.
   - There were no regular meetings previously, but they will occur during implementation.
   - There were no regular meetings previously and none are anticipated.
5. What services will be available to DMC-ODS clients upon year one implementation under this county plan

REQUIRED

☐ Withdrawal Management (minimum one level)
☐ Residential Services (minimum one level)
☐ Intensive Outpatient
☐ Outpatient
☐ Opioid Narcotic Treatment Programs
☐ Recovery Services
☐ Case Management
☐ Physician Consultation
☐ How will these required services be provided?
☐ All county operated
☐ Some County and some contracted
☐ All contracted

Review Note: These are all required services. All boxes must be checked.

OPTIONAL

☐ Additional Medication Assisted Treatment
☐ Partial Hospitalization
☐ Recovery Residence
☐ Other (specify): __________________________________________

6. Has the county established a toll free 24/7 number with English as well as prevalent languages for prospective clients to call to access DMC-ODS services?

☐ Yes (required)
☐ No. Plan to establish by________

Review note: If the county is establishing a number, please note the date it will be established and operational.

7. The county will participate in providing data and information to the University of California Los Angeles (UCLA) Integrated Substance Abuse Programs for the DMC-ODS evaluation.

☐ Yes (Required)
8. The county will comply with all quarterly reporting requirements as contained in the Standard Terms and Conditions (STCs).
   □ Yes (Required)

9. Each county’s Quality Improvement Committee will review the following data at a minimum on a quarterly basis since EQR site reviews will begin after county implementation. These data elements will be incorporated into the EQRO protocol.
   - Number of days to first DMC-ODS service/follow-up appointments at appropriate level of care after referral and assessment
   - Existence of a 24/7 telephone access line with English and prevalent non-English language(s)
   - Access to DMC-ODS services with translation services in English and prevalent non-English language(s).
   - Number, percentage of denied and time period of authorization requests approved or denied
   □ Yes (required)
PART II PLAN DESCRIPTION (Narrative)

In this part of the plan, the county must describe DMC-ODS implementation policies, procedures, and activities.

General Review Notes:

Number of responses to each item to correspond with the outline.

Keep an electronic copy of your implementation plan description. After DHCS and CMS review the plan description, the county may need to make revisions. When making changes to the implementation plan, use track changes mode so reviewers can see what has been added or deleted.

County must submit a revised implementation plan to DHCS when the county requests to add a new level of service. County must also submit a revised implementation plan to DHCS due to other numerous scenarios not listed here.

Narrative Description:

1. Collaborative Process. Describe the collaborative process used to plan DMC-ODS services. Describe how county entities, community parties, and others participated in the development of this plan and how ongoing involvement and effective communication will occur.

   Review Note: Stakeholder engagement is required in development of the implementation plan.

2. Client Flow. Describe how clients move through the different levels identified in the continuum of care (referral, assessment, authorization, placement, transitions to another level of care). Describe what entity or entities will conduct American Society of Addiction Medicine (ASAM) criteria interviews, the professional qualifications of individuals who will conduct ASAM criteria interviews and assessments, how admissions to the recommended level of care will take place, how often clients will be re-assessed, and how they will be transitioned to another level of care accordingly. Include the role of how the case manager will help with the transition through levels of care and who is providing the case management services. Also, describe if there will be timelines established for the movement between one level of care to another. Please describe how you plan to ensure
successful care transitions for high-utilizers or individuals at risk of unsuccessful transitions,

Review Note: A flow chart may be included.

3. Beneficiary Notification and Access Line. For the beneficiary toll free access number, what data will be collected (i.e., measure the number of calls, waiting times, and call abandonment)? How will individuals be able to locate the access number? The access line must be toll free, functional 24/7, accessible in English and prevalent non-English languages, and Americans with Disabilities compliant.

Review Note: Please note that all written information must be available in English and the prevalent non-English languages identified by the state in a service area. The plan must notify beneficiaries of free oral interpretation services and how to access those services.

4. Treatment services. Describe the required types of DMC-ODS services (withdrawal management, residential, intensive outpatient, outpatient, opioid/narcotic treatment programs, recovery services, case management, physician consultation) and optional (additional medication assisted treatment, recovery residences) to be provided. What barriers, if any does the county have with the required service levels? Describe how the county plans to coordinate with surrounding opt-out counties in order to limit disruption of services for beneficiaries who reside in an opt-out-county.

Review Note: Include in each description the corresponding ASAM level, including opioid treatment programs. Names and descriptions of individual providers are not required in this section; however, a list of all contracted providers will be required within 30 days of the waiver implementation date. This list will be used for billing purposes.

5. Coordination with MH: How will the county coordinate MH services for beneficiaries with co-occurring disorders? Are there minimum initial coordination requirements or goals that you plan to specify for your providers? How will these be monitored? Please briefly describe the county structure for delivering SUD and MH services. When these structures are separate, how is care coordinated?
6. Coordination with PH. Describe how the counties will coordinate PH services within the waiver. Are there minimum initial coordination requirements or goals that you plan to specify for your providers? How will these be monitored? Please briefly describe the county structure for delivering SUD and MH services. When these structures are separate, how is care coordinated?

7. Coordination Assistance. The following coordination elements are listed in the Standard Terms and Conditions (STCs). Based on discussions with your health plan and providers, do you anticipate substantial challenges and/or need for technical assistance with any of the following? If so, please indicate which and briefly explain the nature of the challenges you are facing.
   - Comprehensive substance use, physical, and mental health screening
   - Beneficiary engagement and participation in an integrated care program as needed
   - Shared development of care plans by the beneficiary, caregivers and all providers
   - Collaborative treatment planning with managed care
   - Navigation support for patients and caregivers
   - Facilitation and tracking of referrals between systems

8. Availability of Services: Pursuant to 42 Code of Federal Regulations (CFR) 438.206, the pilot county must ensure availability and accessibility of adequate number and types of providers of medically necessary services. At minimum, the county must maintain and monitor a network of providers that is supported by written agreements for subcontractors and that is sufficient to provide adequate access to all services covered under this contract. In establishing and monitoring the network, describe how the county will consider the following:
   - The anticipated number of Medi-Cal clients.
   - The expected utilization of service type.
   - The numbers and types of providers required to furnish the contracted Medi-Cal services.
   - A demonstration of how the current network of providers compares to the expected utilization by service type.
   - Hours of operation of providers.
   - Language capability for the county threshold languages.
• Specified access standards and timeliness requirements, including number of days to first face-to-face visit after initial contact and first DMC-ODS treatment service, timeliness of services for urgent conditions and access afterhours care, and frequency of follow-up appointments in accordance with individualized treatment plans.
• The geographic location of providers and Medi-Cal beneficiaries, considering distance, travel time, transportation, and access for beneficiaries with disabilities.
• How will the county address service gaps, including access to Medication Assisted Treatment (MAT)?
• As an appendix document, please include a list of network providers indicating if they provide MAT, their current patient load, their total DMC-ODS patient capacity, and the populations they treat (i.e., adolescent, adult, perinatal).

9. Access to Services. Describe how the County will assure the following:
• Meet and require providers to meet standards for timely access to care and services, taking into account the urgency of need for services.
• Require subcontracted providers to have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal patients.
• Make services available to beneficiaries 24 hours a day, 7 days a week, when medically necessary.
• Establish mechanisms to ensure that network providers comply with the timely access requirements.
• Monitor network providers regularly to determine compliance with timely access requirements.
• Take corrective action if there is a failure to comply with timely access requirements.

10. Training Provided. What training will be offered to providers chosen to participate in the waiver? How often will training be provided? Are there training topics that the county wants to provide but needs assistance?

Review Note: Include the frequency of training and whether it is required or options.

11. Technical Assistance. What technical assistance will the county need from DHCS?
12. Quality Assurance. Describe the County’s Quality Management (QM) and Quality Improvement programs (QI). This includes a description of the QI Committee (or integration of DMC-ODS responsibilities into the existing MHP QI Committee). The monitoring of accessibility of services outlined in the Quality Improvement Plan will at a minimum include.

Timeliness of first initial contact to face-to-face appointment
- Frequency of follow-up appointments in accordance with individualized treatment plans
- Timeliness of services of the first dose of Opioid (Narcotic) Treatment Program services
- Access to after-hours care
- Responsiveness of the beneficiary access line
- Strategies to reduce avoidable hospitalizations
- Coordination of physical and mental health services with waiver services at the provider level
- Assessment of the beneficiaries’, including complaints, grievances and appeals
- Telephone access line and services in English and in the prevalent non-English languages.

Review Note: Plans must also include how beneficiary complaints data shall be collected, categorized and assessed for monitoring Grievances and Appeals.

At a minimum, plans shall specify:
How to submit a grievance, appeal, and state fair hearing
- The timeframe for resolution of appeals (including expedited appeal)
- The content of an appeal resolution
- Record Keeping
- Continuation of Benefits
- Requirements of state fair hearings

13. Evidence Based Practices (EBP’s). How will the counties ensure that providers are implementation at least two of the identified evidence based practices? What action will the count take if provider is found to be in non-compliance? The allowable EBP’s include Psycho Social, Motivational Interviewing, Cognitive
Behavioral Therapies, Trauma Informed Care, Relapse Prevention, and Psycho-Education.

14. Regional Model. If the county is implementing a regional model, describe the components of the model. Include service modalities, participating counties, and identify any barriers and solutions for beneficiaries.

15. Memorandum of Understanding (MOU). Submit a signed copy of each MOU between the county and the managed care plans. The MOU must outline the mechanism for sharing information and coordination of service delivery as described in Section 152 “Care Coordination” of the STCs. If upon submission of an implementation plan, the managed care plan(s) has not been signed and the expected timeline for receipt of the signed MOU(s).

Review Note: The following elements in the MOU should be implemented at the point of care to ensure clinical integration between DMC-ODS and managed care providers:

- Comprehensive SUD, PH, and MH screening, including ASAM Level 0.5 Screening, Brief Intervention, and Referral to Treatment services;
- Beneficiary engagement and participation in an integrated care program as needed;
- Shared development of care plans by the beneficiary, caregivers and all providers;
- Delineation of case management responsibilities.
- A process for resolving disputes between the county and the Medi-Cal managed care plan that includes a means for beneficiaries to receive medically necessary services while the dispute is being resolved;
- Availability of clinical consultation, including consultation on medications;
- Care coordination and effective communication among providers including procedures for exchanges of medical information
- Navigation support for patients and caregivers; and
- Facilitation and tracking of referrals.

16. Telehealth Services. If a county chooses to utilize telehealth services, how will telehealth services be structured for providers and how will the county ensure
confidentiality? (Please note: group counseling services cannot be conducted through telehealth).

17. Contracting. Describe the county’s selection provider contracting process. What length of time is the contract term? Describe the local appeal process for providers that do not receive a contract how will the county ensure beneficiaries will continue receiving treatment services?

18. Additional MAT: If the county chooses to implement additional MAT beyond the requirements for NTP services, describe the MAT and delivery services.

19. Residential Authorization. Describe the county’s authorization process for residential services. Prior authorization requests for residential services must be addressed within 24 hours.

20. One Year Provisional Period. For counties, unable to meet all the mandatory requirements upon implementation, describe the strategy for coming into full compliance with the required provisions in the waiver. Include in the description the phase-in plan by services or waiver requirements that the county cannot begin upon implementation of their Pilot. Also, include a timeline with deliverables.

Review Note: This question only applies to counties participating in the one-year provisional program and only needs to be completed by these counties.

County Authorization: The County Behavioral Health Director for Los Angeles and Napa Program Director must review and approve the Implementation Plan.
EXAMPLES OF QI PLAN RESPONSES TO
ATTACHMENT Z REQUIREMENTS

LOS ANGELES COUNTY (selected excerpts)

The Quality Improvement (QI) Program will establish various committees including: Quality Improvement/Risk Management (QI/RM), Utilization Management, Research and Data Management, Professional Development, Community Liaison (with subcommittees for providers and consumers), and Cultural Competence. The QI/RM Committee will meet every other month and consist of The Department of Public Health- Substance Abuse Prevention and Control (DPH)-SAPC representatives from each major division/unit, including the Director’s Office, Office of the Medical Director and Science Officer, Adult and Youth Programs, Contracts, Strategic Planning, Information Systems, Finance, and the evaluation services contractor who will be collaborating with DPH-SAPC on quality assurance and training activities. The QI/RM Committee will work closely with other committees in order to incorporate feedback into the continuous quality improvement process. The QI program section of the Quality Improvement and Utilization Plan (Attachment 4) includes further detail on how DPH-SAPC intends to address the following topics: access to care, workforce, documentation, medical necessity criteria, clinical practice guidelines, levels of care guidelines, recovery support services, case-management/care coordination, performance and outcome measures, peer review quality improvement projects, confidentiality risk management, and complaints/grievances and appeal process. This attachment also describes how these activities will meet the minimum data requirements of the DMC-ODS waiver.

Marin County (selected excerpts)

Quality Improvement Plan and Quality Improvement Committee

The DMC-ODS Quality Improvement Plan and Quality Improvement Committee (QIC) are integrating with the existing Mental Health Plan Quality Improvement Plan and QIC. Quality Improvement Plan goals initially will focus on establishing baseline measures and performance standards, and developing the infrastructure necessary to track and report on data related to timeliness, access to and quality of care, client outcomes, beneficiary satisfaction, integration with mental and physical health and other CFR 438 requirements related to network adequacy and beneficiary protections.

Refer to Attachment B for a summary of the initial draft Quality Improvement Plan goals, which reflects the data requirements listed through the STCs.
QI Committee Descriptions, Marin County (continued)

“The QIC meets quarterly and for the waiver will be responsible for recommending policy decisions; reviewing and evaluating the results of Quality Improvement activities; ensuring follow-up of Quality Improvement processes; and documenting Quality Improvement Committee minutes regarding decisions and actions taken. At a minimum, the QIC will also review the following data:

- Number of days from referral to the first DMC-ODS service at the appropriate level of care
- Performance of the 24/7 telephone access line with appropriate language capacity
- Access to DMC-ODS services with interpretation services in the threshold language(s)
- Number and percentage of approved and denied requests for Residential treatment and the time period of authorization request approvals or denials
- The QIC membership includes representation County Mental Health Substance Use Services Access, Quality Improvement, Compliance and Program Managers and Supervisors, contracted mental health and substance use service providers, and consumer and family representatives”.

Please refer to Attachment C for the full listing of the QIC members.

Riverside County (selected excerpts)

B. “The Contractor’s QI program shall monitor the Contractor’s service delivery system with the aim of improving the process of providing care and better meeting the needs of its beneficiaries. The QI Program shall be accountable to the Contractor’s Director.

C. The Contractor shall establish a QI Committee to review the quality of SUD treatment services provided to beneficiaries. The QI Committee shall recommend policy decisions; review and evaluate the results of QI activities, including performance improvement projects; institute needed QI actions; ensure follow up of QI processes; and document QI Committee meeting minutes regarding decisions and actions taken. The QI committee shall recommend policy decisions; review and evaluate the results of QI activities; institute needed QI actions, ensure follow-up of QI process and document QI committee minutes regarding decisions and actions taken.
D. Each Contractor’s QI Committee shall review the following data at a minimum on a quarterly basis since external quality review (EQR) site reviews will begin after county implementation. These data elements shall be incorporated into the EQRO protocol:

1). Number of days to first DMC-ODS service at appropriate level of care after referral

2. Existence of a 24/7 telephone access line with English and prevalent non-English language(s)

3. Access to DMC-ODS services with translation services in the prevalent language.
EXAMPLES OF QI PLAN RESPONSES TO ATTACHMENT Z REQUIREMENTS

APPROACHES TO EVIDENCE BASED PRACTICES

LOS ANGELES COUNTY (selected excerpts)

The County will require that its network providers implement and use, at minimum, the evidence-based practices of Cognitive Behavioral Therapy and Motivational Interviewing by July 2016. In addition, network providers will be encouraged to adopt additional evidence based practices and promising practices tailored to the needs of each provider’s focus patient population. Implementation of these evidence-based practices will be a contract requirement and monitored through the contract compliance monitoring process. In accordance with current contract language and monitoring guidelines, Contract Services Division will oversee and conduct at minimum annual site visits to ensure evidence-based practices are being conducted effectively and with fidelity. Any non-compliance issues will be addressed with appropriate provider staff and resolved through a corrective action plan, up to and including contract termination. Corrective action ranging from technical assistance to disallowance will occur depending on the nature of the deficiency, frequency and/or severity of the findings.

MARIN COUNTY (selected excerpts)

12. Evidence Based Practices. How will the counties ensure that providers are implementing at least two of the identified evidence based practices? What action will the county take if the provider is found to be in non-compliance?

Marin County MHSUS will ensure that all providers are implementing at least two of the identified evidence based practices (EBP’s) through the following:

- Incorporating the requirement to implement at least two of the EBP’s listed in the STCs in all Request for Proposals for DMC-ODS services.
- Including provisions in all contracts for DMC-ODS services requiring providers to implement at least two of the identified EBP’s. Providers will need to list the specific EBP’s in the contract as well as information how they will be implementing the EBP’s with fidelity
- Similar to all quality and compliance monitoring, Marin MHSUS will monitor adherence to implementing at least two of the identified EBP’s through review and
approval of the contract language; mid-year monitoring which includes a written Provider Self-Audit and onsite monitoring visit, and review of progress/annual reports.

If a provider is found to be in non-compliance, Marin MHSUS will offer technical assistance to adhere to requirements, as well as issue a written report documenting the non-compliance and requiring a Corrective Action Plan be submitted to the County.

RIVERSIDE COUNTY (Selected excerpts)

13. Evidence Based Practices. How will the counties ensure that providers are implementing at least two of the identified evidence based practices? What action will the county take if the provider is found to be in non-compliance?

Riverside University Health System-Behavioral Health Substance Abuse Prevention and Treatment Program (RUHS-BH) Outpatient Drug Free (ODF) and Intensive Outpatient Treatment (IOT) Clinics:

- Living in Balance: Moving from a Life of Addiction to a Life of Recovery;
- The Matrix Model Training; and
- Cognitive Behavioral Therapy (CBT) for Post-Traumatic Stress Disorder (PTSD): A Program for Addiction Professionals.

RUHS-BH Drug Court Program Staff:

A New Direction: A Cognitive Behavioral Treatment Curriculum

The Matrix Model Training; and

Cognitive Behavioral Therapy (CBT) for PTSD: A Program for Addiction Professionals.

RUHS-BH-AB 109 Program Staff:

A New Direction: A Cognitive-Behavioral Treatment Curriculum; and

Cognitive Behavioral Therapy (CBT) for PTSD: A Program for Addiction Professionals.

The training will be enforced in RUHS-BH programs through policy and contractor scope of work requirements as follows:
Annual Contract Monitoring Reviews audit overall annual compliance through review of charts and files.

Quarterly monitoring reviews monitor quality and adherence to EBP best practices through chart review, and auditing live groups scheduled for the day.

Training is coordinated when deficiencies are found.

Documentation of findings through audit reports requires a corrective action plan from the provider, addressing how the issue(s) will be addressed and corrected.

Punitive financial consequences may occur for subsequent non-compliance after training, and corrective actions are exhausted.

Escalated consequences for unsatisfactory and ongoing non-compliance, including recovery of funds and contract termination.

Curriculum in RUHS-BH clinics includes but is not exclusive to: Living in Balance; The Matrix Model: For Criminal Justice Settings; The Matrix Model for Teens and Young Adults; Beyond Trauma; The Matrix Model: Intensive Outpatient Alcohol and Drug Treatment Program; Cognitive Behavioral Therapy (CBT); Dialectical Behavioral Therapy (DBT); Motivational Interviewing (MI); Motivational Enhancement Therapy (MET); Seeking Safety; Peer Support Services; and Stages of Change.
EXAMPLES OF
APPROVED COUNTY IMPLEMENTATION PLANS

For a comprehensive review of currently approved DMC-ODS Implementation Plans, including their Quality Improvement components, at the following link:

http://www.dhcs.ca.gov/provgovpart/Pages/County-Implementation-Plans.aspx