SUD Facility Site Review Standards

Criteria	I. Site Access/Safety Survey Guidelines
A. Site is accessible and useable by individuals with physical disabilities.	**A. Site is accessible and useable by individuals with physical disabilities.**
1) Site is accessible and useable by individual with physical disabilities	A1. ADA Regulations: Site must meet city, county and state building structure and access ordinances for persons with physical disabilities. A site/facility includes the building structure, walkways, parking lots, and equipment. All facilities designed, constructed; or altered by, on behalf of, or for the use of a public entity must be readily accessible and usable by individuals with disabilities, if the construction or alteration was begun after January 26, 1992 (28 CFR 35.151). Any alteration to a place of public accommodation or a commercial facility, after January 26, 1992, must be made to ensure that, to the maximum extent feasible, the altered portions of the facility are readily accessible to and useable by individuals with disabilities, including individuals who use wheelchairs (28 CFR 36.402). Parking: Parking spaces for persons with physical disabilities are located in close proximity to handicap-accessible building entrances. Each parking space reserved for the disabled is identified by a permanently affixed reflectorized sign posted in a conspicuous place. If provider has no control over availability of disabled parking lot or nearby street spaces, provider must have a plan in place for making program services available to persons with physical disabilities. Ramps: A clear and level landing is at the top and bottom of all ramps and on each side of an exit door. Any path of travel is considered a ramp if its slope is greater than a 1-foot rise in 20 feet of horizontal run. Exit doors: The width of exit doorways (at least 32-in.) allows for passage clearance of a wheelchair. Exit doors include all doors required for access, circulation, and use of the building and facilities, such as primary entrances and passageway doors. Furniture and other items do not obstruct exit doorways or interfere with door swing pathway. Elevators: If there is no passenger elevator, a freight elevator may be used to achieve program accessibility if it is upgraded for general passenger use and if passageways leading to and from the elevator are well-lit, neat, and clean.

	Clear Floor Space: Clear space in waiting/exam areas is sufficient (at least 30-in. x 48-in.) to accommodate a single, stationary adult wheelchair and occupant. A minimum clear space of 60-in. diameter or square area is needed to turn a wheelchair. Sanitary Facilities: Restroom and hand washing facilities are accessible to able-bodied and physically disabled persons. A wheel-chair accessible restroom stall allows sufficient space for a wheelchair to enter and permits the door to close. If wheelchair accessible restrooms are not available within the office site, reasonable alternative accommodations are provided. Alternatives may include: grab bars located behind and/or along the sides of toilet with assistance provided as needed by site personnel; provision of urinal, bedpan, or bedside commode placed in a private area; wheelchair accessible restroom located in a nearby office or shared within a building. Sufficient knee clearance space underneath the sink allows wheelchair users to safely use a lavatory sink for hand washing. A reasonable alternative may include, but is not limited to, hand washing items provided as needed by site personnel. Additionally: communication shall be at a maximum 6th grade level. Reading materials available in large print.
2) If the site is NOT accessible, are reasonable alternatives available?	A2. Note: A public entity may not deny the benefits of its program, activities, and services to individuals with disabilities because its facilities are inaccessible (28 CFR 35.149-35.150). Every feature need not be accessible, if a reasonable portion of the facilities and accommodations provided is accessible (Title 24, Section 2-419, California Administrative Code, the State Building Code). Reasonable Portion and/or Reasonable Alternatives are acceptable to achieve program accessibility. Reasonable Portion applies to multi-storied structures and provides exceptions to the regulations requiring accessibility to all portions of a facility/site. Reasonable Alternatives are methods other than site structural changes to achieve program accessibility, such as acquisition or redesign of equipment, assignment of assistants/aides to beneficiaries, provision of services at alternate accessible sites, and/or other site specific alternatives to provide services (ADA, Title II, 5.2000). Points shall not be deducted if Reasonable Portion or Reasonable Alternative is made available on site. Specific measurements are provided strictly for "reference only" for the reviewer. Site reviewers are NOT expected to measure parking areas, pedestrian path of travel walkways and/or building structures on site.
B. Site environment is maintained in a clean and sanitary condition.	**B. Site environment is maintained in a clean and sanitary condition.**
1) All patient areas including floor/carpet, walls, and furniture are neat, clean, and well maintained.	B1. The physical appearance of floors/carpets, walls, furniture, patient areas and restrooms are clean and well maintained.

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2) Restrooms are clean and contain appropriate sanitary supplies	B2. Appropriate sanitary supplies, such as toilet tissue, hand washing soap, cloth/paper towels, or antiseptic towelettes are made available for restroom use. Environmental safety includes the "housekeeping" or hygienic condition of the site. Clean means unsoiled, neat, tidy, and uncluttered. Well maintained means being in good repair or condition.
3) The program is maintained in a clean, safe, sanitary, and alcohol/drug-free environment.	B3. AOD 12000, "Each program shall comply with all applicable local, state, and federal laws and regulations. The program shall develop written procedures to ensure that the program is maintained in a clean, safe, sanitary, and alcohol and drug-free environment."
4) The Program is free from all of the following (AOD 20000) a. Broken glass, filth, litter, or debris b. Flies, insects, or other vermin c. Toxic chemicals or noxious	B4. The Program is free from all of the following (AOD 20000) a. Broken glass, filth, litter, or debris b. Flies, insects, or other vermin c. Toxic chemicals or noxious fumes and odors d. Exposed electrical wiring e. Other health or safety hazards
5) Program equipment and supplies shall be stored in an appropriate space and shall not be stored in a space designated for other activities	B5. Program equipment and supplies shall be stored in an appropriate space and shall not be stored in a space designated for other activities
6) The program shall safely dispose if contaminated water and chemicals used for cleaning purposes	B6. The program shall safely dispose if contaminated water and chemicals used for cleaning purposes
C. Site environment is safe for all patients, visitors, and personnel.	**C. Site environment is safe for all patients, visitors, and personnel.**
There is evidence that staff has received safety training and/or has safety information available in the following:	There is evidence that staff has received safety training and/or has safety information available in the following:
1) Fire safety and prevention	C1. Fire safety and prevention: There is evidence staff has received safety training and/or has safety information
2) Emergency non-medical procedures (e.g. site evacuation, workplace violence)	C2. Non-medical emergency procedures: Non-medical emergencies include incidents of natural disaster (e.g. earthquakes), workplace violence, etc. Specific information for evacuation procedures is available on site to staff. Personnel know where to locate information on site, and how to use information. Evidence of training must be verifiable, and may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc.
3) Lighting is adequate in all areas to ensure safety.	C3. Illumination: Lighting is adequate in patient flow working and walking areas such as corridors, walkways, waiting and exam rooms, and restrooms to allow for a safe path of travel.

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4) Exit doors and aisles are unobstructed and egress (escape) accessible.	C4. Access Aisle: Accessible pedestrian paths of travel (ramps, corridors, walkways, lobbies, elevators, etc.) between elements (seats, tables, displays, equipment, parking spaces, etc.) provide a clear circulation path. Means of egress (escape routes) are maintained free of obstructions or impediments to full instant use of the path of travel in case of fire or other emergency. Building escape routes provide an accessible, unobstructed path of travel for pedestrians and/or wheelchair users at all times when the site is occupied. Cords (including taped cords) or other items are not placed on or across walkway areas.
5) Exit doors are clearly marked with "Exit" signs.	C5. Exits: Exit doorways are unobstructed and clearly marked by a readily visible "Exit" sign.
6) Clearly diagramed "Evacuation Routes" for emergencies are posted in a visible location.	C6. Evacuation Routes: Clearly marked, easy-to-follow escape routes are posted in visible areas, such as hallways, exam rooms and patient waiting areas. The minimum clear passage needed for a single wheelchair is 36 inches along an accessible route, but may be reduced to a minimum of 32 inches at a doorway.
7) Electrical cords and outlets are in good working condition.	C7. Electrical Safety: Electrical cords are in good working condition with no exposed wires, or frayed or cracked areas. Cords are not affixed to structures, placed in, or across walkways, extended through walls, floors, and ceiling or under doors or floor coverings. Extension cords are not used as a substitute for permanent wiring. All electrical outlets have an intact wall faceplate. Sufficient clearance is maintained around lights and heating units to prevent combustible ignition.
8) At least one type of firefighting/protection equipment is accessible at all times.	C8. Fire Fighting/Protection Equipment: There is firefighting/protection equipment in an accessible location on site at all times. An accessible location is reachable by personnel standing on the floor, or other permanent working area, without the need to locate/retrieve step stool, ladder, or other assistive devises. At least one of the following types of fire safety equipment is on site: 1) Smoke Detector with intact, working batteries 2) Fire Alarm Device with code and reporting instructions posted conspicuously at phones and employee entrances 3) Automatic Sprinkler System with sufficient clearance (10-in.) between sprinkler heads and stored materials. 4) Fire Extinguisher in an accessible location that displays readiness indicators or has an attached current dated inspection tag. Specific information for handling fire emergency procedures is available on site to staff.

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Criteria	II. Office Management Survey Guidelines
A. Confidentiality of personal medical information is protected according to State and federal guidelines. 22 CCR §51009, §53761, §75055; §27 CCR §1300.70; CA Civil Code §56.10 (Confidentiality of Medical Information Act) 42CFR	**A. Confidentiality of personal medical information is protected according to State and federal guidelines. 22 CCR §51009, §53761, §75055; §27 CCR §1300.70; CA Civil Code §56.10 (Confidentiality of Medical Information Act) 42CFR**
1) Substance Use Disorder consult and therapy rooms safeguard patients' right to privacy.	A1. Privacy: Patients have the right to privacy for dressing/undressing, physical examination and medical consultation. Practices are in place to safeguard patient privacy. Because dressing areas and examination room configurations vary greatly, reviewers will make site-specific determinations.
2) Procedures are followed to maintain the confidentiality of personal patient information.	A2. Confidentiality: Personnel follow site policy/procedures for maintaining confidentiality of individual patient information. Individual patient conditions or information is not discussed in front of other patients or visitors, displayed, or left unattended in reception and/or patient flow areas.
3) Medical record release procedures are compliant with State and federal guidelines.	A3. Record release: Medical records are not released without written, signed consent from the patient or patient's representative, identifying the specific medical information to be released as well as an end date for the authorization. The release terms, such as to whom records are released and for what purposes, should also be described. This does not prevent release of statistical or summary data, or exchange of individual identifiable medical information between individuals or institutions providing care, fiscal intermediaries, research entities and State or local official agencies.
4) Copies of the following shall be posted in a prominent place accessible to all beneficiaries: a. Statement of non-Discrimination b. PHC grievance policy and phone number c. Appeal process for involuntary discharge d. Program rules and expectations	A4. Copies of the following shall be posted in a prominent place accessible to all beneficiaries: a. Statement of non-Discrimination b. PHC grievance policy and phone number c. Appeal process for involuntary discharge d. Program rules and expectations

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5) All patient's health service records must be retained for a minimum of ten (10) years from the patient's discharge date or seven years after a minor patient reaches the age of eighteen.	A5. Record retention: Hospitals, acute psychiatric hospitals, skilled nursing facilities, primary care clinics, psychology, psychiatric clinics, and SUD facilities must maintain medical records and exposed x-rays for a minimum of 10 years following patient discharge, except for minors (Title 22, CCR, and Section 75055). Records of minors must be maintained for at least one year after a minor has reached age 17, but in no event for less than 7 years (Title 22, CCR, and Section 75055). Each Plan must maintain all records and documentation (including medical records) necessary to verify information and reports required by statute, regulation or contractual obligation for 5 years from the end of the fiscal year in which the Plan contract expires or is terminated (Title 22, CCR, Section 53761). PER THE INTERGOVERNMENTAL AGREEMENT: DHCS AND CMS MAY AUDIT 10 YEARS FROM THE DATE THE STATE PREPAID HEALTH INSURANCE PROGRAM (PHIP) INTERGOVERNMENTAL AGREEMENT EXPIRES, OR FROM THE DATE OF THE COMPLETION OF ANY AUDIT, WHICHEVER IS LATER.

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Criteria	III. Site Specific Policy/Procedure Survey Guidelines
A. Site has a policy/procedure that addresses each of the following: (each policy in this section should be obtained for evidence)	**A. Site has a policy/procedure that addresses each of the following: (each policy in this section should be obtained for evidence)**
1) Obtaining appropriate documentation of admission and readmission criteria	A1. Obtaining appropriate documentation of admission and readmission criteria- Staff should be able to speak to process and produce policy to review. Review blank forms, see where they are stored.
2) Determining appropriate Medical Necessity	A2. Determining appropriate Medical Necessity- Staff should be able to speak to process and produce policy to review. Review blank forms, see where they are stored.
3) Proof of MediCal eligibility as payment	A3. Proof of Managed Care eligibility as payment- Staff should be able to speak to process and produce policy to review. Review blank forms, see where they are stored.
4) Completing ASAM, how is criteria used to determine medical necessity	A4. Completing ASAM, how is criteria used to determine medical necessity- Staff should be able to speak to process and produce policy to review. Review blank forms, see where they are stored.
5) Completion of all appropriate and required documentation during intake	A5. Completion of all appropriate and required documentation during intake- Staff should be able to speak to process and produce policy to review. Review blank forms, see where they are stored.
6) Completion of initial Problem list and/or Treatment plan	A6. Completion of initial Problem list and/or Treatment plan- Staff should be able to speak to process and produce policy to review. Review blank forms, see where they are stored.
7) Notification to clients of their right to services from an alternative service provider if they object to the religious character of the program	A7. Notification to clients of their right to services from an alternative service provider if they object to the religious character of the program- Program notify clients of their right to services from an alternative service provider if they object to the religious character of the program. The program shall refer to alternative providers when necessitated by religious objection. Programs must document the total number of referrals necessitated by religious objection to other alternative SUD providers, and annually submits this information to PHC Wellness and Recovery program by e-mail wellnessandrecovery@partnershiphp.org, by Sept 15, each year.

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8) Does the program adhere to priority administration requirements and provides interim services when required	A8. Does the program adhere to priority administration requirements and provides interim services when required- (a) Pregnant injecting drug users (b) Pregnant substance abusers (c) Injecting drug users (d) All Others. The program shall admit IV drug users within 14 days of request or provide interim services and admit within 120 days. Interim Services. The Program shall have in place policies, procedures, and practices to support the provision Interim services within their program(s) •Pregnant women receiving interim services shall be placed at the top of the waiting list for program admission •The Program shall make interim services available, either on-site or by referral, within 48 hours for those individuals who are in need of treatment and who cannot be admitted within 14 days of their request for treatment •The Program shall have an established waiting list that includes a unique patient identifier for injecting drug users seeking treatment, including patients receiving interim services while awaiting admission •The Program shall maintain contact with individuals awaiting treatment admission
9) Maintaining confidentiality	A9. Maintaining confidentiality- Personnel follow site policy/procedures for maintaining confidentiality of individual patient information. Individual patient conditions or information is not discussed in front of other patients or visitors, displayed, or left unattended in reception and/or patient flow areas. All SUD treatment services shall be provided in a confidential setting in compliance with 42 CFR, Part 2 requirements.
10) Missed appointments	A10. Missed appointments- If a client fails to keep a scheduled appointment, the program shall discuss the missed appointment with the client and shall document the discussion and any action taken in the client's file.

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11) Progress note requirements	A11. Progress note requirements- MC-ODS Progress Notes (1) Providers shall create progress notes for the provision of all Medi-Cal behavioral health delivery system services. Each progress note shall provide sufficient detail to support the service code(s) selected for the service type(s) as indicated by the service code description(s).11 (i) Should more than one provider render a service, either to a single member or to a group, at least one progress note per member must be completed. The note must be signed by at least one provider. The progress note shall clearly document the specific involvement and duration of direct patient care for each provider of the service. (2) Progress notes for all non-group services shall include: (I) The type of service rendered. (ii) (iii) The date that the service was provided to the member. Duration of direct patient care for the service.12 (iv) Location/place of service. (v) A typed or legibly printed name, signature of the service provider, and date of signature. (vi) A brief description of how the service addressed the member's behavioral health needs (e.g., symptom, condition, diagnosis, and/or risk factors).13 (vii) A brief summary of next steps.14 (3) For group services: (i) When a group service is rendered, a list of participants is required to be documented and maintained by the provider. (ii) (iii) Every participant shall have a progress note in their clinical record that documents the service encounter and their attendance in the group, and includes the information listed in (2)(i-v) above.15 The progress note for the group service encounter shall also include a brief description of the member's response to the service.16 (4) Generally speaking, the contents of the progress note shall support the service code(s) selected and support effective clinical care and coordination among providers. Notes shall include the minimum elements described in (2) or (3) above, but the nature and extent of the information included may vary based on the service type and the member's clinical needs. Some notes may appropriately contain less descriptive detail than others.17 If information is located elsewhere in the clinical record (for example, a treatment plan template), it does not need to be duplicated in
12) Process for self-administered medications	A12. Process for self-administered medications- The Contractor shall implement mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs. Monitoring shall occur at least annually. Case management/care coordination referrals for education, vocation, counseling, job referral, legal, medical, and dental, social and recreational- 1. Care coordination consists of activities to provide coordination of SUD care, mental health care, and medical care, and to support the beneficiary with linkages to services and supports designed to restore the beneficiary to their best possible functional level. Care Coordination can be provided in clinical or non-clinical settings and can be provided in person, by telehealth, or by telephone. 2. Care coordination shall be provided to a beneficiary in conjunction with all levels of treatment.

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13) Case management/care coordination referrals for education, vocation, counseling, job referral, legal, medical, and dental, social and recreational	A13. Care coordination may also be delivered and claimed as a standalone service. Through executed memoranda of understanding, the Contractor shall implement care coordination services with other SUD, physical, and/or mental health services in order to ensure a beneficiary-centered and whole-person approach to wellness.3. Care coordination services shall be provided by an LPHA or a registered/certified counselor.4. Care coordination services shall include one or more of the following components: i. Coordinating with medical and mental health care providers to monitor and support comorbid health conditions. ii. Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers. iii. Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.
14) Clients to obtain or have access to MAT	A14. Clients to obtain or have access to MAT- The Contractor shall require that all DMC-ODS providers, at all levels of care, demonstrate that they either directly offer or have an effective referral mechanisms/process to MAT to beneficiaries with SUD diagnoses that are treatable with Food and Drug administration (FDA)-approved medications and biological products. An effective referral mechanism/process is defined as facilitating access to MAT off-site for beneficiaries while they are receiving treatment services if not provided on-site. Providing a beneficiary the contact information for a treatment program is insufficient. A facilitated referral to any Medi-Cal provider rendering MAT to the beneficiary is compliant whether or not they seek reimbursement through DMC-ODS. Beneficiaries needing or utilizing MAT shall be served and cannot be denied treatment services or be required to be tapered off medications as a condition of entering or remaining in the program. The Contractor shall monitor the referral process or provision of MAT services. 6. Beneficiaries needing or utilizing MAT shall be served and cannot be denied treatment services or be required to decrease dosage or be tapered off medications as a condition of entering or remaining in the program. DMC-ODS providers offering MAT shall not deny access to medication or administratively discharge a beneficiary who declines counseling services. For patients with lack of connection to psychosocial services, more rigorous attempts at engagement in care may be indicated, such as using different evidence-based practices, different modalities (e.g.,telehealth), different staff, and/or different services (e.g., Medi-Cal Peer Support Services). If the DMC-ODS provider is not capable of continuing to treat the beneficiary, the DMC-ODS provider shall assist the member in choosing another MAT provider, ensure continuity of care, and facilitate a warm hand-off to ensure engagement.

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15) Fraud, Waste and Abuse	A15. Fraud, Waste and Abuse- Program must have a policy addressing definition of FWA and procedure for reporting. Program Integrity Requirements (42 CFR §438.608). i. The Contractor, and its subcontractor, to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under this Agreement, shall implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, or abuse. A compliance program that includes, at a minimum, all the following elements: Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and state requirements.
16) Medical record release procedures are compliant with State and federal guidelines	A16. Medical record release procedures are compliant with State and federal guidelines- Medical records are not released without written, signed consent from the patient or patient's representative, identifying the specific medical information to be released as well as an end date for the authorization. The release terms, such as to whom records are released and for what purposes, should also be described. This does not prevent release of statistical or summary data, or exchange of individual identifiable medical information between individuals or institutions providing care, fiscal intermediaries, research entities and State or local official agencies.
17) All patient's health service records must be retained for a minimum of ten (10) years from the patient's discharge date or seven years after a minor patient reaches the age of eighteen	A17. All patient's health service records must be retained for a minimum of ten (10) years from the patient's discharge date or seven years after a minor patient reaches the age of eighteen- Hospitals, acute psychiatric hospitals, skilled nursing facilities, primary care clinics, psychology, psychiatric clinics, and SUD facilities must maintain medical records and exposed x-rays for a minimum of 10 years following patient discharge, except for minors (Title 22, CCR, and Section 75055). Records of minors must be maintained for at least one year after a minor has reached age 17, but in no event for less than 7 years (Title 22, CCR, and Section 75055). Each Plan must maintain all records and documentation (including medical records) necessary to verify information and reports required by statute, regulation or contractual obligation for 5 years from the end of the fiscal year in which the Plan contract expires or is terminated (Title 22, CCR, Section 53761).
~~**18)** Serving Native Americans~~	~~18. Serving Native Americans- The Program shall ensure the availability of culturally competent AOD prevention, treatment, and recovery services to the sites American Indian/American Native population~~

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19) Serving Co-Occurring clients.	A19. Serving Co-Occurring clients- Does the Program provide Co-occurring disorder clients with coordinated/integrated care for both their mental health and substance abuse conditions? If yes, what mechanisms are used to provide this service? i. MOU with mental health Program(s) ii. Referral to COD Program iii. Co-case management with mental health Program iv. Provide both mental health and substance abuse treatment at a substance abuse program
20) Program policy on group counseling- List EBPs used:_____, _____,	A20. Program policy on group counseling - The Program provides documented curriculum that includes individual and group counseling directed toward concepts of withdrawal, recovery, an alcohol and drug-free lifestyle, relapse prevention and familiarization with related community recovery resources.
21) Providers will implement and deliver to fidelity at least two of the following Evidence Based Practices	A21. Providers will implement and deliver to fidelity at least two of the following Evidence Based Practices (EBPs) in patient's treatment- They are as follows: Motivational Interviewing, Cognitive- Behavioral Therapy, Trauma-Informed Treatment, Psycho-Education, Relapse Prevention. • A policy that states what Curriculum are used in counseling. These should coincide to the trainings the providers have taken.

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Criteria	IV. Program Policy Booklet Survey Guidelines
A. Site has a program policy booklet that is available to all employees and volunteers that includes the following, but not limited to: (A copy of this booklet should be obtained, location should be noted AOD 12010 Program PoliciesAll program policies and procedures shall be contained in a manual that is located at each certified site and that shall be available to staff and volunteers)	**A. Site has a program policy booklet that is available to all employees and volunteers that includes the following, but not limited to: (A copy of this booklet should be obtained, location should be noted AOD 12010 Program PoliciesAll program policies and procedures shall be contained in a manual that is located at each certified site and that shall be available to staff and volunteers)**
1) Program Mission and Philosophy Statement	A1. Program mission and philosophy statement(s).
2) Program Description, objectives, and evaluation plan.	A2. Program Description, objectives, and evaluation plan.
3) Admission and Re-admission; including client assignment to counselor and contact information	A3. Admission and Re-admission; including client assignment to counselor and contact information
4) Intake Services	A4. Intake Services
5) Discharge Services	A5.Discharge Services
6) Recovery Services	A6. Recovery Services
7) Individual and Group Sessions	A7. Individual and Group Sessions
8) Alumni involvement and Use of volunteers	A8. Alumni involvement and Use of volunteers
9) Recreational activities	A9. Recreational activities
10) Detoxification Services (if applicable)	A10. Detoxification Services (if applicable)
11) Program administration and personnel practices	A11. Program administration and personnel practices
12) Client grievances/complaints	A12. Client grievances/complaints
13) Fiscal practices and budget mechanisms	A13. Fiscal practices and budget mechanisms
14) Continuous quality improvement	A14. Continuous quality improvement
15) Client rights	A15. Client rights
16) Medical policies	A16. Medical policies
17) Nondiscrimination in provision of employment and services	A17. Nondiscrimination in provision of employment and services
18) Community Relations	A18. Community Relations
19) Confidentiality	A19. Confidentiality

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20) Maintenance of program in a clean, safe, and sanitary physical environment	A20. Maintenance of program in a clean, safe, and sanitary physical environment
21) Maintenance and disposal of client files	A21. Maintenance and disposal of client files
22) Drug screening	A22. Drug screening
23) Staff code of conduct as specified in section 13020 of these Standards	A23. Staff code of conduct as specified in section 13020 of these Standards
24) Client code of conduct	A24. Client code of conduct
25) Care Coordination/Case Management	A25. Care Coordination/Case Management
26) Continuing Services	A26. Continuing Services
27) Cultural Competency Program around CLAS standards (inclusive of all 15 standards)	A27. Cultural Competency Program around CLAS standards (inclusive of all 15 standards)

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Criteria	V. Intake Packet Survey Guidelines
A. At a minimum, the following shall be included during the intake process IV. OM E1-E4 (A-D). These formally stated copies of the following shall be provided to the beneficiary or posted in a prominent place accessible to all beneficiaries. A. A copy of a complete admissions/intake packet should be provided	**A. At a minimum, the following shall be included during the intake process IV. OM E1-E4 (A-D). These formally stated copies of the following shall be provided to the beneficiary or posted in a prominent place accessible to all beneficiaries. A. A copy of a complete admissions/intake packet should be provided**
1) A statement of nondiscrimination by race, religion, sex, ethnicity, age, disability, sexual preference, and ability to pay	A1. A statement of nondiscrimination by race, religion, sex, ethnicity, age, disability, sexual preference, and ability to pay
2) Complaint process and grievance procedures	A2. Complaint process and grievance procedures
3) Appeal process for involuntary discharge	A3. Appeal process for involuntary discharge
4) Program rules and expectations	A4. Program rules and expectations
5) Client rights and responsibilities	A5. Client rights and responsibilities
6) Consent to release information	A6. Consent to release information
7) HIPAA notification	A7. HIPAA notification
8) Consent to treat	A8. Consent to treat
9) Admission agreement	A9. Admission agreement

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Criteria	VI. Interpreter Services Survey Guidelines (a copy of policy should be obtained)
A. Interpreter services	**A. Interpreter services**
1) All sites must provide 24-hour interpreter services for all members either through telephone language services or interpreters on site. Site personnel used as interpreters have been assessed for their medical interpretation performance skills/capabilities.	A1. All sites must provide 24-hour interpreter services for all members either through telephone language services or interpreters on site. Site personnel used as interpreters have been assessed for their medical interpretation performance skills/capabilities. Note: https://lep.gov/commonly-asked-questions
2) If bilingual staff are asked to interpret or translate, they should be qualified to do so. Assessment of ability, training on interpreter ethics and standards, and clear policies that delineate appropriate use of bilingual staff, staff or contract interpreters and translators, will help ensure quality and effective use of resources.	A2. If bilingual staff are asked to interpret or translate, they should be qualified to do so. Assessment of ability, training on interpreter ethics and standards, and clear policies that delineate appropriate use of bilingual staff, staff or contract interpreters and translators, will help ensure quality and effective use of resources.
3) Those utilizing the services of interpreters and translators should request information about certification, assessments taken, qualifications, experience, and training. Quality of interpretation should be a focus of concern for all recipients.	A3. Those utilizing the services of interpreters and translators should request information about certification, assessments taken, qualifications, experience, and training. Quality of interpretation should be a focus of concern for all recipients.
4) Family or friends should not be used as interpreters, unless specifically requested by the member.	A4. Family or friends should not be used as interpreters, unless specifically requested by the member.
5) ACA 2010 § 1557: prohibits from using low-quality video remote interpreting services or relying on unqualified staff, translators when providing language assistance services.	A5. ACA 2010 § 1557: prohibits from using low-quality video remote interpreting services or relying on unqualified staff, translators when providing language assistance services.

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6) A request for or refusal of language/interpreter services must be documented in the member's medical record.	A6. A request for or refusal of language/interpreter services must be documented in the member's medical record.

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Criteria	VII.Staff Requirements Survey Guidelines
A. Personnel files maintained on all employees, LPHA, Medical Director and volunteers/interns contain the following: CA Business & Professional (B&P) Code §2050, §2585, §2725, §2746, §2834, §3500, §4110 (Obtain a complete copy of all documents)	**A. Personnel files maintained on all employees, LPHA, Medical Director and volunteers/interns contain the following: CA Business & Professional (B&P) Code §2050, §2585, §2725, §2746, §2834, §3500, §4110 (Obtain a complete copy of all documents)**
1) Application for employment and/or resume	A1. Application for employment and/or resume
2) Signed employment confirmation statement/duty statement	A2. Signed employment confirmation statement/duty statement
3) Job description includes all of the following: Position title and classification; Duties and responsibilities; Lines of supervision; Education, training, work experience, and other qualifications for the position.	A3. Job description includes all of the following: Position title and classification; Duties and responsibilities; Lines of supervision; Education, training, work experience, and other qualifications for the position.
4) Performance evaluations	A4. Performance evaluations
5) Health records/status as required by program or Title 9	A5. Health records/status as required by program or Title 9
6) Other personnel actions	A6. Other personnel actions
7) Training documentation relative to substance use disorders and treatment	A7. Training documentation relative to substance use disorders and treatment
8) Current registration, certification, intern status, or licensure	A8. Current registration, certification, intern status, or licensure (see table to add in) Note: All medical professional licenses and certifications must be current and issued from the appropriate agency for practice in California. Any license/certification that has been approved during the current re/credentialing process need not be re-checked during the site review. Any licenses/certifications not included in the re/credentialing process must be checked for current status as part of the site review process. Although sites with centralized personnel departments are not required to keep documents or copies on site, copies and/or lists of currently certified or credentialed personnel must be readily available when requested by reviewers.
9) Proof of continuing education required by licensing or certifying agency and program	A9. Proof of continuing education required by licensing or certifying agency and program

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10) Program Code of Conduct and for registered, certified, and licensed staff	A10. Program Code of Conduct and for registered, certified, and licensed staff, a copy of the certifying body's code of conduct as well.
11) Signed annual confidentiality agreement (if not available, a yearly training can meet this requirement)	A11. Signed annual confidentiality agreement (if not available, a yearly training can meet this requirement) For registered and certified counselors, a copy of registration or certification According to AOD 8000 b., "Counseling services may only be provided by individuals registered or certified pursuant to California Code of Regulations, Title 9, Division 4, and Chapter 8 or by a licensed professional acting within their scope of practice." 8 Hour class at hire should be done on day one (Reviewer to Obtain copies of licenses)
12) For registered and certified counselors, a copy of registration or certification	A12. For registered and certified counselors, a copy of registration or certification
B. Program/Facility has a written plan for training staff that is updated annually (Proof of training should be readily available)	**B. Program/Facility has a written plan for training staff that is updated annually (Proof of training should be readily available)**
1) The program/facility has a written plan for training staff that is updated annually	B1. Title 22, C-19020- The program must have a written plan that is updated annually for the training needs of staff. Site personnel have received information and/or training about member rights. Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. If there is no verifiable evidence of staff training, staff is able to locate written member rights information on site and explain how to use information.
2) All providers and staff conducting, reviewing, using ASAM assessments have completed the two e-Trainings.	B2.Intergovernmental Agreement Exhibit A, Attachment I, III, GG, 3,ii, a The Contractor shall ensure that, at minimum, providers and staff conducting assessments are required to complete the two e-Training modules entitled "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care". A third module entitled, "Introduction to The ASAM Criteria" is recommended for all county and provider staff participating in the Waiver. Applies to all providers who co-sign or conduct medical necessity assessments.
3) All employees have mandatory training on annual DMC-ODS requirements	B3. All Employees must complete mandatory DMC-ODS training, provided by PHC on an annual basis.

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4) All appropriate staff have received regular training on evidence based practices (EBP)	B4. Providers will implement and train appropriate staff on at least two of the following EBPs based on the timeline established in the county implementation plan. The required EBP's include: Motivational Interviewing, Cognitive-Behavior Therapy, Relapse Prevention, Trauma-Informed Treatment, and Psycho-Education. Note: Proof of appropriate staff training related to the Evidence Base Practices (EBP's) currently being used on site.
5) Staff are trained in the CalOMS treatment data collection and reporting methods	B5. New staff are trained in the CalOMS Tx data collection and reporting methods: • CalOMS Tx data is reported in a manner consistent with their county contract as well as within the timelines outlines in the State-County contract • a client admission record is uploaded when the participants have been admitted into treatment, and treatment services have started • admission information is gathered within seven days of a person's entry into treatment • annual update is completed for program participants in treatment for a period of 12 months or more, had no break in service exceeding 30 days and participated continuously in the same modality and program • administrative discharges are used only when the client has stopped appearing for treatment services without leave from or notification to the AOD treatment program and the client cannot be located to be discharged and complete the CalOMS Tx discharge interview either in person or by phone • a client is discharged if there has been no contact with the client for 30 days
6) Staff are trained in the DATAR reporting methods	B6. The Program shall have policies, procedures and practices in place to ensure DATAR is reported in a manner consistent with their county contract as well within the timelines outlined in the State-County contract
7) Cultural and Linguistic training annually	B7. The program shall promote the delivery of services in a culturally competent manner to all clients, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity
8) Title 22 training	B8. Title 22, C-19020- The program must have a written plan that is updated annually for the training needs of staff. Site personnel have received information and/or training about member rights. Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. If there is no verifiable evidence of staff training, staff is able to locate written member rights information on site and explain how to use information.
9) Education on the Trafficking Victims Protection Act of 2000	B9. Staff shall be trained on the Trafficking Victims Protection Act of 2000. Trafficking Victims Act: "Shall comply with Section 106(g) of the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7104(g)) as amended by section 1702"

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10) Annual confidentiality training	B10. All employee files shall contain either a new confidentiality agreement signed each year or proof of annual training.
11) ONLY MEDICAL DIRECTOR minimum of five hours of continuing medical education related to addiction medicine each year for medical director	B11. Proof of continuing education required by licensing or certifying agency and program. (pg 169 IGA)
12) ONLY LPHA minimum of five hours of continuing medical education related to addiction medicine each year for LPHA	B12. Professional staff (LPHA's) receive a minimum of 5 hours continuing education related to addiction medicine each year.
13) Tuberculosis (TB) Testing is offered and performed onsite for all staff who have contact with food preparation and/or any clients.	B13. All staff and volunteers whose functions require or necessitate contact with clients or food preparation shall be tested for tuberculosis. The tuberculosis test shall be conducted under licensed medical supervision not more than 45 working days prior to or 5 working days after employment and renewed annually from the date of the last tuberculosis test. Staff and volunteers with a known record of tuberculosis or a record of positive testing shall not be required to obtain a tuberculosis skin test. Unless there is documentation that the staff or volunteer completed at least 6 months of preventive therapy, the staff or volunteer shall be required to obtain, within 30 working days of employment, a chest x-ray result and a physician's statement that he/she does not have communicable tuberculosis and has been under regular care and monitoring for tuberculosis. A chest x-ray within the prior 6 months is acceptable. The physician's statement shall be renewed annually. Any staff or volunteer who has the symptoms of tuberculosis or an abnormal chest x-ray consistent with tuberculosis shall be temporarily barred from contact with clients and other program staff until a written physician's clearance is obtained. At the discretion of the program director, tuberculosis testing need not be required for support or ancillary staff whose functions do not necessitate contact with clients or food preparation, and who are not headquartered at the program.

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14) A code of conduct for the Medical Director shall be clearly documented, signed and dated by a provider representative and the physician.	B14. Written code of conduct addresses at least the following: a) Use of drugs and/or alcohol; b) Prohibition of social/business relationship with clients or their family members for personal gain; c) Prohibition of sexual contact with clients; d) Conflict of interest; e) Providing services beyond scope; f) Discrimination against clients or staff; g) Verbally, physically, or sexually harassing, threatening, or abusing clients, family members or other staff; h) Protection of client confidentiality; i) The element found in the code of conduct(s)for the certifying organization(s) the program's counselors are certified under; j) Cooperation with compliant investigations.
C. Professional health care personnel have current California Licenses and Certifications. CA Business & Professional (B&P) Code §2050, §2585, §2725, §2746, §2834, §3500, §4110	**C. Professional health care personnel have current California Licenses and Certifications. CA Business & Professional (B&P) Code §2050, §2585, §2725, §2746, §2834, §3500, §4110**
1) All staff have received appropriate credentialing	C1. Cross reference with credentialing team
2) At least 30% of staff providing counseling are licensed or certified as Drug & Alcohol Counselors.	C2. Title 22, D-13010- There has to be at minimum 30% of staff who are certified or licensed to be providing Drug/Alcohol Counseling.
3) Staff files are maintained for the required length of time. (6 years current)	C3. Make sure there is proof that this is occurring. Make note of any verbal communication
4) NTP/OTP program only Facility must provide policy showing conforming to CCR, Title 9, and Division 4 with regard to medication practices	C4. NTPs shall comply with all federal and state NTP licensing requirements (Likely has a policy)

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Criteria	VIII. Detox Survey Guidelines
A.During the provision of detoxification services, the minimum staffing or volunteer ratios and health-related requirements shall be as follows: (Clients shall not be used to fulfill the requirements of this section.)	**A.During the provision of detoxification services, the minimum staffing or volunteer ratios and health-related requirements shall be as follows: (Clients shall not be used to fulfill the requirements of this section.)**
1) In a program with 15 or fewer clients who are receiving detoxification services, there shall be at least one staff member or volunteer on duty and awake at all times with a current cardiopulmonary resuscitation certificate and current first aid training.	A1. In a program with 15 or fewer clients who are receiving detoxification services, there shall be at least one staff member or volunteer on duty and awake at all times with a current cardiopulmonary resuscitation certificate and current first aid training.
2) In a program with more than 15 clients who are receiving detoxification services, there shall be at least two staff members or volunteers, per every 15 clients, on duty and awake at all times, one of whom shall have a current cardiopulmonary resuscitation certificate and current first aid training.	A2. In a program with more than 15 clients who are receiving detoxification services, there shall be at least two staff members or volunteers, per every 15 clients, on duty and awake at all times, one of whom shall have a current cardiopulmonary resuscitation certificate and current first aid training. Clients shall not be used to fulfill the requirements of this section.
B. A full ASAM Criteria assessment shall not be required as a condition of admission to a facility providing Withdrawal Management. To facilitate an appropriate care transition, a full ASAM assessment, brief screening, or other tool to support referral to additional services is appropriate.	**B. A full ASAM Criteria assessment shall not be required as a condition of admission to a facility providing Withdrawal Management. To facilitate an appropriate care transition, a full ASAM assessment, brief screening, or other tool to support referral to additional services is appropriate.**
C. Evidence of personnel training shall be implemented and maintained by the licensee pursuant to CCR, Title 9, Section 10564(k).	**C. Evidence of personnel training shall be implemented and maintained by the licensee pursuant to CCR, Title 9, Section 10564(k).**

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1) Evidence of eight (8) hours of training annually that covers the needs of residents who receive Withdrawal Management services in personnel files.	C1. Evidence of eight (8) hours of training annually that covers the needs of residents who receive Withdrawal Management services in personnel files.
2) Evidence of repeated orientation training within 14-days for returning staff following a 180 continuous day break in employment personnel files.	C2. Evidence of repeated orientation training within 14-days for returning staff following a 180 continuous day break in employment personnel files.
3) Evidence of six (6) hours of orientation training for all personnel providing WM services, monitoring and supervising the provision of Withdrawal Management services	C3. Evidence of six (6) hours of orientation training for all personnel providing WM services, monitoring and supervising the provision of Withdrawal Management services
4) Naloxone training policy and completion of naloxone training	C4. Naloxone training policy and completion of naloxone training

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Criteria	IX. Perinatal Services Survey Criteria
A. These standards apply to programs who provide SUD treatment to pregnant and parenting women, which includes: Pregnant women; Women with dependent children; Women attempting to regain custody of their children; Postpartum women and their children; or Women with substance exposed infants	**A. These standards apply to programs who provide SUD treatment to pregnant and parenting women, which includes: Pregnant women; Women with dependent children; Women attempting to regain custody of their children; Postpartum women and their children; or Women with substance exposed infants**
1) The Program publicizes that pregnant women are given preference in admission to recovery and treatment programs and encourage women in need of treatment services to access them	A1. The Program publicizes that pregnant women are given preference in admission to recovery and treatment programs and encourage women in need of treatment services to access them. The Program shall ensure that Injection drug-using women must be admitted within 14 days after request or within 120 days if interim services are provided interim Services are: HIV and TB education and counseling and testing; Referrals for prenatal care; Education on the effects of AOD use on the fetus
2) Does the Program adhere to priority admission requirements as follows: a. Pregnant injecting drug users b. Pregnant substance abusers c. Injecting drug users d. All Others	A2. The Program publicizes that pregnant women are given preference in admission to recovery and treatment programs and encourage women in need of treatment services to access them.
3) The program shall admit IV drug users within 14 days of request or provide interim services and admit within 120 days	A3. The Program shall ensure that Injection drug-using women must be admitted within 14 days after request or within 120 days if interim services are provided. Interim Services are: • HIV and TB education and counseling and testing; • Referrals for prenatal care; • Education on the effects of AOD use on the fetus
B. The Program shall have in place policies, procedures, and practices to support the provision Interim services within their program(s)	**B. The Program shall have in place policies, procedures, and practices to support the provision Interim services within their program(s)**
1) Pregnant women receiving interim services shall be placed at the top of the waiting list for program admission	B1. The Program publicizes that pregnant women are given preference in admission to recovery and treatment programs and encourage women in need of treatment services to access them.

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2) The Program shall make interim services available, either on-site or by referral, within 48 hours for those individuals who are in need of treatment and who cannot be admitted within 14 days of their request for treatment	B2. The Program shall ensure that Pregnant women are referred for interim services within 48 hours if a treatment slot is not available (To assist in making appropriate referrals, the County must make available a current directory of community resources.) and if placed on waiting list, pregnant women are at top of waiting list.
3) The Program shall have an established waiting list that includes a unique patient identifier for injecting drug users seeking treatment, including patients receiving interim services while awaiting admission	B3.
4) The Program shall maintain contact with individuals awaiting treatment admission	B4. The Program shall ensure that Injection drug-using women must be admitted within 14 days after request or within 120 days if interim services are provided. Interim Services are: • HIV and TB education and counseling and testing; • Referrals for prenatal care; • Education on the effects of AOD use on the fetus
5) The Program shall ensure that Injection drug-using women must be admitted within 14 days after request or within 120 days if interim services are provided	B5.
C. The Program shall:	**C. The Program shall:**
1) The Program shall make referrals based on individual assessments, such as 12 step groups, housing support, food and legal aid, case management, children's services, medical service and social services	C1. The Program shall make referrals based on individual assessments, such as 12 step groups, housing support, food and legal aid, case management, children's services, medical service and social services.

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2) The Program shall ensure that child care is provided on-site for participants' children between birth and 36 months while the mothers are participating in the program	C2. Child care may be provided on-site or off-site for participants' children who are between 37 months and 12 years of age. Child care for children between 13 and 17 years of age, if necessary or appropriate, may be on-site or off-site as long as their inclusion in the program does not negatively impact the younger children. In a perinatal program, daycare is a service that needs to be available for clients while receiving treatment. The Pro-Children Act of 1994 prohibits smoking in any indoor facility where services for children are federally funded
3) Program has a policy that addresses therapeutic intervention for children of the women receiving SUD treatment services to address the child's: Developmental needs, Sexual Abuse, physical abuse and neglect.	C3. The Program shall provide or arrange therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, and neglect.
4) Program shall ensure Perinatal /Pediatric Patient Care is available	C4. Immunizations, pediatric care, transportation to appointments, monitored and documented while mother is in treatment if baby is with her.
5) Program shall provide or arrange for sufficient case management	C5. The Program shall provide or arrange for sufficient case management to ensure that women and their children have access to primary medical care, pediatric care, and other needed services
6) Program shall provide or arrange for primary medical care for women in treatment	C6. Provide or arrange for primary medical care for women in treatment
7) Program shall provide or arrange for primary pediatric care	C7. The Program shall provide or arrange for primary pediatric care, including immunizations, for dependent children. Programs providing direct primary medical care for women and/or primary pediatric care for dependent children must seek alternative funding for these services before using federal perinatal funds. Medi-Cal, Medicare and other health insurance must be billed first, and programs using federal perinatal funds must document that alternative funding is not available. Programs may use client fees. State General Funds cannot be used to provide medical treatment.
8) Program shall provide or arrange for transportation	C8. The Program provides or arranges for transportation to and from the recovery and treatment site, and to and from ancillary services or women in need of transportation.
9) Program shall maintain a vehicle log	C9. The Program shall ensure a vehicle log is maintained
10) Program shall provide or arrange therapeutic interventions for children	C10. The Program shall provide or arrange therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, and neglect.

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11) Program shall program shall provide or arrange for required services	C11. The Program shall provide or arrange for the following services: (a) Educational/vocational training and life skills resources (b) TB and HIV education and counseling (c) Education and information on the effects of alcohol and drug use during pregnancy and breastfeeding (d) Parenting skills-building and child development information

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Criteria	X. Pharmaceutical/Laboratory Services Survey Guidelines
A. Drugs and medication supplies are maintained securely to prevent unauthorized access. CA B&P Code §4051.3, §4071, §4172; 22 CCR §75037(a-g), §75039; 21 CFR §1301.75, §1301.76, §1302.22 Deficiencies: All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, etc.) must be addressed in a corrective action plan.	**A. Drugs and medication supplies are maintained securely to prevent unauthorized access. CA B&P Code §4051.3, §4071, §4172; 22 CCR §75037(a-g), §75039; 21 CFR §1301.75, §1301.76, §1302.22 Deficiencies: All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, etc.) must be addressed in a corrective action plan.**
1) Drugs are stored in specifically designated cupboards, cabinets, closets, or drawers.	A1. • All drugs for dispensing are stored in an area that is secured at all times (CA B&P Code, §4172). The Medical Board defines "area that is secure" to mean a locked storage area within a physician's office. • Keys to locked storage area are available only to staff authorized by the physician to have access (16 CCR, Chapter 2, Division 13, Section 1356.3) • The Medical Board of California interprets "all drugs" to also include both sample and over-the-counter drugs (22 CCR §75032 and §75033)
2) Controlled drugs are stored in a locked space accessible only to authorized personnel.	A2. Controlled substances are stored separately from other drugs in a securely locked, substantially constructed cabinet (Control Substances Act, CFR 1301.75). Control substances include all Schedule I, II, III, IV, and V substances listed in the CA Health and Safety Code, Sections 11053-11057, and do not need to be double locked. Personnel with authorized access to controlled substances include physicians, dentists, podiatrists, physician's assistants, licensed nurses, and pharmacists.
3) A dose-by-dose medication log is maintained.	A3. Written records are maintained including all medications (inclusive of controlled substances) and include inventory list(s) that have: provider's name, name of medication, original quantity of drug, dose, date, name of patient receiving drug, name of authorized person dispensing drug, and number of remaining doses. Note: During business hours, the drawer, cabinet, or room containing drugs, medication supplies, or hazardous substances may remain unlocked only if there is no access to area by unauthorized persons. Whenever drugs, medication supplies, or hazardous substances are unlocked, authorized clinic personnel must remain in the immediate area at all times. At all other times, drugs, medication supplies and hazardous substances must be securely locked. Controlled substances are locked at all times.
4) There are no expired medications on site.	A4. There must not be any expired medications on site.
5) Site has a procedure to check expiration date and a method to dispose of expired medications.	A5. Site has a procedure to check expiration date and a method to dispose of expired medications.

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6) Site has a procedure to check expiration date and a method to dispose of expired lab test supplies.	A6. Site has a procedure to check expiration date and a method to dispose of expired lab test supplies.
7) Site has appropriate process for handling Sharps	A7. Site has a procedure to dispose of Sharps materials
8) For MAT Treatment Only: Where medications are a part of the beneficiary's treatment, provider practices conform to medical policies with regard to different dosing levels, administration and take home practices.	A8. For MAT Treatment Only: Where medications are a part of the beneficiary's treatment, provider practices conform to medical policies with regard to different dosing levels, administration and take home practices.

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Criteria	Telehealth Guidelines **DHCS requires that every provider offering covered services to a beneficiary via telehealth must also meet the requirements of Business and Professions Code Section 2290.5(a)(3), or otherwise be designated by DHCS as able to render Medi-Cal services via telehealth. All providers that are listed in the California Medicaid State Plan as qualified providers of SMHS, DMC, or DMC-ODS services are designated by DHCS as able to render covered services, within their scopes of practice, via telehealth.** **The California Medicaid State Plan includes qualified provider lists in Supplement 3 to Attachment 3.1-B, Limitation on Services 13.d.5, Substance Use Disorder Services, Provider Qualifications (Drug MediCal); Supplement 3 to Attachment 3.1-B, Limitation on Services 13.d.6, Expanded Substance Use Disorder Treatment Services, Practitioner Qualifications (Drug Medi-Cal Organized Delivery System); and Supplement 1 to Attachment 3.1-A, Qualification of Providers; Supplement 2 to Attachment 3.1-B, Provider Qualifications; and Supplement 3 to Attachment 3.1-A, Provider Qualifications (Specialty Mental Health).**
Provider maintains a policy for telehealth services to only be provided when consent is received from a member	Effective January 1, 2024, all providers furnishing applicable covered services via synchronous audio-only interaction must also offer those same services via synchronous video interaction to preserve beneficiary choice. Effective January 1, 2024, to preserve a beneficiary's right to access covered services in person, a provider furnishing services through telehealth must do one of the following: 1. Offer those same services via in-person, face-to-face contact; or 2. Arrange for a referral to, and a facilitation of, in-person care that does not require a beneficiary to independently contact a different provider to arrange for that care. https://www.dhcs.ca.gov/Documents/BHIN-23-018-Updated-Telehealth-Guidance-for-SMHS-and-SUD-Treatment-Servies-in-Medi-Cal.pdf

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Proof staff received training on the use of telehealth services, including obtaining consent prior to treatment.	Prior to initial delivery of covered services via telehealth, providers are required to obtain verbal or written consent for the use of telehealth as an acceptable mode of delivering services, and 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 MediCal 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.

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Criteria	Peer Support Services Guidelines **Medi-Cal Peer Support Services, Medi-Cal Peer Support Specialists,and Medi-Cal Peer Support Specialists Certification Program Standards** **To provide the requirements and standards for implementing the Medi- Cal Peer Support Services benefit, Medi-Cal Peer Support Specialist provider type, and Medi-Cal Peer Support Specialist Certification Programs.** **Centers for Medicare and Medicaid Services State Medicaid Directors Letter #07-011; Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 1.4; California State Plan Amendment (SPA) #21- 0051.**
Peer Supports have documented and signed Ethics Code in personnel file.	Medi-Cal Peer Support Services are recovery-oriented and resiliency-focused services for those managing behavioral health challenges as well as the parents, family members, and caregivers that support them. Medi-Cal Peer Support Services are evidence-based practices that provide role models to inspire hope, demonstrate a life of recovery and resiliency, and encourage real advocacy. This Code of Ethics document promotes a consistent message to those who are providing, receiving, and supervising services from a Medi-Cal Peer Support Specialist. The values and ethics standards described here formalize and advance Medi-Cal Peer Support Services in California's behavioral health system of care. "Medi-Cal Peer Support Specialist" is a Medi-Cal certified provider type that provides services in the behavioral health field using their "lived experience" to establish mutuality and build resiliency and recovery. This Code of Ethics is non-binding for peer support workers who are not delivering Medi-Cal Peer Support Services. https://www.dhcs.ca.gov/Documents/ENCLOSURE-Peer-Support-Specialist-Ethics-Code.pdf

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Peer Support Specialists staff have necessary documentation with personnel file that outlines qualifications meet state requirements	A Medi-Cal Peer Support Specialist is an individual with a current state-approved certification as a Medi-Cal Peer Support Specialist from a county, or an agency representing the county, who also meets all other applicable California state requirements, including ongoing continuing education requirements. Medi-Cal Peer Support Specialists shall meet the following qualifications: (1) Be at least 18 years of age; (2) Possess a high school diploma or equivalent degree; (3) Be self-identified as having experience with the process of recovery from mental illness or substance use disorder, either as a consumer of these services or as the parent, caregiver or family member of a consumer; (4) Be willing to share their experience; (5) Have a strong dedication to recovery; (6) Agree, in writing, to adhere to the code of ethics; (7) Successfully complete the curriculum and training requirements for a Medi-Cal Peer Support Specialist; and (8) Pass a Medi-Cal Peer Support Specialist certification examination provided by a DHCS-approved Certification Program. •For licensing issued to a servicemember or the spouse of a servicemember see BHIN 25-010 Section 6 Medi-Cal Peer Support Specialists shall provide services under the direction of a Behavioral Health Professional. Behavioral Health Professionals must be licensed, waivered, or registered in accordance with applicable State of California licensure requirements and be listed in the California Medicaid State Plan as a qualified provider of SMHS, DMC, or DMC-ODS. All SUD and Expanded SUD services, including MediCal Peer Support Services, must be medically necessary and recommended by physicians or other Licensed Practitioner of the Healing Arts (LPHAs) acting within their scope of practice. All SMHS, including Medi-Cal Peer Support Services, must be medically necessary and recommended by physicians or other Licensed Mental

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Peer Support Specialists supervising staff have documentation within personnel file that meets or exceeds state requirements and necessary qualifications.	Medi-Cal Peer Support Specialists may be supervised by a Medi-Cal Peer Support Specialist Supervisor who meets applicable State of California requirements; however, the services shall be under the direction of a Behavioral Health Professional pursuant to Section 6, subdivision (e) of this BHIN. Medi-Cal Peer Support Specialist Supervisors shall meet at least one of the following qualifications: (1) Have a Medi-Cal Peer Support Specialist certification, have at least two years of experience providing behavioral health services directly to consumers, and complete a DHCS-approved Peer Support Specialist Supervisor training curriculum pursuant to subdivision (b); OR (2) Be a practitioner that is eligible to provide SMHS, SUD Treatment Services, or Expanded SUD Treatment Services as described in the state plan including, Licensed Practitioner of the Healing Arts (LPHA), Licensed Mental Health Provider (LMHP), Clinical Trainee, Alcohol or Other Drug Counselor, Mental Health Rehabilitation Specialist, or Physician Assistant, have at least two years of experience providing behavioral health services directly to consumers, and complete a DHCS approved Medi-Cal Peer Support Specialist Supervisor training curriculum pursuant to subdivision (b); OR (3) Have a high school diploma or GED, have at least four years of experience providing behavioral health services directly to consumers (which may include providing Medi-Cal Peer Support Services), and complete a DHCS-approved MediCal Peer Support Specialist Supervisor training curriculum pursuant to subdivision. (b) (b)Medi-Cal Peer Support Specialist Supervisors shall complete a one-time DHCSapproved Medi-Cal Peer Support Specialist Supervisor training within 60 days of beginning to supervise Medi-Cal Peer Support Specialists. Medi-Cal behavioral health delivery systems may require additional supervisor training requirements. Reference https://www.dhcs.ca.gov/formsandpubs/laws/Documents/Supp3-to-Attach3-1-

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Provider maintains policies related to supervision provided to Peer Support staff which is documented, tracked, and billed according to BHIN 25-010	(b) Under W&I Code Section 14045.15 (a), Medi-Cal Peer Support Specialists shall meet the following qualifications: (1) Be at least 18 years of age; (2) Possess a high school diploma or equivalent degree; (3) Be self-identified as having experience with the process of recovery from mental illness or substance use disorder, either as a consumer of these services or as the parent, caregiver or family member of a consumer; (4) Be willing to share their experience; (5) Have a strong dedication to recovery; 13 (6) Agree, in writing, to adhere to the code of ethics; (7) Successfully complete the curriculum and training requirements for a Medi-Cal Peer Support Specialist; and (8) Pass a Medi-Cal Peer Support Specialist certification examination provided by a DHCS-approved Certification Program. Policy includes supervising staff meet the following criteria: Section 7 - Medi-Cal Peer Support Specialist Supervisor Requirements (a) Medi-Cal Peer Support Specialists may be supervised by a Medi-Cal Peer Support Specialist Supervisor who meets applicable State of California requirements; however, the services shall be under the direction of a Behavioral Health Professional pursuant to Section 6, subdivision (e) of this BHIN. Medi-Cal Peer Support Specialist Supervisors shall meet at least one of the following qualifications: (1) Have a Medi-Cal Peer Support Specialist certification, have at least two years of experience providing behavioral health services directly to consumers, and complete

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Criteria	Adolescent Services Guidelines Note that all portion of the addition are tied to the Adolescent Best Practice Guide that can be found here: https://www.dhcs.ca.gov/Documents/CSD_CMHCS/Adol%20Best%20Practices%20Guide/AdolBestPracGuideOCTOBER2020.pdf
Provider assessment is inclusive of all required elements	Provider assesses for the following: •substance use (including tobacco/nicotine use); •co-occurring mental health disorders; •physical health; •cognitive, social, and affective development; •family, peer, and romantic relationships; •trauma; •current or past emotional, physical, or sexual abuse; suicidality; and safety. Treatment and recovery should address the nuances of adolescent experience (including cognitive, emotional, physical, social, and moral development) and how these nuances interface with their alcohol and other drug use.
Provider has policies related to high-risk members who is a danger to themself or others.	Policy addresses how the issue is immediately addressed through referral to an appropriate source, and family/ guardian notification, if appropriate.
Services, materials, and resources are ta	Services, materials, and resources provided to adolescents should be accessible in that they will be developmentally appropriate and tailored to adolescents. Staff should communicate and deliver services that are age appropriate in terms of the adolescent's developmental stage, cognitive ability, and relevant environmental and socioculturalfactors. At every level of care, program services for adolescents should be designed and implemented in ways that are developmentally relevant (e.g., taking age, maturation, cognitive processing, decision-making skills, and special needs of the individual adolescents into consideration). Adolescents should be treated in the least restrictive environment possible.
Providers are trained in adolescent development	Staff should understand the developmental stages, growth, behavior, values/beliefs, and cultural differences among adolescents (e.g., stages of development, brain development, puberty)

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Provider has policies related to how co-occurring needs for members are addressed.	A comprehensive service system for adolescents with co-occurring substance use and mental health disorders must have support at the highest levels and be consumer-centered and culturally competent. These systems should take a “no wrong door” approach such that services are available and accessible no matter where and how an individual enters the system. To address adolescents’ needs in a coordinated way, systems should use common data and assessment tools, train substance abuse and mental health staff in each other’s disciplines, and use flexible funding mechanisms (National Association of State Mental Health Program Directors (NASMHPD) and National Association of State Alcohol and Drug Abuse Directors (NASADAD), 1999). Service coordination among the mental health, substance abuse, and primary health care systems should correspond to the level of severity of the disorder. Coordination begins with consultation across systems, which ensures both mental health and substance use disorders are addressed. Counties and providers may formally collaborate to ensure both substance use and mental health issues are included in the treatment regimen. In cases of high severity, counties/providers may engage in services integration, which merges substance use and mental health disorder treatment efforts into a single treatment setting and treatment regimen (NASMHPD & NASADAD, 1999). Adolescent SUD treatment providers work together with adolescents and their families to ensure access to primary care services, either directly or through coordinated referral and linkages to appropriate service providers. Integrated care may also address other aspects of the adolescent’s life, including culture; gender identity and sexuality issues of abuse

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Provider has policies indicating the use of EBPs that are age, gender, developmentally, and culturally appropriate.	Examples of EBPs include screening tools, assessment tools, counseling, family counseling, group counseling practices, and use of medications in treatment. In acknowledgement of the ever-evolving field of SUD treatment, specific EBPs are not listed in this document, but providers are encouraged to seek out and use developmentally appropriate EBPs. a) Providers should have an understanding of models and theories of SUDs and behavioral, psychological, physical, and social effects of psychoactive substances. They should also remain up to date on current research and evidence-based and best practices for adolescent treatment and recovery. b) To use EBPs effectively, providers should ensure staff members are adequately trained and qualified to implement the practices with fidelity and have the appropriate supervision. c) Provider personnel files should document training(s) and/or certification(s) in the evidence-based model(s) the staff member is using in the provision of adolescent services. d) Providers should be able to demonstrate which EBP is implemented, how trainings and supervision are conducted, and how fidelity is assured. e) Providers should use EBPs that are age, gender, developmentally, and culturally appropriate as identified by national or state-level EBP clearinghouses (e.g., EBPs listed in SAMHSA's National Registry of Evidence-Based Programs and Practices).