Reaching the 95 Percent "R95" FAQ

#	QUESTIONS	ANSWERS
	General R95 Capacity Building and Reimbursement Questions	
1.	Has there been a consideration to create a community outreach services structure that is billable, allowing programs to bill for outreaching prospective clients as part of 'reaching the 95'?	Yes – this is one of the benefits of the 30- and 60-day initial engagement policy in non-residential settings. Currently, the 30- and 60-day (d) policy allows for reimbursable outreach and engagement activities prior to a diagnosis or assessment, though this is only available in non-residential settings, per State policy. Outreach services, billed as counseling and care coordination, are claimed once the patient's financial eligibility for services has been established. For patients who are not ready to complete the full ASAM, providers can take advantage of the 30d/60d initial engagement policy for non-residential services and provide ongoing recovery support services until the patient is ready for more intensive treatment services. While CalOMS should be completed on schedule, the 30d/60d initial engagement policy for non-residential services can serve as the basis for billing for community outreach services. R95 Focus Area 1: Outreach and Engagement and Capacity Building 2A-1, 2A-2 & 2A-3 - Formalizing New Partnerships are intended to support an agency in part to divert staff from direct services and instead cover salary expenses to find and build new referral partnerships and begin to increase the number of R95 patient admissions who do not currently have abstinence goals but want services, which is a mechanism for building these community outreach services initially outside of Medi-Cal billing. Capacity Building 2B - Expanding Field Based Services can build upon relationships established under Capacity Building 2A –Formalizing New Partnerships and leverages new community-based locations that already attract the focus population to deliver SUD treatment services. Capacity Building 2C – 30d/60d Engagement in part enables agencies to go outside of their treatment programs to engage individuals in the community and perform limited services (e.g., Individual sessions, care coordination).
2.	Why are the templates are being created after the implementation?	All templates will be created before the due dates associated with each respective capacity deliverable. Templates will serve as a point of reference for SAPC when evaluating agency's implementation in alignment with agency attestations and template submissions. It was a priority to launch the Capacity Building and Incentives (CBI) initiative with payment reform which necessitated creating forms and processes during the FY 23-24.
3.	Does setting up transportation through the Medi-Cal benefit fall under care coordination.	Yes. SAPC patients are eligible for the managed care transportation option. NEMT - Non-Emergency Medical Transport is covered by Medi-Cal.

4.	If we are using a language line during a screening is the screening activity with interpretation services reimbursable by DMC? Is TA available for solving language assistance in group settings?	The focus here should be on language assistance for screening and rapidly assessing and engaging the patient. Co-triage is a good tool to use here. The interpretation is an add-on. T1013 is the add-on code for use of interpretation services during the delivery of care. This code should be used in addition to the primary service codes (e.g., individual counseling, care coordination, etc) to indicate that service was delivered with the assistance of language interpretation services. This is an add on code with no lock outs, meaning it can be used with all primary service codes. As an add on code, it also cannot be billed individually without a primary service code. For example, if you are an SUD Counselor and used a language line to provide Spanish interpretation while administering the ASAM Co-Triage for 30 mins, you would bill 2 units of H0001 (Assessment) and add-on 2 units of T1013 (Interpretation services) onto the same claim. There is an additional $30 per unit for T1013 (Interpretation Services). Please note: Interpretation services involve language interpretation provided by another person and NOT services delivered in a 2nd language by bilingual staff. It can be used for telephonic interpretation, in person interpretation, or in-person interpretation provided by a separate bilingual staff member. Yes, TA is available. Please contact eapu@ph.lacounty.gov to receive technical assistance. Generally, it is ideal to have groups separated by language, but there are times this may not be feasible (primarily when there is only one person who speaks a different language). In this case, it is best to offer simultaneous translation with the use of headsets.
5.	My agency did not include R95 in our Invoice #1 for start -up funds. Can we still participate in R95? If yes, how do we bill as I don't see a space on Invoice #2.	Invoice #2 is in the process of being revised to include categories that were previously start up activities. To allow providers to benefit from these categories, they will be able to submit the invoice, along with supporting documentation, AFTER they've completed these actions. We will review submissions and once approved, we will issue payment.
6.	Have the due dates for any deliverables changed? **(New 12/28/23)**	Some of the deadlines have changed. Please see the most current version of the Provider R95 Meeting Calendar and Due Dates. The 12/21/23 version is posted here. For a complete list of Due Date extensions, Tier Level rate increases and additional updates across all Capacity Building Categories please review the SAPC FY23-24 Capacity Building Package here and the Invoice #2 SAPC FY 23-24 Capacity Building Deliverable Based Efforts here. Please note that SAPC is aware that on the current posted PDF document of Invoice #2 the dropdowns are not working properly, and we are actively working to correct this.
R95 – FOCUS AREA 1 OUTREACH AND ENGAGEMENT Preparation and Planning – 2A-1 (New Partner Meetings), 2A-2 (Partnership Plan), 2A-3 (MOUs)		
7.	Can we count a MOU with an agency under multiple MOU capacity building categories (2A-3, 2B-1, 2F-1)? **(New 12/28/23)**	No. Each MOU can only be counted a single time under the R95 deliverables where an MOU is a deliverable (2A-3, 2B-1, and 2F-1). As an example, if there is an MOU with "Agency X" being submitted under deliverable 2A-3 (New Partner MOU 2A-3 for Outreach and Engagement), that MOU cannot also be submitted for 2B-1 Field-Based Services Partnerships or 2F-1 Harm Reduction

		Syringe Services Program Partnerships. To receive the full set of R95 incentives for MOU deliverables, agencies should identify separate partner agencies for 2A-3, 2B-1, and 2F-1 and submit separate MOUs reflecting each partnership. Provider agencies can email sapc-cbi@ph.lacounty.gov if there are specific questions about whether a specific agency partnership can count towards which category of deliverable.
8.	Can new partner meetings (2A-1) and/or new partner MOUs be with another SAPC contracted provider? **(New 12/28/23)**	No. One SAPC provider cannot count new partner meeting(s) or new partner MOU(s) with another SAPC treatment provider for the purpose of capacity building. This is intended to be for agencies outside of the SAPC network. Provider agencies can email sapc-cbi@ph.lacounty.gov if there are specific questions about whether a specific agency partnership can count towards which category of deliverable.
9.	Can agencies establish MOU's with each other? Sometimes when a client is not working out at one site, and they move them to another site and a new environment they do better.	No, MOUs cannot be established with other SAPC contractors for the purpose of participation and compensation for 2A-3. Independent of the capacity building effort, providers can establish MOUs for this purpose.
10.	Has SAPC defined the full span of potential partners applicable to 2A-3 (Bidirectional Referrals)? Guidance notes they must be different from 2B-1 and 2F-1; FAQs suggest priority is engagement with community health and social service providers. Has there been a specific definition of ideal/applicable providers provided? **(New 12/28/23)**	The aim of 2A-3 New Partner MOU is for providers to establish agreements with local community, health and social service providers to create referral or bidirectional referral processes to better reach and enroll the 95% of individuals who need SUD treatment but who are not accessing it. The New Partner Log (2A-1) suggests the following examples for types of providers which includes but is not limited to community-based organizations, schools, government agencies, homeless services etc. Providers should also consider the populations served (e.g., young adults, persons experiencing homelessness, other underserved groups) when developing new partnerships. Providers should connect with organizations serving individuals who are at varying stages of readiness for treatment continuum, including those who are unsure if they want SUD treatment services and/or who may not be ready to cease all substance use.
11.	Do you have a template for an MOU that includes all the requirements that you can share? **(New 12/28/23)**	Each Capacity Building R95 deliverable with an MOU requirement has an accompanying MOU guidance document(s) which can be accessed on the SAPC website under Treatment Provider Meetings, R95 Workgroup Meetings. For New Partner MOU 2A-3 click here and for Guidance for Bidirectional Referrals – SUD Treatment and Harm Reduction 2F-1 click here. Guidance on the MOU requirements for Field Based Services (FBS) can be found on the recently updated Field Based Services Standards and Practices Application documents available on the SAPC website under Manuals, Bulletins and Forms under Informational Notice 23-14 here.

12.	Does the MOU for 2A-3 have to be with a site outside of the current SAPC network or can we collaborate with our local SAPC colleagues? (Ex, our facility offers robust psychiatric services and medication stabilization for higher acuity mental health concerns that seek treatment for primarily SUD. A client may be closer in proximity to another site but could benefit from traveling to our facility initially to be stabilized on medication and then transfer to a partner site for the rest of their SUD treatment.)	As one of the primary aims of Capacity Building 2A-3 is to identify new community health and social service providers in your area that serve people who may not know of your SUD services, most if not all of your MOU's for Capacity Building 2A-3 should be with a new provider.
R95 – FOCUS AREA 1 OUTREACH AND ENGAGEMENT Field-Based Service (FBS) Expansion - 2B-1 (MOU), 2B-2 (Verified Claims)		
13.	Does FBS need to be added to our Master Contract before we can participate in 2B?	Yes, a Field Based Services Application including a memorandum of understanding with the site operator must be submitted and approved by SAPC to participate in 2B (see SAPC Bulletin 19-06 for application information).
14.	What is the turn-around approval process for FBS? We are awaiting approval for one submitted back in July/August.	The turnaround time to approve complete FBS applications is 15 business days. However, incomplete applications may take longer to review, because additional information will be requested from the submitting provider. Please email SAPCMonitoring@ph.lacounty.gov if you would like a status update on your application.
15.	When would the new FBS policy be in place?	The updated Field Based Policy is expected to be completed by early December 2023. However, providers should continue to utilize the existing FBS policy as outlined under SAPC Bulletin 19-06.
16.	Would telehealth be acceptable for community referrals and potentially field-based services?	Telehealth and field-based services are different methods of delivering substance use disorder services. Establishing Memorandum of Understandings (MOU) with local health and social service providers for referral processes that result in telehealth or field-based services could be done for 2A-3. However, since telehealth and field-based services are different, telehealth may NOT be utilized to verify claims for new admissions for field-based services (2-B2).
17.	Can organizations satisfy 2B-1 (Field Based Services [FBS] MOUs) by establishing referral-based MOUs with organizations already providing field-based services? (As opposed to, or in addition to, establishing direct FBS capacity)? **(New 12/28/23)**	No. The intention of 2B-1 is to expand the number of FBS sites associated with the SAPC treatment provider that is submitting for reimbursement and where the site was specifically selected to reach and serve the R95 population with new SUD services.

18.	Can we count a MOU with an agency under multiple MOU capacity building categories (2A-3, 2B-1, 2F-1)? **(New 12/28/23)**	No. Each MOU can only be counted a single time under the R95 deliverables where an MOU is a deliverable (2A-3, 2B-1, and 2F-1). As an example, if there is an MOU with "Agency X" being submitted under deliverable 2A-3 (New Partner MOU 2A-3 for Outreach and Engagement), that MOU cannot also be submitted for 2B-1 Field-Based Services Partnerships or 2F-1 Harm Reduction Syringe Services Program Partnerships. To receive the full set of R95 incentives for MOU deliverables, agencies should identify separate partner agencies for 2A-3, 2B-1, and 2F-1 and submit separate MOUs reflecting each partnership. Provider agencies can email sapc-cbi@ph.lacounty.gov if there are specific questions about whether a specific agency partnership can count towards which category of deliverable.
R95 – FOCUS AREA 1 OUTREACH AND ENGAGEMENT 30- and 60-Day Engagement Policy – 2C-1 (Policy), 2C-2 (Verified Auths)		
19.	Has there been any further consideration about extending the initial engagement auth flexibilities to residential LOC's?	No, State policy does not currently permit initial engagement authorizations for residential LOCs, so that is not a flexibility that SAPC can offer our provider network.
20.	How should we verify medical necessity for 30–60-day authorizations- do referring agencies need credentials to authorize medical necessity for service or does a valid referral work?	Initial engagement authorizations are approved without documentation of medical necessity. The process is explained in several UM meetings., most recently at the Nov 15th meeting posted here: http://publichealth.lacounty.gov/sapc/providers/treatment-provider-meetings.htm Initial engagement authorization specific slides 21-27 cover how initial engagement authorizations work: http://publichealth.lacounty.gov/sapc/NetworkProviders/qiumpm/111523/Provider-UM-Meeting.pdf With PCNX, providers indicate which of their non-residential treatment authorizations are initial engagement authorizations on page 4 of Sage-PCNX Service Authorization Request Guide. We'll be using this PCNX radio button to manage our count on initial engagement authorizations. Initial engagement authorizations are submitted within 30 days of the initial date of service and are submitted irrespective of the source of referral.
R95 – FOCUS AREA 2 LOWERING BARRIERS TO CARE Admissions & Discharge (A&D) Policies – 2D-1 (Admission), 2D-2 (Discharge), 2D-3 (Presentation)		
21.	What is the definition of Same Day Admission?	Same Day Admission is defined as admitting someone the same day they seek services. For example, they call on Thursday and receive their first service on same Thursday.
22.	How can this be implemented with a criminal justice client with timeline deadlines from the court and probation officers' requirements of abstinence?	Similar to implementation of DMC-ODS, SAPC's position is that while treatment may be mandated by courts, the specifics of that treatment (what setting, how long, what type of treatment, etc) are based on clinical determinations made by substance use disorder (SUD) providers and not courts/judges. This is the approach taken with mental health (MH) services and there should be an equal approach taken with SUD services. If SUD agencies are asked to abide by court mandates on specifics of treatment, SAPC

		suggests highlighting this position with them and contacting SAPC so we can assist with these communications. While we expect some courts to question this approach, we have made progress after DMC-ODS implementation and also anticipate being able to achieve this more appropriate approach to SUD care delivery.
23.	We have those elements in other P&Ps (some in admissions, some in other documents) will that be okay for submission?	It is the intention that each required element in SAPC's Admission and Discharge (A&D) policy is explicitly included in participating agencies updated A&D P&P to be compensated for Capacity Building deliverables 2D-1 and 2D-2. This is because it is important that direct service staff understand each of these elements and how these key components fit together to more comprehensively engage the R95 population and other patients. If there are further agency specific questions, please direct to sapc-cbi@ph.lacounty.gov with subject "A&D Policy".
24.	How do we balance serving those who are not committed to abstinence while ensuring a drug-free environment for others in a **residential setting**?	Provider agencies are encouraged to view readiness for abstinence as continually evolving for their clients. Even clients in long-term recovery experience moments where they question their desire to maintain their abstinence, and clients who are currently using drugs will also have instances where they practice periods of abstinence and reduction in use. When SAPC encourages broadening our acceptance of individuals who are not ready for long-term abstinence, the focus is around not wanting to create barriers to accessing SUD care. This does not mean that using substances during SUD treatment is ideal or appropriate, or that discouraging use of substances is prohibited. However, having policies that require abstinence as a pre-requisite of admission or policies that result in automatic discharges for lapses and momentarily re-engaging in substance use while in treatment is what SAPC is looking to evolve/change with its R95 efforts focused on Admissions and Discharge policies. While there are unique considerations in residential settings that need to be individualized according to the circumstances of individual clients, the reality is that providers often mix these populations every day, so providers are already admitting people who are not currently practicing full sustained abstinence into their programs today. The aim in these situations is to provide pathways for clients to feel open, comfortable, and trusting with providers to share with providers where they are in their readiness for abstinence so that providers can try to move them along the readiness continuum. As is the case with all levels of care, the "R95" approach to this situation would be to: 1. Ensure that there are policies in place that not only avoid creating barriers to care, but widen the entry door into SUD treatment settings (e.g., do not require abstinence as a pre-requisite to receive services) 2. Addressing instances of problematic use of substances during treatment on a case-by-case basis that considers both the treatment of the client using substances as well as the treatment environment of others in treatment. This balance should not always result in the discharge of the individual who used substances, as there are instances when people

		lapse and use substances but are still committed to their recovery. In these instances, it can be therapeutic both for the individual client as well as their peers to demonstrate that clients can make mistakes but still be accepted by others and treated for their SUD. 3. In some instances, the discharge of people who use/relapse while in treatment is unavoidable and, in these instances, it is important for provider agencies to consider connecting them with another level of care and/or care coordination or other services, as appropriate, so as not to disconnect the client from treatment all together. For example, even if a client who used/relapsed needs to be discharged from a residential setting, an agency needs to attempt to discharge them to an outpatient setting where they can continue to receive treatment services but not in the residential environment that was too problematic and necessitated the client’s discharge. While going into a higher level of care after relapses is ideal, if the options are connecting a client who recently relapsed to a lower level of care or having the client be completely disconnected from the treatment system because they either are unwilling or unable to be cared for in a higher level of care, it is preferable to connect those clients to some treatment in the lower level of care as opposed to no treatment. Recovery Services are also an option and better than disconnecting from treatment all together. These are complex considerations that are challenging to fully address in an FAQ and will be further discussed in R95 workgroup meetings.
25.	Are we allowed to admit someone who has used in the past 24 hours?	Yes, SAPC has no restrictions on our providers admitting patients who are functionally able to participate in treatment regardless of recent substance use and are advocating to bring state policy into alignment. Should provider agencies run into any regulatory or auditor barriers with providing treatment services for people who have recently used intoxicant, please alert us.
26.	How does the State think about Residential Licensed facilities letting clients in while still using drugs? **(New 12/28/23)**	There is a distinction between admitting someone who indicates substance use in the previous 24-hours, or not discharging someone who indicates recent use (perhaps while away from the facility on a pass) but maintains a desire to continue to receive services and permitting someone to continue substance use while in residential treatment. Participation in the updated admission policy does not mean that residential providers are encouraging substance use or should permit patients to continue using substances on or off the property. SAPC will continue to engage in dialogue with agency leadership and staff to address these nuances and support enrollment of patients in the most appropriate level of care based on treatment goals.
27.	How does one distinguish what **a non-abstinence focused withdrawal management** system might look like?	Provider agencies are encouraged to view readiness for abstinence as continually evolving for their clients. Even clients in long-term recovery experience moments where they question their desire to maintain their abstinence, and clients who are currently using drugs will also have instances where they practice periods of abstinence and reduction in use. When SAPC encourages broadening our acceptance of individuals who are not ready for long-term abstinence, the focus is around not wanting to create

		barriers to accessing SUD care. This does not mean that using substances during SUD treatment is ideal or appropriate, or that discouraging use of substances is prohibited. However, having policies that require abstinence as a pre-requisite of admission or policies that result in automatic discharges for lapses and momentarily re-engaging in substance use while in treatment is what SAPC is looking to evolve/change with its R95 efforts focused on Admissions and Discharge policies. For withdrawal management, clients typically will be seeking to withdraw from the substances they are using, which often influences and may reduce the likelihood of clients using certain substances while receiving withdrawal management services. Use of substances while people are withdrawing from substances, including when medications are used as part of the withdrawal management services, can be counterproductive and even may be harmful to clients. It is important that this is meaningfully discussed with clients. Nonetheless, there will be instances when withdrawal management clients may use substances or relapse, as is the case in all other levels of care. And as is the case with all levels of care, the “R95” approach to this situation would be to: 1. Ensure that there are policies in place that not only avoid creating barriers to care, but actually widen the entry door into SUD treatment settings (e.g., do not require abstinence as a pre-requisite to receive services) 2. Addressing instances of problematic use of substances during treatment on a case-by-case basis that considers both the treatment of the client using substances as well as the treatment environment of others in treatment. This balance should not always result in the discharge of the individual who used substances, as there are instances when people lapse and use substances but are still committed to their recovery. In these instances, it can be therapeutic both for the individual client as well as their peers to demonstrate that clients can make mistakes but still be accepted by others and treated for their SUD. 3. In some instances, the discharge of people who use/relapse while in treatment is unavoidable and, in these instances, it is important for provider agencies to consider connecting them with another level of care and/or care coordination or other services, as appropriate, so as not to disconnect the client from treatment all together. For example, even if a client who used/relapsed needs to be discharged from a residential setting, an agency should consider discharging them to an outpatient setting where they can continue to receive treatment services but not in the residential environment that was too problematic and necessitated the client’s discharge. While going into a higher level of care after relapses is ideal, if the options are connecting a client who recently relapsed to a lower level of care or having the client be completely disconnected from the treatment system because they either are unwilling or unable to be cared for in a higher level of care, it is preferable to connect those clients to some treatment in the lower level of care as opposed to no treatment. Recovery Services are also an option and better than disconnecting from treatment all together.

		These are complex considerations that are challenging to fully address in an FAQ and will be further discussed in R95 workgroup meetings.
28.	How do A&D policy changes impact Class A deficiencies (the fine for those deficiencies is about $500.00 per day)?	SAPC has reviewed this State-level issue and believes there are various options to address this. While it will take time, we anticipate working with the State to make progress on this issue. Please inform SAPC Contracts and Compliance Chief, Marika Medrano, if the State issues a citation for this reason. In the meanwhile, Class A deficiencies do not conflict with the operationalization of R95 and there are ways to operationalize R95 in nuanced ways without triggering Class A concerns. For example, having policies that accept clients who are not ready for abstinence as a pre-requisite of admission or policies that do not result in automatic discharges for lapses.
29.	Do we need to update our Admission Agreement to align with the new Admission policy?	Yes, the Admission Agreement needs to be updated as applicable and attached to the Admission Policy upon submission. This has been added as an Attachment at the end of the Admission Policy. The Admission Policy template being developed as part of the R95 Initiative under Capacity Building 2-D is required to be used for agencies interested in accessing Capacity Building funds. SAPC has engaged its provider network in the development of the Admission Policy template to ensure its feasibility while still staying consistent with R95 aims. While participation in R95 and Capacity Building activities is not currently required, it is highly encouraged by SAPC.
30.	If someone comes in psychotic, due to substance use or mental health disorder, how should an agency determine the safest place for them? The challenge is over ever-increasing acuity levels, and the question are we SUD or Mental Health or are we both?	Participation in R95 does not mean SUD providers will need to provide services to patients with high mental health acuity – those will continue to need to be managed by the specialty DMH system – but if the patient is capable of participating in treatment, regardless of their mental health diagnosis, SAPC provider should admit the patient and provide treatment. The key determination if whether a client with a psychotic and/or MH condition can be safely treated in your SUD care setting is based upon an assessment of their behaviors (aggression, ability to reasonably benefit from SUD treatment, etc). If, based upon the assessment, the patient is functionally capable of participating in treatment (regardless of their diagnosis), that individual should be provided SUD setting in your care setting. It is important to recognize that a client's MH diagnosis does not directly speak to their acuity level, as diagnoses are both sometimes incorrect (especially for people with co-occurring SUD and MH conditions) and also are time dependent. Someone with a severe MH diagnosis such as schizophrenia or schizoaffective disorder can be sufficiently stable to be safely and treated in an SUD treatment setting with good clinical outcomes.

31.	Will we keep the "Drug Free Environment" Policy? Drug Free Environment is a state requirement.	SAPC has flagged the Title 9 issue as needing to get changed to establish lower barrier SUD treatment across the State. SAPC is currently exploring options and partners that can be engaged to change this policy. There are a few other regulatory changes we'd seek that address the issue of residential facilities being considered "non-medical". As far as California's Drug Free Workplace Policy, it is not clear that this is a key barrier; drug-free workplaces are able to serve people who may have drugs on them given that most places don't pad people down. It's important to distinguish between the fact that our R95 policies will not promote drug use or possession; our R95 policies will promote serving people at different levels of readiness for abstinence. The State does not require providers to discharge a client for using substances on or off site.
32.	What about the liability and the potential for civil lawsuits stemming from: residential with clients who use…triggering others, possibly putting child residents at risk, and the risk of overdose? Some clients have prison sentences hanging over their heads and DCFS cases.	These will need to be individualized responses – perhaps connecting that person with other services even if your door isn't the door for help. If we discharge people who are at risk for having overdose it doesn't reduce their risk but rather reduces the risk for them to overdose on your site. We need to interpret risk carefully whereas it has been used to justify things that don't help people. We understand the purpose of having rules in place and residential requirements. We would also like to encourage providers to have a more nuanced approach that is focused on lowering barriers. We are trying to make a shift and are actively working at state level to make modifications. SAPC has provided support to agencies in past in addressing concerns from the state and will continue to do so as needed.
33.	As counselors we cannot ethically conduct some services if person is under the influence as the client may not be able to consent to services. How do we protect ourselves as a counselor, an organization and the client?	There is not an ethical issue in treating people who are intoxicated. Our ability to determine whether a patient is intoxicated is based upon our observations of their behavior, and we do not have the ability to definitively confirm whether an intoxicant is present in the patient's body without toxicology testing. Patients are able to be treated based on their capacity to consent to and participate in treatment; being intoxicated does not universally impair a patient from consenting to treatment. Patient treatment should be aligned with the patient's functionality, not intoxication status. SAPC supports providers who incorporate ethical practice into their work and who understand the welfare and trust of their clients are dependent on a high level of professional conduct. It is our hope that providers will use a low barrier approach while navigating the process of obtaining informed consent while prioritizing what is best for the client's wellbeing.

34.	Can the R95 Policy be specifically for the R95 population and we have another Admission Policy for the criminal justice and DCFS population? **(New 12/28/23)**	No. Your agency's admission and discharge policies should be applicable to all patients in your care. To receive reimbursement for an updated admission and discharge policy, agencies must apply it to all individuals served funded by the SAPC contract, including those involved with Probation and DCFS. These policies are not inconsistent with serving individuals who consent to release information to DCFS and/or Probation and who indicate a commitment to be abstinent and participate in toxicology testing, and who also may be ambivalent about abstinence or lapse during the treatment episode. SAPC supports continued dialogue on this topic to increase provider understanding and adoption of lowering barriers to care and addressing associated implementation challenges.
35.	How do we need to update our drug testing policy to align with R95? **(New 12/28/23)**	Contracted providers can continue to have toxicology (known also as "drug" or "urinalysis") testing policies and participate in R95 efforts, however, they need to be flexible enough to address individualized patient needs. Toxicology testing is one available (but not required) tool that can be offered alongside other clinical interventions, and toxicology testing is not a required prerequisite to patient's achieving their treatment goals and/or to demonstrate treatment progress. For example, every patient may not need to submit to toxicology testing as a part of treatment participation, while others may request or be required (if authorized via consent to release information) as part of an agreement with Probation or DCFS. The toxicology testing policy just needs to outline what is done under these circumstances.
36.	Is SAPC going to submit admission and discharge policies for DHCS review and/or approval? **(New 12/28/23)**	No. SAPC has communicated with DHCS on the local R95 initiative and DHCS is supportive of establishing lower barrier access to care. SAPC should be contacted if State representatives indicate concern or cite agencies as a result of implemented changes.
R95 – FOCUS AREA 2 LOWERING BARRIERS TO CARE Service Design - 2E-1 (Service Design), 2E-2 (Customer Walk-Through), 2E-3 (Plan)		
37.	Are treatment providers who are also harm reduction sites still eligible for this incentive?	Yes, when the site(s) used as part of the Service Design component of the R95 Initiative is also a treatment site.
R95 – FOCUS AREA 2 LOWERING BARRIERS TO CARE Bidirectional Referrals – 2F-1 (MOU), 2F-2 (Verified Claims)		

38.	Can providers partner with other SAPC treatment providers for Bidirectional Referrals 2F-1 Executed MOU?	Yes. Partnerships resulting in executed Memoranda of Understanding (MOUs) with SAPC certified harm reduction syringe services program are essential to success in bidirectional referrals. SAPC is working to facilitate conversations between treatment providers and SAPC-certified harm reduction syringe services programs to help support this process. Specifically, SAPC contracted substance use treatment agencies who also have SAPC-certified harm reduction syringe services programs are permitted to submit the policies and procedures demonstrating their internal coordination of referrals and services between substance use treatment programs and internal harm reduction syringe services programs in lieu of one MOU towards the 2F-1 incentive units *only* when they have established MOU's with one fewer than the maximum number of MOUs of external partners listed in the current version of R95 Capacity Building Package. SAPC's Harm Reduction Syringe Services Program (SSP) Certification process is described in an information notice posted on http://publichealth.lacounty.gov/sapc/providers/manuals-bulletins-and-forms.htm?tm#bulletins (currently SAPC-IN 22-09 Harm Reduction Syringe Services Program Certification
39.	Most of them answer to a Board of Directors and large constituency groups. They would rather not have their agencies spend time putting out fires that could be avoided through preemptive conversations and trainings with leadership and staff.	It is still on SAPC's radar to have discussions with provider agency Board of Directors. SAPC understands that no one wants used syringes in parks and parking lots but notes that they can work with local officials and EOP hubs. SAPC may also be able to provide additional support with trainings.
40.	Are harm reduction providers aware that treatment agencies will be reaching out? **(New 12/28/23)**	Yes. SAPC's contracted harm reduction syringe services programs have been informed of this initiative. If you have reached out on more than one occasion and have not received a response, please email HarmReduction@ph.lacounty.gov with the names of the agencies and brief description of your existing outreach. SAPC's Harm Reduction Section can assist with facilitating connections with LA County certified harm reduction syringe services programs.
41.	Can we count a MOU with an agency under multiple MOU capacity building categories (2A-3, 2B-1, 2F-1)? **(New 12/28/23)**	No. Each MOU can only be counted a single time under the R95 deliverables where an MOU is a deliverable (2A-3, 2B-1, and 2F-1). As an example, if there is an MOU with "Agency X" being submitted under deliverable 2A-3 (New Partner MOU 2A-3 for Outreach and Engagement), that MOU cannot also be submitted for 2B-1 Field-Based Services Partnerships or 2F-1 Harm Reduction Syringe Services Program Partnerships. To receive the full set of R95 incentives for MOU deliverables, agencies should identify separate partner agencies for 2A-3, 2B-1, and 2F-1 and submit separate MOUs reflecting each partnership. Provider agencies can email sapc-cbi@ph.lacounty.gov if there are specific questions about whether a specific agency partnership can count towards which category of deliverable.