B. PROVIDING DMC-ODS SERVICES

The County of San Diego Drug Medi-Cal Organized Delivery System (DMC-ODS) provides access to a full continuum of SUD benefits modeled after the American Society of Addiction Medicine (ASAM) Criteria. This approach is expected to provide clients with access to the care and services they need for a sustainable and successful recovery.

The goal of the ASAM Criteria is to improve assessment and outcomes-driven treatment and recovery services. It is also used to match clients to appropriate types and levels of care.

Generally speaking, ASAM criteria are used to ensure the client receives the appropriate level of care in the correct program at the right time. The guiding principles of ASAM criteria are:

- Moving from one-dimensional to multi-dimensional assessments
- Moving from program-driven to clinical-driven and outcomes-driven treatment
- Moving from fixed length of service to variable length of service
- Moving from a limited number of discrete levels of care to a broad and flexible continuum of care
- Identifying adolescent-specific needs
- Clarifying the goals of treatment
- Not using previous "treatment failure" as an admission prerequisite
- Moving toward an interdisciplinary approach to care

For more information about DMC-ODS levels of care and services, see the following documentation guide:

- SUD Clinical Documentation Guide

Levels of Care

Early Intervention (ASAM Level 0.5)
Early intervention services are covered for members under the age of 21. Any member under age 21 who is screened and determined to be at risk of developing an SUD may receive any service component covered under the outpatient level of care as early intervention services. Early intervention services are provided under the outpatient treatment modality and must be available as needed based on individual clinical need, even if the member under age 21 is not participating in the full array of outpatient treatment services.

A full assessment utilizing the ASAM Criteria© is not required for a member under the age of 21 to receive early intervention services; an abbreviated ASAM screening tool may be used.

- If the member under 21 meets diagnostic criteria for SUD, a full ASAM assessment shall be performed, and the member shall receive a referral to the appropriate level of care indicated by the assessment.
- Services may be delivered in a wide variety of settings, and can be provided in person, by telehealth, or by telephone. Nothing in this section limits or modifies the scope of the EPSDT mandate.

Early Intervention Model

- May be embedded in TRCs and their respective school sites and in other programs that serve clients under 21 years of age.

- 0.5 services are separate from TRC and other treatment services
- Includes school-based programs which often include education, skills training, and counseling for students and their family members
- Services include assessment, education, screening, brief intervention, and referral to treatment (SBIRT), other interventions aimed at reducing or preventing substance misuse, care coordination
- Service durations are individualized from one to multiple sessions
- Utilize a variety of evidence-based curricula available and approved for 0.5 level of care

Outpatient Services, OS (ASAM Level 1)

In this level of care, clients receive up to nine hours a week for adults and less than six hours a week for adolescents when determined by a Medical Director or LPHA to be medically necessary. Services may exceed the maximum based on individual medical necessity. Services may be provided in person, by telehealth, or by telephone.

These services shall include:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- MAT for Opioid Use Disorder (OUD)
- MAT for Alcohol Use Disorder (AUD) and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

County is required to either offer medications for addiction treatment directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for members while they are receiving outpatient treatment services if not provided on-site. Providing a member, the contact information for a treatment program is insufficient. County shall monitor the referral process or provision of MAT services.

Intensive Outpatient Services, IOS (ASAM Level 2.1)

In IOS, adult clients receive a minimum of nine hours up to a maximum of 19 hours per week, when determined by a Medical Director or LPHA to be medically necessary. Services may exceed the maximum based on individual medical necessity. Adolescents receive a minimum of six hours up to a maximum of nineteen hours a week when determined by a Medical Director or LPHA. Services may exceed the maximum based on individual medical necessity. Services may be provided in person, by telehealth, or by telephone. Intensive outpatient services shall include:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- MAT for Opioid Use Disorder (OUD)
- MAT for Alcohol Use Disorder (AUD) and other non-opioid SUDs
- Patient Education

- Recovery Services
- SUD Crisis Intervention Services

County is required to either offer medications for addiction treatment directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for members while they are receiving outpatient treatment services if not provided on-site. Providing a member, the contact information for a treatment program is insufficient. County shall monitor the referral process or provision of MAT services.

Residential Services (ASAM Level 3.1, 3.5)
Level 3.1 clinically managed, low-intensity residential services are designed to prepare clients for a successful transfer to outpatient treatment services. Clients meeting criteria for Level 3.1 have an impaired ability to practice recovery skills and sustain change behaviors outside of a 24-hour structured setting. Clients are open to recovery and may have some knowledge of relapse prevention, however their ability to structure daily life in an outside environment requires additional skill building and the development of community supports to prevent relapse. Treatment goals for a client meeting criterion for 3.1 may include learning and practicing coping skills, building community connections, relapse prevention, self-efficacy, and an improved ability to structure and organize tasks of daily living. Services are driven by the member's care needs and shall be transitioned to other levels of care when clinically appropriate and served in the least restrictive setting; services shall address functional deficits documented in the ASAM Criteria©, aimed to restore, maintain, and apply interpersonal and independent living skills and access community support systems. Services include:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- MAT for OUD
- MAT for AUD and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

The average statewide length of stay goal is 30 days; however, this is not a quantitative treatment limitation and there is no hard "cap" on individual length of stays. Lengths of stay shall be determined by individualized clinical need. Members shall be transitioned to appropriate levels of care as medically necessary. County shall adhere to length of stay monitoring requirements established by DHCS and the external quality review organization.

In a Level 3.1 program, clients must receive 20 hours a week of structured activities. Of those 20 hours, 5 of them must be clinical services (defined as individual counseling, group counseling, family therapy, collateral services, crisis intervention, treatment planning, or discharge services).

In order for residential treatment to be reimbursed on a daily basis, there needs to be one service per day.

Level 3.5 clinically managed, high-intensity residential services are designed to prepare clients for a successful transfer to lower intensity treatment services. Clients meeting criteria for Level 3.5 have severe, unstable SUD symptoms, functional impairments, demonstrate a repeated inability to control impulses, and are in imminent danger of substance use outside of a 24-hour structured setting. Level 3.5 services sufficiently address complex needs, including significant emotional, behavioral, or cognitive conditions related to a mental health disorder. Clients receiving level 3.5 services have limited coping skills and an outside living environment that is highly conducive to substance use. Treatment services are comprehensive and address severe instability as a result of an SUD, and contributing issues which may include justice-involvement, a personality disorder, antisocial values and other maladaptive behaviors. Treatment goals include stabilization, the development of prosocial behaviors, and relapse prevention skills. Services are driven by the member's care needs and shall be transitioned to other levels of care when clinically appropriate and served in the least restrictive setting; services shall address functional deficits documented in the ASAM Criteria©, aimed to restore, maintain, and apply interpersonal and independent living skills and access community support systems. Services include:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- MAT for OUD
- MAT for AUD and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

The average statewide length of stay goal is 30 days; however, this is not a quantitative treatment limitation and there is no hard "cap" on individual length of stays. Lengths of stay shall be determined by individualized clinical need. Members shall be transitioned to appropriate levels of care as medically necessary. County shall adhere to length of stay monitoring requirements established by DHCS and the external quality review organization.

Like a Level 3.1 program, clients in a Level 3.5 residential program must receive 20 hours a week of structured activities. However, of those 20 hours, 10 hours must be clinical services (defined as individual counseling, group counseling, family therapy, collateral services, crisis intervention, treatment planning, or discharge services).

Like a level 3.1 program, in order for residential treatment to be reimbursed on a daily basis, there needs to be a one service per day.

Residential Services (ASAM Level 3.3)

Level 3.3 clinically managed, Population Specific High-Intensity residential services are designed to meet the functional limitations of patients to support recovery from substance-related disorders. Clients meeting criteria for Level 3.3 the effects of the substance use or other addictive disorder or a co-occurring disorder resulting in cognitive impairment on the individual's life are so significant, and resulting level of impairment so great, that outpatient motivational and/ or relapse prevention strategies are not feasible or effective. The patient's cognitive limitations make it unlikely that he or she would benefit from other levels of residential care. The functional limitations seen individuals who are appropriately places at level 3.3 are primarily cognitive and can be either temporary or permanent.

24-hour case with trained and residential personnel providing clinical directed less intense program activities and professional directive treatment to stabilize and maintain SUD symptoms and to develop and apply recovery skills specific for individuals with cognitive or other functioning impairments.

Level 3.3 programs generally are considered to deliver high intensity services, which may be provided in a deliberately repetitive fashion to address the special needs of individuals for whom a Level 3.3 program is considered medically necessary. Such individuals often are elderly, cognitively impaired or developmentally delayed, or are these for whom the chronicity and intensity of the primary disease process required a program that allows sufficient time to integrate the lessons and experiences of treatment into their daily lives. Typically, they need a slower pace of treatment because of mental health problems or reduced cognitive functioning, or because of the chronicity of their illness. Reintegration of patients in a level 3.3 program into the community requires case management activities directed toward networking patients into community-based ancillary or "wrap around" service such as housing, vocational services, or transportation assessment so that they are able to attend activities after discharge.

Services include:

- Consultation with physician, physician assistant or nurse practitioner and emergency services 24 hours a day.
- Coordination with less intensive levels of care and other services such as supportive employment, literacy training, and adult education.
- Medical, psychiatric, psychological, laboratory and toxicology services, available through consultation or referral as appropriate.
- Assessment
- Care Coordination
- Counseling (individual and group)
- Regular monitoring of resident's medication adherence
- Education on benefits of MAT
- Recovery Services

Clients in a Level 3.3 residential program must a minimum of 5 hours per week of clinical services specific for individuals with cognitive or other functioning impairments (defined as individual counseling, group counseling, family therapy, collateral services, crisis intervention, treatment planning, or discharge services).

Withdrawal Management

Withdrawal management services are also provided on a continuum, including ambulatory and non-

ambulatory WM services, consistent with ASAM levels of care and client-specific needs. WM services focus on the stabilization and management of psychological and physiological symptoms associated with withdrawal, engagement in care and effective transitions to a level of care where member can receive comprehensive treatment services.

For additional information regarding Withdrawal Management and ASAM Levels of Care, please see the ASAM Level of Care (LOC) Determination Guidelines in Appendix B.1 and the Withdrawal Management (WM) Standards posted on the Optum site under Toolbox.

The levels of Withdrawal Management are as follows:

Ambulatory Withdrawal Management (ASAM Level 1-WM)
WM services are provided as a part of a continuum of care to members experiencing withdrawal in the following outpatient, residential, and inpatient settings. Member shall be monitored during the detoxification process. Services are urgent and provided on a short-term basis. A full ASAM Criteria© assessment shall not be required as a condition of admission to a facility providing WM. Service activities focus on the stabilization and management of psychological and physiological symptoms associated with withdrawal, engagement in care and effective transitions to a level of care where member can receive comprehensive treatment services.

Level 1-WM: Ambulatory withdrawal management without extended on-site monitoring (Mild withdrawal with daily or less than daily outpatient supervision). Service components include:

- Assessment
- Care Coordination
- Medication Services
- MAT for OUD
- MAT for AUD and other non-opioid SUDs
- Observation
- Recovery Services

WM services are urgent and provided on a short-term basis. Practitioner shall conduct a full ASAM Criteria© assessment, brief screening, or other tools to support referral to additional services as appropriate. If a full ASAM Criteria© assessment was not completed as part of the withdrawal management service episode. Receiving program shall adhere to initial assessment timeliness requirements.

Medication Assisted Treatment (MAT) Providers must offer MAT directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for members while they are receiving partial hospitalization services if not provided on-site (Providing a member the contact information for a treatment program is insufficient).

Ambulatory Withdrawal Management with extended on-site monitoring (ASAM Level 2-WM)
WM services are provided as a part of a continuum of care to members experiencing withdrawal in the following outpatient, residential, and inpatient settings. Member shall be monitored during the detoxification process. Services are urgent and provided on a short-term basis.

A full ASAM Criteria© assessment shall not be required as a condition of admission to a facility providing WM. Service activities focus on the stabilization and management of psychological and physiological symptoms associated with withdrawal, engagement in care and effective transitions to a level of care where member can receive comprehensive treatment services.

Level 2-WM: Ambulatory withdrawal management with extended on-site monitoring (Moderate withdrawal with daytime withdrawal management and support and supervision in a non-residential setting). Service components include:

- Assessment
- Care Coordination
- Medication Services
- MAT for OUD
- MAT for AUD and other non-opioid SUDs
- Observation
- Recovery Services

WM services are urgent and provided on a short-term basis. Practitioner shall conduct a full ASAM Criteria© assessment, brief screening, or other tools to support referral to additional services as appropriate. If a full ASAM Criteria© assessment was not completed as part of the withdrawal management service episode. Receiving program shall adhere to initial assessment timeliness requirements.

Medication Assisted Treatment (MAT) Providers must offer MAT directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for members while they are receiving partial hospitalization services if not provided on-site (Providing a member the contact information for a treatment program is insufficient).

Clinically Managed Residential Withdrawal Management (ASAM Level 3.2-WM)
This is an organized service delivered by an appropriately trained staff member who provides 24-hour supervision, observation, and support for clients who are intoxicated or experiencing withdrawal. Programs providing ASAM 3.2 – WM are strongly encouraged to obtain an Incidental Medical Service (IMS) license through DHCS. This level provides services for client's whose intoxication/withdrawal signs and symptoms are sufficiently severe to require 24-hour structure and support. The clinical components of this level of care include the necessary services for assessment and medication or non-medication withdrawal management, support, services to families and significant others and referrals for ongoing support or transfer planning.

Medically Managed Intensive Inpatient Withdrawal Management (ASAM Level 4-WM)
County may voluntarily cover and receive reimbursement through DMC-ODS program for inpatient ASAM Levels 3.7 and 4.0 delivered in general acute care hospitals. Regardless of whether County covers these levels of care, the County must have a clearly defined referral mechanism and care coordination for these levels of care. DHCS All-Plan Letter 18-001 clarifies coverages of voluntary inpatient detoxification through the Medi-Cal Fee-for-Service program. A member shall live on the premises and considered a "short-term resident" of the inpatient facility where the member receives services under this DMC-ODS level of care.

Treatment services under these levels are provided by DMC-certified providers who must be licensed and enrolled in accordance with all applicable state and federal laws and regulations. This includes residential facilities licensed by DHCS, residential facilities licensed by the DHCS, residential facilities licensed by the Department of Social Services, Chemical Dependency Recovery Hospitals (CDRHs) licensed by the Department of Public Health or freestanding Acute Psychiatric Hospitals (FAPHs) licensed by Department of Public Health (DPH).

Services shall address functional deficits documented in the ASAM Criteria© and are aimed to restore, maintain, and apply interpersonal and independent living skills and access community support systems. Services may be provided in person, by telehealth, or by telephone. Most services shall be in person. Telehealth and telephone services shall be used to supplement, not replace, the in-person services and in-person treatment milieu. Services are driven by the member's care needs and shall be transitioned to other levels of care when clinically appropriate and served in the least restrictive setting. Service components include:

- Assessment
- Care Coordination
- Counseling (individual and group)
- Family Therapy
- Medication Services
- MAT for OUD
- MAT for AUD and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services

Providers must offer MAT directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for members while they are receiving partial hospitalization services if not provided on-site. Providing a member the contact information for a treatment program is insufficient). County shall monitor the referral process or provision of MAT services.

The average statewide length of stay goal is 30 days; however, this is not a quantitative treatment limitation and there is no hard "cap" on individual length of stays. Lengths of stay shall be determined by individualized clinical need. Members shall be transitioned to appropriate levels of care as medically necessary. County shall adhere to length of stay monitoring requirements established by DHCS and the external quality review organization.

Narcotic Treatment Program (NTP)-ASAM Level 1.0
Narcotic Treatment Program (NTP), also described in the ASAM Criteria© as an Opioid Treatment Program (OTP), is an outpatient program that provides Food and Drug Administration (FDA)-approved medications and biological products to treat SUDs when ordered by a physician as medically necessary. NTPs are required to administer, dispense, or prescribe medications to members covered under the DMC-ODS formulary. NTPs shall comply with all federal and state NTP licensing requirements. If the NTP cannot comply with all federal and state NTP requirements, then the NTP must assist the member in choosing another MAT provider, ensure continuity of care, and facilitate a warm hand-off to ensure engagement. NTP services are provided in DHCS-licensed NTP facilities pursuant to the California Code

of Regulations, title 9, Chapter 4, and Title 42 of the Code of Federal Regulations (CFR).

NTPs are required to administer, dispense, or prescribe medications to members covered under the DMC-ODS formulary including:

a. Methadone
b. Buprenorphine (transmucosal and long-acting injectable)
c. Naltrexone (oral and long-acting injectable)
d. Disulfiram
e. Naloxone
f. If the NTP is unable to directly administer or dispense medically necessary medications covered under the DMC-ODS formulary, the NTP must prescribe the medication for dispensing at a pharmacy or refer the member to a provider capable of dispensing the medication.

Service components include:

- Assessment
- Care Coordination
- Counseling (individual and group)
    - Counseling services- minimum of forty-five (45) minutes per calendar month
    - Counseling services may be provided in-person, by telehealth, or by telephone
- Family Therapy
- Medical Psychotherapy
- Medication Services
- MAT for OUD
- MAT for AUD and other non-opioid SUDs
- Patient Education
- Recovery Services
- SUD Crisis Intervention Services
- Medical evaluation for methadone treatment
    - Medical history
    - Laboratory tests
    - Physical exam
    - Medical evaluation must be conducted in-person

In accordance with CCR Title 9 10270(c)(3), clients under the age of 16 years can enter detoxification treatment if they have the written consent of their parent(s) or guardian prior to the administration of the first medication dose. In accordance with CCR Title 9 10270(d)(3), the client would need to be 16 years of age to receive maintenance treatment. A licensed NTP does have the option of submitting a SMA-168 Exception Request through the SAMHSA/CSAT Opioid Treatment Program Extranet if a client under 16 years is in need of maintenance treatment. When serving a minor, the contractor shall provide a written summary, guardian consent, and SMA-168 Exception Request and results to the Children Youth and Families Supervising Psychiatrist and the COR.

NTP provides, at minimum, 45 minutes of counseling sessions with a therapist or counselor for up to 200 minutes per calendar month. The medical director may adjust or waive at any time after admission, by medical order, the minimum number of minutes of counseling services per calendar month. The medical director shall document the rationale for the medical order to adjust or waive counseling services in the

patient's care plan. If medical necessity is met that requires additional NTP counseling beyond 200 minutes per calendar month, NTP subcontractors may bill and be reimbursed for additional counseling.

Effective 7/1/2021, prior to admission of detox or maintenance treatment, the client evaluation must include the following lab tests. See DHCS Info Notice 20-050 for more information.

- Oxycodone and fentanyl
- Hep C
- HIV testing must be offered

There are three options for NTPs to provide MAT to incarcerated members under BHIN 25-034. The purpose of this behavioral health information notice is to provide treatment options and requirements for incarcerated members diagnosed with an opioid use disorder (OUD) .

- Provision of MAT via a Medication Unit (MU) or Mobile Narcotic Treatment Program (MNTP)
- Provision of MAT via Courtesy Dosing
- Provision of MAT by Authorized correctional facility Staff

Medication Assisted Treatment (MAT)

Research has shown that for the treatment of addiction, a combination of medications and behavioral therapies is more successful than either intervention alone. Subsequently, medication-assisted treatments (MAT) must be part of a comprehensive, whole-person approach to the treatment of a SUD that includes psychosocial interventions like counseling, behavioral therapies, case management, and care coordination. Providers shall not discourage the use of FDA approved addiction medications as part of this comprehensive, whole-person approach to the treatment of a SUD. Similarly, providers shall not deny services based solely on the fact that the clients are taking prescribed medication, regardless of the type of medication. Programs shall directly offer MAT to members with SUD diagnoses that are treatable with FDA-approved medications and biological products in oral, transmucosal, and long-acting injectable forms. For more information, see the NTP section.

Providers must offer MAT directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for members while they are receiving partial hospitalization services if not provided on-site. Providing a member the contact information for a treatment program is insufficient). County shall monitor the referral process or provision of MAT services.

Additional MAT

Additional MAT services may include the ordering, prescribing, administering, and monitoring of all medications for substance use disorders for programs contracted to provide additional MAT. Medically necessary services are provided in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber.

Scope of Practice

Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. For example, DHCS has clarified that although RNs are considered LPHAs, they are not permitted to determine a SUD diagnosis because it is not within their scope of practice. Therefore, programs shall not use a RN as a LPHA to identify a diagnosis. Diagnostic determination shall be made by an LPHA.

Service Descriptions

Intake/Assessment

An intake/assessment session is the process of admitting a client into substance use disorder treatment program. The intake/assessment includes the evaluation of the cause and nature of mental, emotional, psychological, behavioral, and substance use disorders. Intake occurs upon admission to the program on the first day of treatment. The assessment continues the process of the intake to further evaluate the client to determine the diagnoses and individual service needs utilizing the ASAM criteria and YAI for youth. In the treatment of persons with a SUD, assessments are an essential and ongoing process in order to help the provider focus their service delivery to best meet the individual client needs. Practitioners shall use the American Society of Addiction Medicine (ASAM) to determine the appropriate level of SUD treatment service.

Consists of activities to evaluate or monitor the status of a member's behavioral health and determine the appropriate level of care and course of treatment for that member. Assessments shall be conducted in accordance with applicable State and Federal laws, and regulations, and standards. Assessment may be initial and periodic and may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the member. Assessment services may include one or more of the following components:

- Collection of information for assessment used in the evaluation and analysis of the cause or nature of the substance use disorder.
- Diagnosis of substance use disorders utilizing the current DSM and assessment of treatment needs for medically necessary treatment services. This may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for treatment and evaluation conducted by staff lawfully authorized to provide such services and/or order laboratory testing (laboratory testing is covered under the "Other laboratory and X-ray services" benefit of the California Medicaid State Plan).
- Treatment planning, a service activity that consists of development and updates to documentation needed to plan and address the member's needs, planned interventions and to address and monitor a member's progress and restoration of a member to their best possible functional level.

For more information about assessments, see Section D: Practice Guidelines.

Group Counseling

Group counseling sessions are designed to support discussion among clients with guidance from the facilitator to support understanding and encourage participation on psychosocial issues related to substance use. Group counseling sessions need to utilize evidence-based practices.

Individual Counseling

Consists of contacts with a member. Individual counseling can include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the member by supporting the achievement of the member's treatment goals.

Family Therapy

Family therapy is a rehabilitative service that includes family members in the treatment process, providing education about factors that are important to the member's recovery as well as the holistic recovery of the family system. Family members can provide social support to the member and help motivate their loved

one to remain in treatment. There may be times when, based on clinical judgment, the member is not present during the delivery of this service, but the service is for the direct benefit of the member.

Collateral Services

Collateral services are sessions between significant persons in the life of the client and SUD counselors or LPHA's. Significant persons are individuals that have a personal, not official or professional relationship (e.g., teachers or probation officers) with the client. These sessions are used to obtain useful information regarding the client to support their recovery. The client may be present, but it is not a requirement that the client is present. A progress note must document each session in the client's chart.

Crisis Intervention

Consists of contacts with a member in crisis. A crisis means an actual relapse or an unforeseen event or circumstance which presents to the member an imminent threat of relapse. SUD Crisis Intervention Services shall focus on alleviating the crisis problem, be limited to the stabilization of the member's immediate situation and be provided in the least intensive level of care that is medically necessary to treat their condition.

Care Coordination

Care coordination was previously referred to as "case management" for the years 2015-2021. Care coordination shall be provided in conjunction with *all* levels of treatment. Service components include one of more of the following:

a. Coordinating with medical and mental health care providers to monitor and support comorbid health conditions.
b. 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.
c. 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.

Care Coordination may also be delivered and claimed as a standalone service in a DMC-ODS County. Services can be provided in clinical or non-clinical settings, including the community. Services may be provided in-person, by telehealth, or by telephone. Care coordination services shall be provided with other SUD, physical, and/or mental health services in order to ensure a client-centered and whole-person approach to wellness.

Note: There is not a separate billing code for care coordination services, so these types of activities are billed to "Case Management."

For more information, see Section D: Practice Guidelines.

Discharge Planning

Discharge planning is the process of preparing the client to transition from the current services to another level of care or out to return to the Community. Discharge planning should begin at the onset of treatment services. This ensures sufficient time to plan and prepare the client for change. It also assists in conveying

the concept that recovery is an ongoing life process and not a single event or service. Discharge planning sessions are defined as face-to-face contact between one SUD counselor, or LPHA and one client at the same time. The Discharge Summary is a narrative summary that summarizes the treatment experience. Note: For details on documentation requirements for these services, please refer to the section on Documentation.

Recovery Services

Recovery Services are available for all clients and can be delivered and claimed as a standalone service, concurrently with other levels of care and immediately after incarceration with a prior diagnosis of SUD. Clients can receive recovery services immediately after leaving incarceration, whether or not they received SUD treatment during their incarceration. The last treatment provider of care will serve as the default provider of Recovery services, unless necessary services are not offered, or the client prefers a change in provider. These services can be delivered by either an SUD counselor, or LPHA and will be offered after completion of a treatment episode. Recovery Services shall not be denied to clients based on relapseor continued substance use, although assessment for appropriate level of care may be needed when client substance use patterns have changed.

Clients may receive recovery services concurrently with other DMC services and levels of care as clinically indicated. Clients receiving MAT, including NTP services, may receive recovery services.

Recovery Services include outpatient individual or group counseling (relapse prevention), peer support services, recovery monitoring/coaching, care coordination/linkages to education and job skills services, family support (i.e., childcare, parent education, etc.), support groups, and other linkages (such as to housing, transportation, etc.) Recovery services are provided either face-to-face, by telephone, or by telehealth, and in any appropriate setting in the community with the member. Providers may accept Recovery Service clients from other treatment programs. If a client is accessing Recovery Services within 90 days of concluding their treatment phase, the Adult ASAM Criteria Assessment is not required but should be reviewed if within the same program. If a client is accessing Recovery Services more than 90 days after concluding their treatment phase, the Adult ASAM Criteria Assessment form shall be completed.

Recovery Services shall be utilized when the member is triggered, when the member has relapsed, or simply as a preventative measure to prevent relapse. Recovery Services are designed to support recovery and prevent relapse with the objective of restoring the member to their best possible functional level. Recovery Services emphasize the member's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to members. Members may receive Recovery Services based on self assessment or provider assessment of relapse risk. Members do not need to be diagnosed as being in remission to access Recovery Services. Additionally, recovery services are provided based on medical necessity.

For more information:

- See Care Coordination for expectations for offering Recovery Services to clients.

Clinical Consultation

Clinician Consultation is not a direct service provided to DMC-ODS members. Rather, Clinician Consultation is designed to support DMC-ODS licensed clinicians with complex cases and may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. It includes consultations between clinicians designed to assist DMC clinicians with seeking

expert advice on treatment needs for specific DMC-ODS members. DMC-ODS Counties may contract with one or more physicians, clinicians, or pharmacists specializing in addiction in order to provide consultation services. These consultations can occur in person, by telehealth, by telephone, or by asynchronous telecommunication systems.

The Center Substance Use Management team at UCSF provides free peer-to-peer consultation from physicians, clinical pharmacists, and nurses with special experts in substance use evaluation and management. Advice on all aspects of substance use management is provided, including:

- Assessment and treatment of opioid, alcohol, and other substance use disorders
- Approaches to suspected misuse, abuse, or diversion of prescribed opioids
- Methods to simplify opioid-based pain regimens to reduce risk of misuse and toxicity
- Urine toxicology testing – when to use it and what it means
- Use of buprenorphine and the role of methadone maintenance
- Withdrawal management for opioids, alcohol, and other CNS depressants
- Harm reduction strategies and overdose prevention
- Managing substance use in special populations (pregnancy, HIV, hepatitis)
- Productive ways of discussing known or suspected addiction with clients

This service does not occur in real-time, so is not appropriate for emergent and/or urgent consultation needs. Cases may be submitted for consultation via internet at the UCSF Clinical Consultation Center website http://nccc.ucsf.edu/clinician-consultation/substance-use-management/ or by calling Monday-Friday, 9 a.m. – 8 p.m. EST at 855-300-3595.

Clinician services are strictly limited to routine consultation requests. Emergent and urgent consultation needs should be directed to more appropriate resources (e.g., emergency department, psychiatric emergency services, etc.).

All local, state, and federal confidentiality requirements involving HIPAA and 42 CFR Part 2 will be followed during the Clinician Consultation process.

Peer Services

Peer Support Services may be provided face-to-face, by telephone or by telehealth with the member or significant support person(s) and may be provided anywhere in the community.

Peer Support Services include the following service components:

- **Educational Skill Building Groups** means providing a supportive environment in which members and their families learn coping mechanisms and problem-solving skills in order to help the members achieve desired outcomes. These groups promote skill building for the members in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.
- **Engagement** means Peer Support Specialist led activities and coaching to encourage and support members to participate in behavioral health treatment. Engagement may include supporting members in their transitions between levels of care and supporting members in developing their own recovery goals and processes.
- **Therapeutic Activity** means a structured non-clinical activity provided by a Peer Support

Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the member's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the member; promotion of self-advocacy; resource navigation; and collaboration with the members and others providing care or support to the member, family members, or significant support persons.

Housing Needs & DMC-ODS

Recovery Residences

Recovery Residences (also known as Sober Livings) are privately-owned homes or complexes that provide transitional housing for adults actively receiving SUD Outpatient Treatment Services or Recovery Services. (On rare occasions, clients actively receiving SUD Residential Recovery Services that do not meet ASAM criteria for Residential or Outpatient Services or who decline Outpatient Services may also be referred to Recovery Residences). Recovery Residences serve residents who are in need of a recovery oriented, supportive housing environment. Recovery Residences serve as a housing option for clients who are homeless and/or in unsafe living environments.

The County has contracted with CHIP (Community Health Improvement Partners) to develop a Recovery Residence Association (RRA) to provide oversight and support for our local Recovery Residences, their proprietors, owners, and clients to ensure the highest quality of living environment and to address any issues that may arise. They will identify and implement a training curriculum and a set of quality standards and best practices for Recovery Residences that are part of RRA. BHS Providers are encouraged to use Recovery Residences that are part of the RRA.

Recovery Residence supplemental funding is an option for clients who are receiving treatment at a DMC-ODS outpatient or residential program. Refer to Recovery Residences – Supplemental Funding Guidelines posted on the Optum site for more details on the requirements and maximum costs. County reimbursement is only available for daily utilized beds. It is important to note supplemental funding for Recovery Residences should only be utilized when other safe housing options (e.g., supportive family residence) are not readily available for the client. Recovery Residence funding can also be used on a case-by-case basis for immediate short-term/time limited housing (e.g., motel) needs when a client is at risk and there is a delay in transitioning them to a stable long-term recovery residence. Programs should contact their COR for approval in these circumstances.

Programs are responsible for having an active MOU/MOA with recovery residence providers and shall monitor compliance of the recovery residence annually to ensure treatment services are not provided in recovery residences and that the recovery residence locations are secure, safe, and alcohol/drug free. Evidence of required monitoring shall be made available to the County upon request.

Please note: For CalOMS reporting of living arrangements, clients residing in a recovery residence should be reported in the dependent living category. See CalOMS Tx Collection Guide for more information.

Outreach Services

Documentation of Outreach Services

Documentation of providers' outreach services shall be made available in the event of a County audit.

General and Injection Drug User (IDU) Alcohol and Drug Outreach Services
Providers shall conduct outreach to individuals experiencing substance use disorders problems, with special attention to reaching injection drug users and helping them to access treatment and recovery services.

Information and Education
Providers shall provide information and education to prevent and minimize the health risks of substance use disorders. Providers shall promote awareness about the relationship between substance use and the personal health risks of communicable disease such as Sexually Transmitted Infections (STIs) and Human Immunodeficiency Virus (HIV) and, for pregnant women, the relationship between substance use and the risks to their children.

Homeless Shelter Outreach Services
Providers shall make available staff or volunteer participation in regional homeless shelter outreach services throughout the year. To assist members who are homeless please see link: Get Help - Regional Task Force on Homelessness.

Homeless Outreach Worker Services
The target population for the provision of Homeless Outreach Services are individuals who are homeless and may have a serious mental illness and/or substance use disorder. Homeless Outreach consists of the following services:

- Outreach and engagement
- Screening for mental health, physical health, and substance use disorders
- Linkage to services which may include:
    - Mental Health
    - Substance Use Disorder
    - Physical Health
    - Social Services
    - Housing
    - Employment Services
    - Advocacy
    - Other services as indicated
- Referral and placement in emergency homeless shelters
- Short-term care coordination and case management
- Coordination and collaboration with other providers to include psychiatric hospitals and other fee-for-service (FFS) providers.

Homeless Outreach Workers (HOWs) respond to community requests, as directed by their COR. HOWs will be notified of any known environmental safety hazards at the time of the initial referral and program shall notify COR of any safety concerns identified during outreach. Program shall develop policies and procedures for Outreach Safety in the community. Programs are required to complete a follow up report for COR requested HOW outreach services. For an overview of the HOW services model and documentation requirements, see County Technical Resource Library.

Homeless Funds
Homeless incidental funds are used for client-related needs including food, clothing, transportation, and other incidentals necessary for accessing ongoing benefits.