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 provided by TRC's 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, 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.

Prevention Services & Specialty Populations

San Diego County's substance use prevention strategy primarily utilizes environmental prevention, a federally approved community-change model to prevent substance use problems throughout the region. Providing a targeted focus on these issues allows the County to develop long term, strategic, cost effective and sustainable prevention plans for each initiative, provides coordination and shared resources where possible, and provides flexible prioritization in each region regarding how each initiative will be tailored to

individual community needs.

Primary Prevention
Since the inception of the San Diego County Prevention Framework in 1997, the County has initiated regional substance use disorder prevention initiatives aligned with the County of San Diego's Strategic Initiatives:

- Binge and Underage Drinking Initiative (1996)
- Marijuana Initiative (2005)
- San Diego County Substance Use and Overdose Prevention Task Force (2022)

In 2022, the Methamphetamine Strike Force and the Prescription Drug Abuse Task Force were combined to form the San Diego County Substance Use and Overdose Prevention Task Force.

Each of the County substance use prevention initiatives has a subject matter expert facilitator who provides leadership and expertise on the specific initiative's, goals and work plans, and actively engages stakeholders and community throughout the region for each effort.

The County of San Diego's prevention system is implemented through a broad array of contracted community-based prevention service providers. The providers incorporate the activities of the County Prevention Plan to ensure full coordination and continuation of efforts by working together in focused workgroups for each initiative.

The San Diego Prevention system includes a substance use prevention provider located in each of the six HHSA Regions to implement the State approved County Prevention Plan.

A key component to the San Diego Prevention system is a commitment to continuous improvement and professional development in the prevention arena by working closely with the community to mitigate issues they are concerned about. As such, each prevention contract requires a designated position for a media advocacy specialist, a community organizer and a prevention specialist to ensure capacity and expertise at service delivery.

A countywide media advocacy project provides technical expertise training and facilitates a monthly media advocate's meeting to share expertise, resources and experiences conducting media advocacy efforts.

To evaluate and measure the impact of prevention services, all prevention service providers are required to work with the evaluation provider and to provide working documents to the "Prevention Information and Resource Library" (PIRL) portal, which is accessible to County SUD prevention providers. Information includes meeting agendas, sign in sheets, media advocacy calendar, notes and other relevant information. Each County Initiative has an evaluation plan designed to measure the impact of each activity and progress is reviewed annually and over time. Access to PIRL is controlled by the evaluation contractor.

Each substance use prevention provider is required to develop an implementation manual that describes how the Statement of Work (SOW) will be implemented and updated as needed.

Service for Co-Occurring Populations
San Diego County Behavioral Health Services recognizes that members who have co-occurring mental health and substance use conditions are present in all parts of the system of care. Co-occurring conditions, while common, are associated with poor outcomes and higher costs for care. It is expected that all programs be welcoming to individuals with co-occurring needs.
The MHP has adopted a treatment and recovery philosophy that promotes the integrated treatment of members with both mental health and substance use conditions, as this approach is recognized as best clinical practice. Integrated treatment coordinates substance use and mental health interventions to treat the whole person more effectively. As such, integrated care broadly refers to the process of ensuring that treatment interventions for co-occurring conditions are combined within a primary treatment relationship or service setting.

Research has generally supported that the ideal approach toward treatment for co-occurring is to address all conditions simultaneously, as opposed to addressing the substance use disorder and mental health condition separately and in a silo of separate treatment approaches. When providers have staff who possess the skills and training to adequately address the needs of the co-occurring population within their scope of practice, integrated care is best provided in-house.

For additional information on Screening and Treatment of Co-Occurring Disorders: Managing Life with Co-Occurring Disorders | SAMHSA.

Programs Serving Children, Youth & Family Services

Adolescent Services
Teen Recovery Centers (TRCs) are specialty population outpatient programs for adolescents experiencing substance use disorders. They also have the capacity to meet the needs of youth with substance use experiencing complex behavioral and mental health issues. TRCs provide substance use early intervention and treatment services for adolescents aged 12-17 and their families. Outpatient early intervention and treatment services, crisis intervention, family therapy, and peer support are offered in our urban and rural communities in each region of San Diego County. Each TRC has a main clinic, and two or more school sites to increase access and coordination with school personnel. The goals of BHS TRC services are as follows:

- Provide developmentally and culturally appropriate substance use early intervention and treatment services for adolescents throughout the County
- Increase access to care by minimizing access times to entering programs
- Increase prosocial skills and eliminate illicit and harmful substance use
- Provide co-occurring disorder treatment
- Improve capability and functioning for youth and their families
- Provide family counseling and support, including peer support
- Support the youth in becoming self-sufficient through education/employment
- Decrease justice system involvement and incidence of crime

Contracted providers are required to follow the DHCS Adolescent Best Practices Guide in developing and implementing youth treatment programs/services.

Teen Recovery Centers (TRCs) have been designed to include one TRC primary site, and at least two TRC ancillary school sites within each regionally based TRC contract. It is required that all TRC sites, both TRC primary sites and TRC school sites or ancillary sites, are DMC-certified.

DMC-certified TRC school sites are required to follow all rules, regulations, and DMC-ODS Special Terms and Conditions (STCs), to include regulations which prohibit members from receiving services at more than one DMC certified facility. This guidance, as applied to TRCs, means that a member can only be seen at the location where they were admitted, and cannot receive services at other DMC- certified sites. Although it may be convenient for a TRC to serve members at multiple locations within the TRC contract, this is not allowed.

TRC programs may encounter occasions when program staff cannot access TRC school sites due to holiday closures, summer break, and/or unique situations where the students are not allowed on campus due to disciplinary action or other reasons. To assist TRC programs with navigating these situations, BHS has provided the following guidelines:

- Members admitted to a TRC school site shall utilize that site's specific facility ID and CalOMS number for SmartCare documentation.
- Members admitted to a TRC school site may receive services at the TRC primary site, on occasion, when the TRC school site is not available due to school closures, holidays, summer breaks, or other reasons as indicated by documentation in progress note (such as school suspension or expulsion). **Group services may not be mixed with members who are admitted to the TRC primary site and the TRC school site**.
- When a service is provided to a member admitted to the TRC school site at the TRC primary site, the service location shall be documented as "in the community." As with all services that are provided in the community, documentation shall explain how program staff maintained the member's privacy in accordance with 42 CFR.
- Members admitted to TRC primary sites shall not receive services at TRC school sites, due to school/school district rules.
- If a member admitted to a TRC primary site attends a school which provides TRC school-site services and wishes to receive services at the TRC school-site, member shall be discharged from the TRC primary site as "referred" and admitted to the TRC school-site as a transfer.
- TRC ancillary sites that are not located on school campuses shall follow all guidelines listed above.

TRCs shall utilize the CRAFFT Questionnaire as a screening tool to evaluate need for treatment services or referral to early intervention services.
Additionally, it is a requirement for all DMC-ODS Teen Recovery Centers to utilize SchooLink and all required forms. SchooLink is a collaborative training program and tool kit for County-funded behavioral health providers and school staff in the County of San Diego. It provides successful strategies for linking eligible children and youth to on-campus, County-funded behavioral health services. The project launched for the 2018/2019 school year, and provides strategies and specific tools, based on best practices in the field, for a collaborative process to ensure student access to behavioral health services is used to its full capacity. Focus areas include:

- **Provider Orientation/Annual Meeting**

Setting the stage for schools and behavioral health providers to work together throughout the school year.

- **School Outreach**

Identifying and establishing school outreach strategies. Communication and connection of behavioral health staff to school staff to understand behavioral health services available on-campus.

- **Parent Outreach**

Identification of parent outreach strategies. Informing parents about on-campus behavioral health services and encourage distribution of parent brochure and educational materials.

- **Eligibility**

Informing parents/guardians of behavioral health service providers and eligibility. Describing the ways parents/guardians may access behavioral health services for their adolescent.

- **Referral and Assessment**

Creating a standardized referral process. Describing the standardized referral process and introducing the referral form and first contact procedures.

- **Treatment**

Best practices to connect adolescents with early intervention and treatment. Gain an understanding of best practices for summoning students and for sending monthly status reports via the Monthly Referral Communication Log.

- **Confidentiality**

Understanding confidentiality standards and limitations. Strategies for how behavioral health providers can respond within confidentiality limitations when school staff express caring and concern about how a student is responding to treatment.

- **Suicide/Self-Harm Procedures**

Understanding roles and responsibilities when responding to suicide risk or evidence of self-harm.
Clarifying that the Principal or designee takes responsibility for response to suicide/self-harm concerns and that the behavioral health provider follows school policy.

- **Special Education**

Understanding how to assist parents who inquire about special education services.
Best practices for behavioral health staff to respond to parent questions related to special education resources.

Perinatal Services for Women & Girls

Women and adolescents who are pregnant and/or parenting, and women seeking gender-specific services, with substance use and/or co-occurring disorders may receive SUD services through the Perinatal Services Network. Health and safety of both the mother and her child/children are key. The following are essential service elements:

- Outreach and engagement
- Screening and assessment
- Trauma Informed, gender specific, and culturally competent treatment
- Medications for Addiction Treatment (MAT)
- Withdrawal Management in outpatient and residential settings
- On-site licensed child care in accordance with child care licensing requirements, or on-site, license-exempt child care through a cooperative arrangement (aligned with DHCS Perinatal Practice Guidelines, page 20). Partnership with local licensed child care facilities for off-site provision of child care requires COR approval.
- Evidence-based parenting curriculum, such as Incredible Years
- Vocational training and job-finding assistance

- Transportation for pregnant and parenting women and their children
- Housing support for enrolled women and their children, including Community Support Services through the Managed Care Plan (MCP), such as Transitional Rent Services, and temporary housing through Recovery Residences
- Registered/certified SUD counselors and licensed/license-eligible License Practitioners of the Healing Arts (LPHA)
- Assessment and therapeutic interventions, arranged or provided to address developmental and behavioral needs of children in the custody of women in treatment
- Age- and developmentally-appropriate SUD treatment services for pregnant and/or parenting girls ages 15 and older
- Dependency Drug Court services, including screening and referral to treatment, care coordination, and supportive services

In accordance with SUBG requirements, all SUD treatment providers must treat the family as a unit and admit both women and their child(ren) into treatment services, if appropriate. Treatment providers must serve the following individuals with a SUD.

- Women who are pregnant.
- Women with dependent children.
- Women attempting to regain custody of their children.
- Postpartum women and their children.
- Women with substance exposed infants.

Additionally, SUD providers offering services funded by DMC or DMC-ODS shall address specific treatment and recovery needs of pregnant and parenting women.

The postpartum coverage period for individuals receiving postpartum care services begins after the last day of pregnancy through the last day of the month in which the 365th day occurs. Individuals will maintain coverage through their pregnancy and the 12-month postpartum coverage period regardless of income changes, citizenship, immigration status, or how the pregnancy ends. Questions concerning the postpartum coverage period should be sent to Pregnancy@dhcs.ca.gov.

It is required that SUD providers serving women shall provide preference to pregnant women with access to more urgent treatment services due to the harmful effects of substance use on the fetus. Specifically, priority must be given to pregnant women who are seeking or referred to treatment in the following order:

- Pregnant injecting drug users
- Pregnant substance users
- Injection drug users
- All others

In addition, SUD treatment and recovery services provided to women who are pregnant and/or parenting need to be cognizant of the stigma that is often directed toward this population for use of substances, which can be a barrier to seeking services and to full disclosure of substance use behavior, including relapse, due to fear of negative consequences.

Additional information regarding perinatal service delivery requirements, best practices, capacity management, and recovery support may be found in the Perinatal Practice Guidelines.

Incredible Families

The Incredible Families Program (IFP) was designed to consolidate needed services and improve outcomes for children and their families involved with Child Welfare Services (CWS), in three (3) service areas of San Diego County: 1) Central/North Central regions, 2) East/South regions and 3) North Coastal/North Inland regions. Utilizing proven methods from the evidence-based Incredible Years model, the goal of the program is safe and successful family reunification (for families of children in foster care), improved family functioning, and improved mental health functioning for referred children.

The target population includes children ages 2-14, who meet medical necessity diagnostic and impairment criteria in accordance with California Code of Regulations Title 9 and who are dependents of Juvenile Dependency Court due to abuse and/or neglect, and their families. Most of the participating children reside in foster homes, with a smaller portion residing with relatives and/or parents under CWS supervision. In order for these families to safely reunify, parenting skills education, consistent and meaningful family visitation and mental health treatment are typically among the most critical (and often court-ordered) service needs. In collaboration with CWS and Behavioral Health Services, Programs Serving Children, Youth & Families, the Incredible Families Program seeks to combine these elements under one organizational umbrella, with one primary clinician assigned to each family, thus providing maximum efficiency and effectiveness for the families as well as the supervising CWS worker.

Specific service components include a weekly multi-family parent-child visitation event and meal for all family members. Immediately following the family visitation, a 15-week parenting group, utilizing the Incredible Years evidenced-based curriculum, is provided to parents. Their children, ages 2 to 14 are provided a full range of Title 9 outpatient-based services as an entitled Medi-Cal member. Services are focused on alleviating trauma and strengthening parent-child relationships. Evidence-based therapeutic interventions offered include Trauma Focused Cognitive Behavioral Therapy (TF-CBT) and Eye-Movement De-sensitization and Reprocessing (EMDR.) Additional interventions will include clinical support and facilitation of visitation events and individual therapeutic contacts with parents to address specific problems and further support their attainment of effective parenting skills.

A primary therapist is assigned to each family and is responsible for implementing all program components: Parent group, clinical support during family visitation events and individual/family therapy. All family members (parents and children) are also assessed and referred for additionally needed services, including further mental health treatment, substance use disorder services, and if needed, ancillary services. The primary therapist will be responsible for documenting all services in the electronic health record.

Credentials

- All IF staff must attend a three-day Incredible Years parenting training session
- Therapists are to be licensed or registered associates working toward their licensure
- Therapists are also required to attend ongoing Trauma Focused trainings
- Parent Partners attend Youth and Family Roundtable

Dependency Drug Court SUD Coordination (DDCSC)

The Dependency Drug Court SUD Coordination (DDCSC) program provides screening and referral for substance use treatment, care coordination, and support to families that are involved with Child and Family Well-Being (CFWB). Substance Use Specialists (SUS) collaborate with the Juvenile Dependency Courts within the County of San Diego Superior Court. The role of the SUS is to provide support and

coordination between the member, the SUD treatment program, Courts, and CFWB, and to give updates to the Court on the member's status/progress in treatment.

Services for Children of Parents Receiving SUD Services

The Perinatal Outpatient and Residential treatment programs utilize licensed/license-eligible mental health clinicians to work directly with the children of mothers receiving SUD services to:

- Screen children to determine need for mental health services, to include but not limited to, parent-child bonding
- Provide assessment and therapeutic interventions for children screened to have emotional, developmental, behavioral, attachment needs and/or trauma history
- Identify and link children with higher level needs to specialty behavioral health services
- Collaborate with County-designated contractors offering therapeutic services for children, to include but not limited to, Healthy Development Services (HDS) and Developmental Screening and Enhancement Program (DSEP)

Justice-Involved SUD Services

For many people in need of alcohol and drug services, contact with the criminal justice system is their first opportunity for treatment. Outlined below are specific requirements for providers to follow and utilize in serving the specific needs of this population. Note: Providers will not be reimbursed for report writing.

PC 1210/Prop 36

Providers who receive members referred to SUD services by the Court under PC 1210/Prop 36, shall provide reports and communication to the Court regarding member treatment status as directed by Program COR.

Community Resource Directory (CRD)

The Probation Department Community Resource Directory (CRD) is a web-based catalog of countywide services to which adults and youth can be referred. It assists in linking individuals on probation to appropriate community-based intervention services based on the individual's assessed needs. Service providers receive probation referrals through the CRD and utilize the CRD as a mechanism to report back to probation officers on an individual's progress toward meeting their program goals.

As directed by COR, Contractor shall enroll in and utilize the CRD to include referral management and weekly status updates, as one route to work closely with the case-carrying Probation Officer.

Communication with Probation

Program staff shall contact Probation within 24 hours whenever noteworthy incidents arise involving a member on probation. These noteworthy incidents include but are not limited to: Program enrollment/exit; violent behavior; positive urinalysis results; law enforcement contact; change in program location; and critical incidents, such as death or hospitalization of a member. Providers shall work closely with and be available to meet monthly or as agreed upon with case carrying Probation Officers to discuss member progress in treatment. Communication with Probation shall be documented in

the member's treatment record. Contractors shall provide pertinent treatment information received from Recovery Residences, Independent Living Homes, or Board and Care Facilities to the assigned case-carrying Probation Officer to include providing information about noteworthy incidents within 24 hours of receiving the information. Providers shall be available to meet quarterly with Probation representatives to discuss systemic improvements and collaboration. Providers shall return emails and phone calls from Probation staff within two (2) business days.

Correctional Program Checklist (CPC)
As directed by COR, Contractor will fully participate in the Corrections Program Checklist (CPC) to improve treatment quality for members who are assessed to be moderate to high risk for recidivism. Additional information regarding the CPC is found in the Technical Resource Library.

High Risk Services
As directed by COR, contractor shall utilize criminogenic risk and need assessment results (i.e. COMPAS) to inform individualized treatment planning and to develop specific "treatment tracks" for members who are assessed at medium to high criminogenic risk. These treatment tracks will include evidence base practices with a target of reducing recidivism as a focus of treatment.

Criminal Offender Record Information (CORI)
Please refer to the Staffing and Training Section.

Justice Overrides
While in residential treatment, members on "justice overrides" may be allowed to hold a job and/or receive vocational activity in lieu of a structured activity. The vocational activities may replace "program structure activity hours" but minimums of 3.1 clinical hours would still be in place. County recommends members to be referred to programs directly whenever possible.

- Provider would need to utilize a DMC-billable cost center when a court-ordered members is a Medi-Cal member, meets the Program LOC, and is opened to the Program.
- Provider would need to utilize a County-billable cost center to claim the cost of screening a court-ordered member but not opened to the Program and/or the member is opened to the program but is not a Medi-Cal member.

County of San Diego Justice-Related SUD Programs

Driving Under the Influence (DUI) Programs
The Driving Under the Influence (DUI) programs are licensed by the California Department of Health Care Services and administered locally by BHS. Services are designed to meet the requirements of the Department of Motor Vehicles (DMV) and courts as stipulated for individuals who have been arrested for driving under the influence. Available services include: 3, 6, 9, 12, and 18-month programs and education only. This program is completely funded by participant fees. Spanish services are available at all locations. All facilities are wheelchair accessible.

Penal Code Section 1000 (PC 1000)
California Penal Code Section 1000 (PC 1000) establishes the authority for counties to create drug diversion programs for eligible participants who are referred from a court. A referral will be made to a County certified PC 1000 Drug Diversion program when a participant is eligible and suitable for the PC

1000 program. Persons who have a need for Substance Use Disorder (SUD) treatment, and who have private insurance, will be referred to their healthcare provider. The criminal charge is dismissed, pursuant to statute, if the participant successfully completes the program and complies with the conditions established by the court.

PC 1000 Two-Track Drug Diversion Program is intended to provide participants with either education on substance use or treatment for a diagnosed substance use disorder (SUD). The Drug Medi-Cal Organized Delivery System, and changes in state law, bring about the following changes to providers: 1) elimination of the AIDS education component, 2) maintenance of the education track, and 3) addition of a treatment track. The education track will continue at the existing sites, and on September 1, 2019, the new treatment track will be available at the six Regional Recovery Centers. All participants will be assessed SUD need through the American Society for Addiction Medicine (ASAM) criteria. If participant is assessed as having a need for treatment, they will only participate in the treatment track. Please see Appendix C.1 for service and program requirements, including communication with court requirements.

Drug Court and Re-entry Court

Drug Court Programs shall establish and maintain a program to provide non-residential substance use disorders (SUD) treatment and testing program services to serve non-violent adult male and female offenders who have been referred to Adult Drug Court. Members of the Adult Drug Court Team, which include the Adult Drug Court Judge, District Attorney, law enforcement, Public Defender, and Programs, shall participate in case conferencing and Adult Drug Court sessions.

Indian Health Care Providers

The county shall not disallow reimbursement for clinically appropriate and covered SUD prevention, screening, assessment, and treatment services due to lack of inclusion in an individual treatment plan, or lack of member signature on the treatment plan.

- Members can receive Traditional health care services while in residential or inpatient
- Regarding residential treatment, services can be provided in facilities of any size.
- The two new service types that may be provided include: Traditional Healer and Natural Helper Services. For additional detail on these service types, please see BHIN 25-036.
- Details regarding opt-in templates for participating providers, additional SUD services available, and Indian Health Care Programs and approved IHCPs can be found in BHIN 25-036.For questions related to traditional health care practices or BHIN 25-036, please email: traditionalhealing@dhcs.ca.gov.

American Indian and Alaska Native individuals who are eligible for Medicaid and reside in counties that have opted into the DMC-ODS can also receive DMC-ODS services through Indian Health Care Providers (IHCPs). IHCPs include:

- Indian Health Service (IHS) facilities
- Tribal 638 Providers - Tribal 638 providers enrolled in Medi-Cal as a Tribal FQHC must appear on the "List of Tribal Federally Qualified Health Center Providers"
- Urban Indian Organizations (UIO)

All American Indian and Alaska Native (AI/AN) Medi-Cal members whose county of responsibility is a DMC-ODS county may choose to receive DMC-ODS services at any DMC-certified IHCP, whether or not the IHCP has a current contract with the member's county of responsibility and whether or not the IHCP is located in the member's county of responsibility.

DMC-ODS counties:

- must reimburse DMC-certified IHCPs for the provision of these services to AI/AN Medi-Cal members, even if the DMC-ODS county does not have a contract with the IHCP.
- are not obligated to pay for services provided to non-AI/AN members by IHCPs that are not contracted with the DMC-ODS county.
- must adhere to all 42 CFR 438.14 requirements.
- select the DMC-certified providers with whom they contract to establish their DMC-ODS provider networks, with the exception of IHCPs.

Note: American Indian/Alaska Native (AI/AN) MC members can request DMC services from an AI/AN provider of their choice. Non-AI/AN programs shall assist members with these requests, with a warm hand-off by using the IHCP Referral Resource posted on the Optum website under the IHCP tab/IHCP resources. https://www.optumsandiego.com/content/dam/san-diego/documents/dmc-ods/toolbox/IHCP_Referral_Resource.pdf.

BHIN 25-013, Section III-f highlights that County Behavior Health Plans (BHP) and DMC-ODS shall demonstrate compliance with federal regulations addressing protections for American Indians and American Indian Health Services provided within a managed care system (42 CFR Part 438.14).

Indian Health Care Providers are not required to contract with BHP/DMC-ODS counties; however, shall document good-faith efforts to contract with all IHCPs in the BHP's County. If County BHP/DMC-ODS has a valid contract with an IHCP, the BHP/DMC-ODS County shall submit a copy of the contract with their annual submission and complete the MHP/DMC-ODS 274 data fields corresponding with IHCP. If the County BHP/DMC-ODS does not have a contract with any of the IHCPs in the County, County BHP/DMC-ODS shall submit to DHCS an attestation on county letterhead including an explanation to DHCS to justify the absence of an IHCP in the BHP/DMC-ODS' provider network, along with supporting documentation. If a BHP/DMC-ODS County is unable to contract with an IHCP, County BHP/DMC-ODS must allow eligible Members to obtain services from out-of-network IHCP in accordance with 42 CFR section 438.14. DHCS will review the BHP/DMC-ODS submission to determine compliance.

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, 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 relapse or 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.